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 _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	**150 CARING WAY LANDER, WY 82520**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 12/26/2024 to 01/14/2025. The survey was prompted by complaint intake WY00003909, WY00003948, WY00004052,WY00004073, WY00004074,WY00004076, WY00004096, and WY00004136. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant RN: Registered Nurse BIMS: Brief Interview for Mental Status Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		

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

Electronically Signed | 02/07/2025

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F 600	Continued From page 1 by: 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 7/29/24 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 7/2/24 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	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

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..."

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

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F 600	Continued From page 3 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.	F 600		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: 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	F 684	Past noncompliance: no plan of correction required.	

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F 684	Continued From page 4	F 684		

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

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F 684	Continued From page 5 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.	F 684		