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	05/22/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident representative, hospital staff, and staff interview, the facility failed to ensure residents were allowed to return following acute hospitalization for 1 of 4 sample residents (#1) reviewed for transfer and discharge. The findings were: 1. Review of a discharge MDS assessment dated [DATE] showed resident #1 admitted to the facility on [DATE] and had an unplanned hospital discharge return not anticipated on 4/10/26. Review of progress notes dated 4/10/26 and timed 7:50 AM, 8/24 AM, and 1:01 PM showed at approximately 6 am the resident had increased agitation with behaviors. Further review showed the resident had an elevated blood glucose, was administered insulin per a sliding scale, and was transferred via EMS for evaluation and treatment. The following concerns were identified:a. Review of a progress note dated 4/10/26 and timed 1:28 showed LATE ENTRY Note Text: IDT team met with Westward Height's management company. That meeting included Director of Facility Operations, Director of Clinical Services, Social Worker, and Director of Revenue Services. Given the background of situation and current status of theresident [sic], the team discission was to issue an involuntary discharge notice d/t: The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; and it is necessary for resident's welfare, and [his/her] needs cannot be met in the facility. Call was then placed to ER to notify of immediate discharge of facility at 11:17 AM. ER supervisor [Name] stated that resident did not qualify for admission or psych stay stating denying suicidal or homicidal ideation. Call then placed to [name] state ombudsmen to notify of situation. Ombudsmen recommended placement at a psychiatric skilled nursing facility in Utah that has had good results in the past for a similar situation. IDT placed call to Utah facility called [Name of facility] in SLC. They stated they have open beds at this time and information given to provide referral via fax. Call then placed by IDT team back to ER director, the information was passed to ER director for [Name of facility] information. ER director stated that no case management was in ER, it was not her responsibility to send the referral, and the ER is not able to send referrals. Then IDT placed phone call to [name], the resident's [spouse] notifying [him/her] of [Name of facility] aspotential [sic] option for safe placement. [Spouse] was also notified of involuntary discharge d/t [due to] level of care and safety and health of the individual in facility due from the Administrator and IDT team. [Spouse] was in agreement with no return to Westward Heights d/t concerns listed above that [Name of facility] would be a better fit for [him/her] right now. [Spouse] was going to make [his/her] way to the hospital and discuss this with ER staff. [Spouse] then called IDT team back and stated ER was ready to discharge [him/her] and [s/he]was [sic] ready for pickup and please coordinate with hospital in regard to plan moving forward. [Spouse] did state at this time that [s/he] was willing to help with anything that needed to be coordinated but would be unable to provide facility with any 1:1 resident support needed for [his/her] return. IDT then called to discuss with management company and give update on current situation. Management company re-irritated to IDT that it was unsafe to take resident back d/t suicidal ideation and safety and health of individuals in the facility. Nurse manager then called IDT team back again and stated resident discharged from ER and WHCC staff needed to (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	work on transport. IDT team then again re-iterated involuntary discharge was issued and was no longer a resident effectiveimmediately [sic] on 4/10/26 d/t health and well being [sic] of others and suicidal ideation. IDT then placed a phone call to Westward Height's Medical Director to notify of situation at hand. Medical Director in agreement with discharge of resident. She placedcall [sic] to ER and discussed the situation with the ER. ER provider refused to speak with Westward Height's Medical Director. Medical Director spoke with the nurse manager explaining the discharge and asked questions regarding the psych evaluation. Medical Director returned call to DON and notified DON that she was waiting on call from psychiatrist to discuss the severity of resident's mental health. After Medical Director spoke with psychiatrist at hospital, he was in agreement to make an addendumto [sic] his recommendation that [s/he] was unsafe to return to WHCC and required placement in memory care. [Name], the ER nurse manager then called facility and asked IDT if they have received records in attempt again to make arrangements for transport, IDT team re-iterated again that involuntary notice has been issued and [s/he] is no longer a resident of this facility. The nurse manager then asked if family had been notified. IDT was able to confirm that family was also notified of discharge. [Name] then informed IDT that [s/he] would be discharged from ER and would need to return home with family. [Name] [spouse] then placed phone call to IDT team stating the hospital was discharging [him/her] with an unsafe plan and he was unable to care for [him/her] at home. IDT team then againexplained [sic] that we could not accept back due to safety of individual and the safety of all residents in facility. Following this phone call Social Services called [Name of facility] in SLC and asked if we could send a referral on behalf of hospital. [Name] at [Name of facility] reviewed referral however, did recommend WHCC excuse themselves from referral process as it needs to come from the hospital. Call then placed to [spouse] to notify [him/her] of referral was placed to [name of facility]. [Name]was appreciative of this call and had since calmed down from previous conversation and stated the hospital admitted her since he is unable to care for her at his home. DON then placed a phone call to primary care provider to be aware of situation. Primary care stated he has talked with ER and agreed that [Name of facility] would be in [his/her] best option for a transition. Provider was thankful for phone called placed with no further questions or concerns.b. Review of a Social Services Transfer/Discharge Plan and Notice to Resident dated 4/13/26 and timed 9:30 AM showed the resident was transferred on 4/10/26 to the hospital, and the reason for transfer was Suicidal ideation/ combative. Further review showed the notice was provided to the resident/representative by mail on 4/13/26.c. Review of a hospital Psychiatry [NAME] Note dated 4/10/26 and timed 10:21 AM showed .Discussed treatment options with the patient. The patient does not need inpatient psychiatric treatment at this time. [S/he] can be discharged if [s/he] is medically stable.d. Review of an addendum to hospital Psychiatry [NAME] Note dated 4/10/26 and timed 3:21 PM showed [His/her] current facility does not want to accept [him/her] because of [his/her] recent behavioral changes. They do not feel safe to keep [him/her]. The patient is unable to take care of [him/herself]. [S/he] will not be safe to be discharged without any placement. At this time I recommend to transfer [him/her] to a memory care unit .e. Review of a hospital note dated 4/11/26 showed .Patient with dementia that has been somewhat increased since [s/he] had changed blood pressure medications about a week ago and [s/he] has had some increased confusion. [S/he] had been sent up here from the nursing home and they would NOT take [him/her] back and discharged [him/her] from their facility declining to allow [him/her] back into their facility today. The ER had done a workup and planned to send [him/her] back however they would not take [him/her]. Administration here was notified and request to me to place patient in hospital. Patient will be placed in the hospital with supportive care. Ordered a one-to-one staff. Working on getting the patient to facility that will be most supportive for [him/her] with memory Care ideally. Will work on controlling [his/her] anxiety as well here. [S/he] was seen by tele psychiatry has [sic] it was reported from the facility that [s/he] was suicidal however [s/he] has not been suicidal at all and the psychiatrist did not feel like [s/he] was suicidal .f. Review of the hospital notes showed the resident received (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1-to-1 from hospital staff on 4/10/26 and 4/11/26, and had been removed from 1-to-1 on 4/12/26 at 7:15 AM.g. Review of a hospital note dated 4/15/26 and timed 5:24 AM showed .No new issues reported overnight. Patient overall does not have any specific new complaints or problems. [S/he] is calm and pleasant this morning.h. Review of a hospital note dated 4/16/26 and timed 5:58 AM showed .Patient slept well overnight. There are no new issues reported. [S/he] is calm and pleasant.i. Review of a hospital note dated 4/17/26 and timed 10:14 AM showed .pt very chatty today, a little stream of conscious. pleasant .waiting on placement.m. Review of a hospital Discharge summary dated [DATE] and timed 12:52 PM showed .1. Dementia, w overlying acute metabolic encephalopathy likely due to acute respiratory infection, possible clonidine use. Reportedly worsening dementia. Possibly in part due to recent initiation of clonidine contributing, though appears may have been longer in history. UA and other workup for other causes of worsened dementia were negative. [S/he] had been sent up here from the nursing home and they would NOT take [him/her] back and discharged [him/her] from their facility - declining to allow [him/her] back into their facility.[His/her] mental status after being taken off Clonidine has seemed to have improved some.Has been appropriate and cooperative here. Per family did have improvement in the acute confusion and seemed back to [his/her] baseline.j. Interview with the resident's representative on 5/19/26 at 2:42 PM revealed the resident had been on a 1-to-1 at the hospital for 24 hours, and had stabilized within a day after medication changes had been made. Further interview revealed the resident had been moved to a long term care facility 2 and a half hours away, and did not require memory care.k. Interview hospital staff #1 on 5/19/26 at 3:14 PM revealed facility staff did not reassess the resident at the hospital.l. Interview with the NHA and DON on 5/20/26 at 10 AM revealed the facility could not provide mental health services or 1-to-1 supervision for the resident, and an emergent discharge had been issued for the resident's safety and the safety of other residents in the facility based on his/her behaviors at the time of discharge. Further interview confirmed the resident had not been assessed because s/he had already been discharged as a resident from the facility.m. Interview with the DON on 5/20/26 at 1:14 PM revealed the resident had been provided with a 1-to-1 on for approximately 1 1/2 hours prior to being discharged to the hospital. Further interview revealed the resident had never been involved in any resident-to-resident altercations.