STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535034	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westward Heights Care Center	150 Caring Way Lander, WY 82520

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50665 Based on medical record review, staff interview, facility incident review, and policy and procedure review, the facility failed protect the resident's right to be free from physical abuse by another resident for 1 of 3 sample residents (#2). Corrective measures were implemented prior to the survey and compliance was determined to be met on 8/9/24. The findings were: 1.Review of the quarterly MDS assessment dated [DATE] showed resident #2 had a BIMS score of 5 out of 15, indicating severe cognitive impairment, had diagnoses which included non-Alzheimer's dementia, and did not exhibit behaviors. Review of the admission MDS assessment dated [DATE] showed resident #3 had a BIMS score of 9 out of 15, indicating moderate cognitive impairment, had diagnoses which included non-Alzheimer's dementia, and did not exhibit behaviors. The following concerns were identified: a. Review of an incident report dated 7/20/24 and timed 5 PM showed both resident #2 and #3 were in the dining room when resident #3 was seen rubbing resident #2's shoulder. Resident #3 then put his/her hand in resident #2's groin area. Resident #2 and #3 were separated at the time of the incident. b. Interview with CNA #1 on 12/27/24 at 12:05 PM revealed s/he witnessed resident #3 massaging resident #2' s groin area outside his/her pants. The CNA revealed resident #3 was immediately redirected and separated from resident #2. The CNA stated the residents didn't know what happened, they both have dementia. The CNA stated resident #2 showed no changes in demeanor following the incident. c. Interview with RN #2 on 12/27/24 at 2 PM with revealed s/he did not witness the incident but was made aware of it by CNA #1 immediately after it happened. The RN revealed s/he followed the facility policy and procedure for reporting abuse which included notifying the social services director. RN #1 confirmed resident #2 and #3 were separated and resident #3 was placed on increased supervision. RN #1 revealed no effects were noted after the incident but it's hard to tell with dementia. 2.Review of the Resident Rights provided on admission and last revised 05/19 showed .Restraint and Abuse, your right to be free from abuse and neglect . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.Review of the facility's policy titled Abuse and Neglect Prevention Standard, last revised 1/23 showed .the resident has the right to be free from abuse . The definition of sexual abuse was .non-consensual sexual contact of any type with a resident . The definition of sexual abuse included .capacity and consent-residents have the right to engage in consensual sexual activity, however anytime the facility has a reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility must take steps to ensure that the resident is protected from abuse . 4.The following corrective action was implemented on 8/9/24 and verified during the survey: a. Resident #3 was monitored with increased supervision. b. Daily behavioral/intervention flow record was implemented for resident #3 until discharge from the facility on 8/9/24. c. New focus area with interventions was initiated in care plan on 7/25/24 for resident #3 to include out of character responses (sexual desires) due to dementia. Interventions included redirecting behaviors and providing male caregiver. d. Facility initiated assistance on 7/22/24 to family with helping find a memory care center for transfer. e. Abuse and neglect drill was performed 8/1/2024 and included summary of drill, improvement needed/actions taken and trends noted. f. Abuse and neglect education was provided at all staff meeting on 8/15/24. g. Safety fair on 11/14/24 for all staff included abuse and neglect training. h. Quality Assurance and Performance Improvement (QAPI) report included monthly abuse and neglect monitoring with trends and actions taken.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 50665 Based on medical record review, staff interview, and review of incident and facility documentation the facility failed to provide care in accordance with physician's orders and professional standards of practice for 1 of 3 residents (#1) with change in condition including resident #1. The facility had implemented corrective action prior to the survey and was determined to be in substantial compliance as of 11/19/24. The following concerns were identified: 1. Review of complaint/grievance report dated 11/13/24 showed resident #1 did not get transported to an appointment after it was ordered by the physician. 2. Medical record review showed resident #1 had a physician's order for an x-ray of his/her hip dated 10/26/24. On 11/8/24 the nurse attempted to have facility scheduler transport the resident for the x-ray; however, the scheduler was unable to take the resident until 11/11/24. Further review showed the resident received hip x-ray on 11/13/24, 5 days after it was ordered. 2. Interview with the social services staff member #4 on 12/30/24 at 11 AM revealed the delay in time of order and when x-ray done was due to facility miscommunication with scheduler and transportation. 3. Interview with the administrator on 12/27/24 at 12:40 PM confirmed the delay in completion of the treatment was due to facility miscommunication and transportation issues. 4.The facility implemented the following corrective action by 11/19/24 a. Inservice documentation on 11/18/24 revealed meeting with scheduling manager and DON regarding communication and transportation. b. Inservice documentation on 11/19/2024 revealed meeting with nursing staff regarding resident care management in regards to appointments and transportation process. c. QAPI report indicated issues with the timely appointment in trends and current actions taken as well as future intervention.