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	03/27/2025

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure a gradual dose reduction was performed for 1 of 5 sample residents (#28) reviewed for unnecessary medications. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #28 had a brief interview for mental status score of 14 out 15, which indicated s/he was cognitively intact, and diagnoses which included end-stage renal disease and insomnia. Further review showed the resident used antidepressant medications during the look-back period. Review of the resident's physician orders showed s/he received trazodone (antidepressant) 50 mg by mouth at bedtime related to insomnia which was ordered on 7/21/23. The following concerns were identified: a. Review of the treatment administration records for January, February, and March 2025 showed the facility was monitoring the resident for restlessness at night and there were no documented episodes of restlessness indicated. b. Review of a Consultation Report dated January 1, 2025 through January 18, 2025 showed the pharmacist recommended to .Please attempt a gradual dose reduction (GDR) to 25 mg qhs (every day at hours of sleep). If you do not wish to decrease, please document risk vs. benefit of continuing Trazadone . The review showed the physician declined the recommendation because a GDR was Clinically Contraindicated for the resident and checked the box for the resident's target symptoms returned or worsened after the most recent GDR attempt within the facility and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder as documented below. Further review showed there was no additional or resident specific information documented below. c. Review of a Consultation Report dated May 20, 2024 through May 22, 2024 showed the pharmacist recommended If clinically appropriate, please consider a gradual dose reduction (GDR) to trazadone 25 mg daily, while concurrently monitoring for reemergence of target and withdrawal symptoms. The review showed the physician declined and checked the box that stated Continued use is in accordance with the current standard of practice and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating and underlying medical condition or psychiatric disorder AS DOCUMENTED BELOW . Further review showed the physician wrote [S/he] is able to sleep with trazadone. (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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	535034	A. Building B. Wing	03/27/2025

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Review of a Consultation Report dated January 29, 2024 through January 30, 2024 showed the pharmacist recommended If clinically appropriate, please consider a gradual dose reduction (GDR) to trazadone 25 mg daily, while concurrently monitoring for reemergence of target and withdrawal symptoms. The review showed the physician declined and checked the box that stated Continued use is in accordance with the current standard of practice and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating and underlying medical condition or psychiatric disorder AS DOCUMENTED BELOW . Further review showed there was no additional or resident specific information documented below. 2. Interview with the DON on 3/27/25 at 10:22 AM revealed the resident #28 previously had a successful gradual dose reduction attempted and she was unable to find any unsuccessful attempts. In addition, she was unable to locate where the physician provided additional resident specific information for the need of the medication. 3. Review of the facility policy titled Psychoactive Medication and Medication Regimen Review Management Standard dated 9.2024 showed .5. Gradual Dose Reduction/Tapering of Medications: The requirements underlying this guidance emphasize the importance of seeking an appropriate dose and duration for each medication and minimizing the risk of adverse consequences, The purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying cases of the original symptoms have resolved, and/or non-pharmacological interventions, including behavioral interventions, have been effective in reducing symptoms .

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 35081 Based on observation, staff interview, and policy and procedure review, the facility failed to ensure infection prevention practices were implemented during meal delivery and assistance during 2 of 3 meal observations in the main dining room. The census was 56. The findings were: 1. Observation on 3/24/25 beginning at 5:43 PM showed CNA #1 was assisting a resident to eat dinner. The CNA was observed touching the resident's shoulder, arm, and wheelchair wheel while assisting the resident. Without performing hand hygiene, the CNA moved around the table and was observed placing her ungloved hand on top of another resident's hamburger and using her other hand to cut the hamburger in half. After it was cut, the CNA picked up half the hamburger, using both hands, and handed it to the resident, which the resident ate. The CNA then used her ungloved hand to pick up a French fry, dip it in ketchup, and hand it to the resident, which s/he ate. The CNA again picked up the resident's hamburger and handed it to the resident before standing from the table at washing her hands at the sink in the dining room. 2. Observation on 3/26/25 beginning at 12:04 PM showed CNA #1 assisted a resident by cutting his/her food and then touched the resident's shirt. The CNA left the table and obtained another plate at the kitchen window and took it to a 2nd resident, where she cut up the food using his/her silverware. The CNA placed her hand into her hair then obtained another plate from the kitchen window and delivered it to a 3rd resident. While delivering the meal tray, the CNA touched the resident's wheelchair before returning to the kitchen window to obtain another tray and delivering it to a 4th resident. No hand hygiene was performed during the observation. 3. Interview with the DON, infection preventionist, and dietary director on 3/27/25 at 9:48 AM revealed hand hygiene should occur during meal service between residents if resident contact occurred. They confirmed the CNA should perform hand hygiene before assisting a second resident and they would like staff to wear gloves if they are touching the resident's food items. Further interview revealed they expected hand hygiene to be performed after touching potentially contaminated items. 4. Review of a facility procedure titled . Hand Hygiene Competency dated 12.2019 showed .When to wash hands .Before each resident contact .After touching a resident or handling their belongings .After handling contaminated items (linens/garbage/briefs, etc.) .When can hand sanitizer be used .Before/after direct contact with resident .After contact with resident's intact skin .After contact with inanimate objects, such as medical equipment in resident's room or vicinity .