STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Weston County Health Services	**1124 Washington Blvd , Newcastle, Wyoming, 82701**

(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
F0000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 12/8/25 through 12/11/25. Also reviewed in the course of the survey were complaint intakes #2565563, #2658579, and #2669141. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set MAR: Medication Administration Record RN: Registered Nurse NSA: Nutrition Support Aide Less commonly used abbreviations will be annotated in each deficiency.	F0000		12/22/2025
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure call lights were placed within residents' reach to accommodate resident needs for 1 of 19 sample residents (#45) reviewed. 1. Review of the quarterly MDS assessment dated 10/13/25 showed resident #45 had a BIMS score of 8 out	F0558	The preparation and execution of this plan of correction is being done to comply with the requirements of federal and state laws and does not constitute an admission by the facility that any of the statements contained in this survey report or the conclusions drawn from these statements are accurate or true. 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice Immediately upon identification of the deficient practice, resident #45's call light was placed within reach by licensed nursing staff. The resident was assessed to ensure no injury or unmet needs occurred as a result of the call light not being within reach.	12/23/2025

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 reverse for further 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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F0558 SS = D	Continued from page 1 of 15, which indicated the resident was moderately impaired and had diagnoses which included, chronic pain syndrome, urinary and bowel incontinence, hemiplegia, and was dependent upon staff for functional abilities, including mobility. Review of the care plan, last revised 10/20/25, showed the resident had a morse fall score of 55, which indicated a high fall risk and required his/her call light within reach. The following concerns were identified: a. Observation on 12/9/25 at 8:22 AM showed CNA #1 and CNA #2 provided cares for the resident. The resident's breakfast tray was given to him/her and s/he was asked to call when finished with his/her breakfast. The resident's call light was observed on the floor, beside the bed, at that time. b. Observation on 12/9/25 at 8:43 AM showed CNA #1 returned to the resident's room, then left, and the call light remained on the floor. c. Observation on 12/9/25 at 9:20 AM showed LPN #1 entered the resident's room and handed the resident his/her call light. Interview with LPN #1 at that time revealed the resident's call light was on the floor when she entered the room and she placed it within the resident’s reach. d. Interview on 12/11/25 at 11:50 AM with CNA #1 revealed the resident's call light should have been operable and left within resident reach. e. Interview with the DON on 12/11/25 at 11:34 AM confirmed staff were expected to provide residents with their call light and ensure it was within reach.	F0558	Continued from page 1 The resident’s care plan was reviewed and confirmed to reflect the requirement for the call light to remain within reach at all times due to high fall risk and functional dependence. All nursing staff involved were counseled and re-educated on the requirement to ensure call lights are operable and within resident reach following all care interactions. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice The Nursing Care Coordinator completed a facility-wide audit of all residents to ensure call lights were present, operable, and placed within reach, with particular focus on residents with cognitive impairment, mobility limitations, and high fall risk. Any concerns identified during the audit were corrected immediately. All residents requiring call lights within reach are verified through care plan review and shift rounds. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Staff education was provided by the Administrator and Director of Nursing to all staff on resident rights, reasonable accommodations, and the importance of ensuring call lights remain within reach after all care and meal delivery. Education on call light placement was given as a required step during: Completion of resident cares Meal tray delivery and removal Shift-to-shift handoff Leadership reinforced expectations during staff meetings and shift huddles.	

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F0558 SS = D		F0558	Continued from page 2 The facility policy regarding resident safety, fall prevention, and resident rights was reviewed with staff. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur The Director of Nursing or Care Coordination Nurse will conduct random call-light placement audits on all shifts: Weekly for 4 weeks Then monthly for 3 months, and thereafter as indicated until substantial compliance is met and achieved. Audit results will be documented and reviewed during QA/QAPI meetings. Any identified noncompliance will result in immediate correction and additional staff education or corrective action as appropriate. 5. Responsible Party Director of Nursing Charge Nurses 6. Date of Compliance 12/23/2025	
F0600 SS = G	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	F0600	The preparation and execution of this plan of correction is being done to comply with the requirements of federal and state laws and does not constitute an admission by the facility that any of the statements contained in this survey report or the conclusions drawn from these statements are accurate or true. 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice	01/05/2026

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F0600 SS = G	Continued from page 3 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 by: Based on medical record review, facility incident review, resident and staff interview, and policy and procedure review, the facility failed to protect the resident's right to be free from physical abuse by a resident for 1 of 6 sample residents (#50) reviewed for abuse. This failure resulted in actual physical harm to resident #50. The findings were: 1. Review of the quarterly MDS assessment dated 9/16/25 showed resident #50 had a BIMS score of 5 out of 15, which indicated severe cognitive impairment, and diagnoses which included non-traumatic brain dysfunction, non-Alzheimer's dementia, and asthma. Further review showed the resident required substantial/maximal assistance from staff to move from sitting to lying, lying to sitting, sitting to standing, and chair/bed-to-chair transfer. The following concerns were identified: a. Interview with resident #50 on 12/9/25 at 9:52 AM revealed another resident had gotten upset with him/her and grabbed resident #50 around his/her neck and twisted. b. Review of a facility incident report dated 10/26/25 and timed 11:15 AM showed a staff member was walking by resident #50's room and observed resident #16 on resident #50's side of the room. The staff member reported resident #16 appeared to be hitting resident #50's head while resident #50 was seated in his/her wheelchair. The incident report showed after the residents were separated, resident #50 had redness noted in a few areas of his/her head. Further review showed resident #50 complained of "intermittent headache" since the incident occurred. c. Review of a "Change of Condition" progress note for resident #50 dated 10/26/25 and timed 11:20 AM showed "...Physical Aggression Received This nurse was called to [resident #50]'s room following NSA [name]'s arrival to the room after hearing yelling. When this nurse arrived, [resident #50] was found seated in [his/her]	F0600	Continued from page 3 Immediately following the incident on 10/26/25, resident #50 was assessed by licensed nursing staff for injuries, including neurological assessment and vital signs. Resident #50's responsible party was notified promptly of the incident and ongoing monitoring. The aggressor resident (#16) was immediately separated and relocated to another room to eliminate further risk. Resident #50 was placed on increased monitoring and reassessed for physical injury, pain, and emotional distress. Social Services and the interdisciplinary team were involved to provide emotional support and reassurance to resident #50. Resident #50's care plan was reviewed and updated to reflect safety interventions, including environmental supervision and roommate compatibility considerations. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice The Director of Nursing, Social Services, and interdisciplinary team completed a facility-wide review to identify residents with: Cognitive impairment Behavioral symptoms History of resident-to-resident conflict or aggression All shared rooms were reviewed by the Director of Nursing, Social Worker, and Nurse Care Coordinators for compatibility and risk factors. Identified residents were reassessed, and care plans were updated as needed to include behavioral monitoring and safety interventions. 3. What measures will be put into place or systemic	

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F0600 SS = G	Continued from page 4 wheelchair and appeared startled after being the recipient of physical aggression from [his/her] roommate. [Resident #50] was assessed for injury with mild redness noted to the back of [his/her] head, no redness to the shoulders which were the affected areas per witness report... [S/He] and [his/her] roommate have bickered in the past. [Resident #50] had been away from the room for a couple of days, just returned home yesterday afternoon... What nurse thinks is going on with resident is: to have been the recipient of physical aggression. When asked what happened, why did [s/he] get hit by [his/her] roommate, [resident #50] stated "I don't know, [S/he]'s got a temper on [him/her]. It's just one of those things." [Resident #50] reported feeling unsafe at the facility with the aggressor as [his/her] roommate. [S/He] reported feeling safe at the facility so long as the aggressor was not [his/her] roommate..." d. Review of a progress note for resident #50 dated 10/26/25 and timed 11:36 AM showed "...Called and spoke with [resident representative] to notify her of [resident #50]'s physical aggression received from [his/her] roommate. Notified [representative] that the roommate was relocated from their shared room to another residence. She verbalized "Poor [resident #50], that poor [guy/gal] just can't catch a break." Notified [representative] [resident #50] is now on regular full VS and neurological observations as [s/he] was hit in the head by [his/her] roommate and she appreciated the update and verbalized understanding to the plan of care. She looks forward to an update as appropriate..." e. Review of a "Late Entry" progress note for resident #50 dated 10/28/25 and timed 2:30 PM showed "...This writer was approached by CNA who stated the following, 'I was just talking with [resident #50] who told me [s/he] saw [resident #16] walk down the hall and [s/he] has to see [him/her] in the lunchroom and [s/he] felt a bit uncomfortable. I told [him/her] I was very sorry that happened to [him/her] and I reassured [him/her] [s/he] was safe and that I would tell the proper person to come and talk with [him/her].' This writer thanked CNA for the information and assured her that we will follow up on this information. This writer also overheard [resident #50]'s new roommate telling [resident #50] that [s/he] needed less oxygen, that [s/he] needed to ask for more medicine if [s/he] had a headache, that [s/he] was a lawyer and [s/he] knew all about 'these situations'. This writer and administrator will speak with [resident #50]'s roommate regarding these comments. This writer and administrator went to [resident #50]'s room to speak with [him/her] and [s/he] appeared in good spirits. [Resident #50] was	F0600	Continued from page 4 changes made to ensure that the deficient practice will not recur Staff were re-educated by the Director of Nursing, Nurse Care Coordinators and Administrator on the Abuse/Neglect Policy, including: Identification of resident-to-resident abuse Immediate intervention and reporting requirements Responsibility to protect residents from known or foreseeable risks The facility strengthened its roommate compatibility review process, including: Behavioral history review prior to room assignments Ongoing reassessment following changes in condition or medication Early identification measures were implemented and reinforced, including: Routine monitoring for verbal aggression, agitation, and behavioral changes Completion of pain assessments when residents exhibit behavioral changes, agitation, or verbal aggression that may indicate unmet needs Prompt communication of identified concerns to the interdisciplinary team for evaluation and intervention Behavioral monitoring was reinforced for residents with a history of agitation, aggression, or cognitive impairment. The interdisciplinary team now reviews all incidents of resident-to-resident altercations to determine root cause and preventative strategies. Policies related to abuse prevention and resident supervision were reviewed and reinforced with all staff.	

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F0600 SS = G	Continued from page 5 asked if [s/he] felt safe here in the facility and in [his/her] room with [his/her] new roommate and [s/he] stated 'yes.' [Resident #50] did state 'I got hit in the head by that [guy/gal] and [s/he] is out of here now.' [Resident #50] did not express any further comments about the incident that occurred this past Sunday. [S/He] did state 'I was just in the hospital and I'm feeling a bit better now.' This writer and administrator will follow up with social services to come and talk with [resident #50] and Geri psych NP will be contacted to get [him/her] on the schedule to be seen this week. This writer and administrator assured [resident #50] that [s/he] is safe and that we are always here monitoring everybody. [Resident #50] thanked this writer and administrator for stopping in." f. Review of a "Change of Condition" progress note for resident #16 dated 10/26/25 at 11:20 AM showed "...Physical Aggression Initiated This nurse was called to [resident #16]'s room following NSA [name]'s arrival to the room after hearing yelling. When this nurse arrived, [resident #16] was found seated in [his/her] recliner and appeared visibly angered yelling "[S/He] wouldn't shut up." Bilateral hands were closed in fists and the right knuckles were notably red. [S/He] had reportedly been hitting [his/her] roommate in [his/her] head and shoulders with closed fist per witness report. Appeared to have started on: 10/26/2025 [resident #16]'s Mirtazapine was recently restarted. [S/He] and [his/her] roommate have bickered in the past. [His/Her] roommate had been away from the room for a couple of days, just returned home yesterday afternoon... [Resident #16] appeared visibly angered... What nurse thinks is going on with resident is: to have been angered by [his/her] roommate and initiated physical aggression. When asked if [s/he] felt safe at the facility, [resident #16] verbalized " I can take care of myself, I can handle myself." [S/He] denied feeling unsafe at the facility. When notified that [s/he] would be vacating [his/her] residence, [s/he] stated "Why do I have to move? [S/He] started it." This nurse notified [resident #16] that [s/he] was physically aggressive towards [his/her] roommate and would be vacating his residence..." 2. Interview with NSA #1 on 12/11/25 at 12:25 PM revealed on the day of the incident, she was in room 20 and heard yelling. The NSA went down the hall and saw resident #16 hitting resident #50. She revealed resident #50 was in his/her wheelchair in front of his/her recliner and resident #16 was yelling. She revealed resident #50 was not saying anything. She revealed she called out for some help, and a CNA, then a nurse came and they took over care. She revealed	F0600	Continued from page 5 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur The Director of Nursing or the Nursing Care Coordinator will review all incident reports related to resident behaviors weekly for 4 weeks, then monthly for 3 months, and thereafter as indicated until substantial compliance is met and achieved. Behavioral and roommate compatibility audits will be conducted: Weekly for 4 weeks Then monthly and reviewed during QA/QAPI meetings Any identified concerns will be addressed immediately through care plan updates by the MDS Coordinator, staff education, or environmental changes. Abuse prevention compliance will be monitored through routine supervisory rounds on all shifts. 5. Responsible Party Administrator Director of Nursing Social Services Interdisciplinary Team 6. Date of Compliance 1/5/2026	

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F0600 SS = G	Continued from page 6 resident #50 did not say if s/he was hurting and the NSA did not see any injuries. Further interview revealed she was unsure what started the altercation. 3. Interview with LPN #2 on 12/11/25 at 12:52 PM revealed she was called down to the residents' room because she was told resident #16 had been hitting resident #50. She revealed resident #50 had some red marks noted and resident #16 had some redness to his/her knuckles. She revealed the residents had bickered with each other in the past; however, she was not sure what was said that provoked the physical altercation. She revealed resident #50 was aware it happened and did indicate s/he had pain. The LPN revealed resident #50 said s/he should have a headache due to all the redness and s/he did not feel comfortable in resident #16's presence. Further interview revealed resident #16 was moved to a different room. 4. Review of the facility policy titled "Abuse/Neglect Policy" last revised 12/2019 showed "...Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility..."	F0600		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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,	F0605	The preparation and execution of this plan of correction is being done to comply with the requirements of federal and state laws and does not constitute an admission by the facility that any of the statements contained in this survey report or the conclusions drawn from these statements are accurate or true. 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #1 and resident #7 were immediately reviewed by the interdisciplinary team, including nursing, the RN care coordinator, and the attending provider. Resident-specific and medication-specific target symptoms for psychotropic medications were identified and documented in the medical record based on diagnosis, provider documentation, and resident interview. Behavioral monitoring tools were updated to reflect individualized target symptoms rather than generic statements. Current psychotropic medication orders were reviewed to	01/05/2026

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F0605 SS = D	Continued from page 7 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)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure	F0605	Continued from page 7 ensure: Appropriate indication Dose appropriateness Ongoing need Monitoring for effectiveness and adverse effects Care plans for both residents were updated to reflect psychotropic medication use, target symptoms, monitoring expectations, and resident preferences. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice The Nurse Care Coordinator completed a facility-wide audit of all residents receiving psychotropic medications, including antidepressants and antianxiety medications, to ensure: Documented diagnosis supporting use Resident-specific target symptoms Evidence of ongoing monitoring Any residents found without documented target symptoms or adequate monitoring had records updated immediately and providers notified as needed. The audit included review of MDS assessments, physician orders, progress notes, and behavior monitoring documentation. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Nursing staff were re-educated Nurse Care Coordinators and DON on psychotropic medication requirements, including:	

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F0605 SS = D	Continued from page 8 that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review and staff interview, the facility failed to ensure adequate monitoring of psychotropic medications for 2 of 5 sample residents (#1, #7) reviewed for unnecessary medications. The findings were: 1. Review of the quarterly MDS assessment dated 9/29/25 showed resident #1 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included anxiety disorder, depression, and post-traumatic stress disorder. Further review showed the resident had no behaviors exhibited and received antianxiety and antidepressant medications. Review of the physician orders showed the resident received buspirone (antianxiety) 10 milligrams	F0605	Continued from page 8 Definition of psychotropic drugs Requirement for resident-specific target symptoms Documentation expectations for monitoring effectiveness and side effects Behavioral monitoring orders were revised to require individualized target symptoms linked to each psychotropic medication. Admission and quarterly review processes were updated to require verification of psychotropic documentation and monitoring. Provider communication was reinforced to ensure medication adjustments are supported by documented assessments and monitoring data. The interdisciplinary team will review all psychotropic medication use during routine care plan reviews and pharmacy reviews. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur The Director of Nursing or Nurse Care Coordinator will complete psychotropic medication audits: Weekly for 4 weeks Then monthly for 3 months, and thereafter as indicated until substantial compliance is met and achieved. Audits will include verification of: Diagnosis and indication Documented target symptoms Ongoing monitoring and effectiveness Findings will be reviewed during QA/QAPI meetings. Any identified deficiencies will result in immediate correction and additional staff education.	

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Weston County Health Services	**1124 Washington Blvd , Newcastle, Wyoming, 82701**

(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
F0605 SS = D	Continued from page 9 [mg] by mouth two times daily, which was ordered on 3/31/25, and sertraline (antidepressant) 100 mg by mouth at bedtime, which was ordered on 3/21/25. The following concerns were identified: a. Review of the physician orders showed "Observe for Behavior: Anxiety *Document if resident is having behavior" and "Observe for Behavior: s/s [signs and symptoms] depression *Document if resident is having behavior..." Review of the medical record showed no evidence the facility had identified resident specific or medication specific target symptoms of anxiety or depression. b. Review of the order history for the sertraline showed the original order was for 25 mg by mouth at bedtime, which was ordered on 8/1/24. The sertraline was increased to 50 mg at bedtime on 10/23/24, 75 mg at bedtime on 1/24/25, and 100 mg at bedtime on 3/21/25. Review of "Behavior Monitoring" for January 2025 and March 2025 showed no evidence of "s/s depression" noted. c. Review of a psychiatry note dated 1/23/25 showed the resident reported struggling with grief and mood instability, significant emotional distress, and a hard time "keeping it together" following the death of a family member. 2. Review of the admission MDS assessment dated 11/23/25 showed resident #7 had a BIMS score of 13 out 15, which indicated the resident was cognitively intact, and diagnoses which included anxiety disorder. Further review showed the resident had no behaviors exhibited and received antianxiety and antidepressant medications. Review of the physician orders showed the resident received fluoxetine (antidepressant) 20 mg by mouth daily, which was ordered on 11/11/25. The following concerns were identified: a. Review of the physician orders showed "Observe for Behavior: Anxiety *Document if resident is having behavior..." Review of the medical record showed no evidence the facility had identified resident specific or medication specific target symptoms of anxiety. 3. Interview with the DON and RN care coordinator on 12/11/25 at 1:29 PM confirmed the facility had not identified resident specific or medication specific target symptoms. The revealed resident #1 was able to verbalize feelings and resident #7 was new to the facility and must have been missed.	F0605	Continued from page 9 5. Responsible Party Director of Nursing RN Care Coordinator Consulting Pharmacist Attending Providers 6. Date of Compliance 1/5/2026	
F0628 SS = D	Discharge Process	F0628	The preparation and execution of this plan of	01/05/2026

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F0628 SS = D	Continued from page 10 CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F0628	Continued from page 10 correction is being done to comply with the requirements of federal and state laws and does not constitute an admission by the facility that any of the statements contained in this survey report or the conclusions drawn from these statements are accurate or true. 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice For resident #50 and resident #9, the facility reviewed the hospital transfer events to ensure that all required information related to transfer and bed-hold policy was communicated. Written transfer and bed-hold notices were provided to the resident representatives, and documentation was placed in the medical record. Nursing leadership and Social Services reviewed both residents' records to verify that discharge summaries, bed-hold policies, and transfer documentation were completed accurately and consistently with regulatory requirements. Staff involved in the transfer process were re-educated on the requirement that verbal notification alone is insufficient and that written notice must be provided and documented. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice The Director of Nursing and Social Services completed a facility-wide audit of all hospital transfers from the date of survey to ensure: Written transfer notices were provided Written bed-hold notices were issued Documentation of delivery and receipt was present in the medical record Any identified gaps were corrected immediately, and additional notices were issued as needed.	

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F0628 SS = D	Continued from page 11 paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone	F0628	Continued from page 11 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The facility revised its Transfer and Discharge Process to require: Completion of written transfer notice and bed-hold notice at the time of hospital transfer Documentation of how the notice was delivered (in person, electronic, or mailed) Certified mail procedures were implemented when applicable, and certified letter receipts will be retained in the resident's medical record and/or administrative file for a minimum of 1 year to ensure verification of delivery. Standardized transfer and bed-hold notice forms were implemented for all hospitalizations. Social Services and nursing leadership now collaborate to ensure compliance with notice requirements for all transfers. Staff education was completed by Director of Nursing and Administrator with nursing staff, Social Services, and leadership on: Transfer and discharge notice requirements Bed-hold policy requirements Required documentation and timelines The discharge checklist was updated to include verification of written notices prior to transfer. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur The Director of Nursing or Social Services will audit all hospital transfers:	

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F0628 SS = D	Continued from page 12 number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F0628	Continued from page 12 Weekly for 4 weeks Then monthly for 3 months, and thereafter as indicated until substantial compliance is met and achieved. Audits will verify: Written transfer notice completion Written bed-hold notice completion Documentation of delivery and receipt Audit results will be reviewed during QA/QAPI meetings. Any noncompliance identified will result in immediate corrective action and staff re-education. 5. Responsible Party Director of Nursing Social Services Charge Nurses 6. Date of Compliance 1/5/2026	

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F0628 SS = D	Continued from page 13 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a transfer notice and bed-hold notice was provided in writing for 2 of 2 sample residents (#9, #50) reviewed for hospitalizations. The findings were: 1. Review of a progress note dated 10/23/25 and timed 2:50 AM showed resident #50 was was sent to emergency room for evaluation and treatment related to low oxygenation, and lung sounds which included expiratory	F0628		

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F0628 SS = D	Continued from page 14 wheezes and rales or crackles. The following concerns were identified: a. Review of a "Resident Bed Hold Notice" dated "10/23" showed the resident's representative was contacted related to transfer and the bed-hold; however, there was no evidence the notifications were provided and received in writing. 2. Review of a "Change of Condition" progress note dated 10/19/25 and timed 2:08 AM showed resident #9 was transferred to the hospital after the resident was found on the floor with "large black colored emesis." The following concerns were identified: a. Review of a "bed Hold Policy" form dated 10/29/25 showed the resident's "agent" was notified by the nurse of the resident's transfer and a different 'responsible party" was notified of the "bed hold policy;" however, there was no evidence the notifications were provided and received in writing. 3. Interview with the DON and social services director on 12/11/25 at 8:49 AM confirmed the facility did not have evidence the residents or resident representatives were notified of transfer or discharge or bed-hold policy in writing. They revealed the notices were mailed; however, they did not have any way to confirm it was received.	F0628		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.	F0644	The preparation and execution of this plan of correction is being done to comply with the requirements of federal and state laws and does not constitute an admission by the facility that any of the statements contained in this survey report or the conclusions drawn from these statements are accurate or true. 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #1 and resident #39 were immediately reviewed by the interdisciplinary team, including Social Services, nursing leadership, and the RN MDS Coordinator. PASRR Level I screenings were completed for both residents to reflect current diagnoses. For resident(s) meeting criteria, referrals for PASRR Level II evaluations were initiated per state PASRR	01/05/2026

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F0644 SS = D	Continued from page 15 This REQUIREMENT is NOT MET as evidenced by: Based on medical record review and staff interview, the facility failed to ensure preadmission screening was performed and was accurate for 2 of 3 sample residents (#1, #39) with qualifying diagnoses. The findings were: 1. Review of the quarterly MDS assessment dated 9/29/25 showed resident #1 had diagnoses which included anxiety disorder, depression, and post-traumatic stress disorder. The following concerns were identified: a. Review of a PASRR Level I completed on 10/10/23 showed no primary psychiatric diagnosis listed and the decision indicated a PASRR level II was not indicated due to no evidence of mental illness or intellectual disability. b. Interview with the social services director on 12/11/25 at 8:27 AM revealed a new mental health diagnosis or significant behavior would trigger a need for a new PASRR. She revealed the diagnosis of post-traumatic stress disorder would trigger a PASRR level II and it should have been completed when the resident returned to the facility. 2. Review of a psychiatric note dated 3/28/25 showed resident #39 received a new diagnosis of post-traumatic stress disorder. The following concerns were identified: a. Review of the medical record showed no evidence a PASSR level I was completed after the resident received the post-traumatic stress disorder diagnosis. b. Interview with the social services director on 12/11/25 at 10:15 AM revealed she was not aware the resident had a diagnosis of post-traumatic stress disorder. She confirmed a new PASRR level I and possibly level II should have been completed.	F0644	Continued from page 15 process. The residents' assessments and care plans were reviewed and updated to incorporate mental health diagnoses and any PASRR recommendations. Documentation was placed in the medical record to reflect PASRR completion, referral, and follow-up. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice The Nurse Care Coordinator and Social Services completed a facility-wide audit of all residents with: Mental health diagnoses Intellectual or developmental disabilities Recent psychiatric evaluations or medication changes Records were reviewed to ensure PASRR Level I accuracy and Level II referrals when indicated. Any residents identified without appropriate PASRR screening were referred immediately and documentation updated. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The facility revised its PASRR process to require: PASRR Level I completion upon admission and readmission. PASRR review upon any new or newly documented serious mental disorder, intellectual disability, or related condition Communication between nursing, Social Services, MDS, and providers was strengthened to ensure new diagnoses are promptly shared.	

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F0644 SS = D		F0644	Continued from page 16 PASRR screening was added to: Admission and readmission checklists Significant change in status assessments Staff education was provided to Social Services, nursing leadership, and MDS staff regarding PASRR requirements and referral triggers. Policies related to PASRR coordination were reviewed and updated to include PASRR Level II requirements if triggered. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur The MDS Coordinator or designee will audit PASRR compliance: Weekly for 4 weeks Then monthly for 3 months, and thereafter as indicated until substantial compliance is met and achieved. Audits will include verification of: Accurate PASRR Level I screenings Timely Level II referrals when indicated Audit results will be reviewed during QA/QAPI meetings. Any identified noncompliance will result in immediate corrective action and staff re-education. 5. Responsible Party Social Services MDS Coordinator Director of Nursing	

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F0644 SS = D		F0644	Continued from page 17 Interdisciplinary Team 6. Date of Compliance 1/5/2026	
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and policy and procedure review, the facility failed to ensure thorough wound assessments were completed for 1 of 4 sample residents (#8) reviewed for wound care. The findings were: 1. Review of the significant change MDS assessment dated 11/6/25 showed resident #8 admitted to the facility on 9/10/24 and had a BIMS score of 99, which indicated the resident had severe cognitive deficits. The resident had diagnoses which included non-traumatic brain dysfunction, non-Alzheimer's dementia, and anxiety disorder. Further review showed the resident was at risk for developing pressure ulcers/injuries, and had 2 unstageable pressure injuries presenting as deep tissue injuries. The following concerns were identified: a. Review of the Situation, Background, Assessment, Recommendation (SBAR) form dated 11/2/25 and timed 5:35 PM showed the resident had 2 new blisters on both heels. The wound assessment showed "…Right heel is 4.5	F0686	The preparation and execution of this plan of correction is being done to comply with the requirements of federal and state laws and does not constitute an admission by the facility that any of the statements contained in this survey report or the conclusions drawn from these statements are accurate or true. 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #8 was immediately reassessed by licensed nursing staff, including comprehensive wound assessments of both heels with measurements, wound characteristics, peri-wound condition, and drainage documented. The certified wound care nurse re-evaluated the resident's wounds and confirmed staging, treatment orders, and off-loading interventions. The resident's care plan was reviewed and updated to reflect: Accurate wound measurements Treatment frequency Pressure-relief interventions Monitoring for healing and complications Nursing staff involved were re-educated on wound assessment documentation requirements, including weekly measurements and evaluation of treatment effectiveness. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice	01/05/2026

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F0686 SS = D	Continued from page 18 cm by 2.5 cm. Left heel is 6 cm by 5 cm. Both are draining. Mepilex applied to both and boots to both feet at all times." b. Review of the "Head to Toe Skin Checks" dated 11/2/25 and timed 9:08 showed "Callouses to left foot remain. New blisters to bilateral heels are unchanged…" c. Review of the Braden Scale for Pressure Sore Risk dated 11/3/25 showed the resident had a score of 13 out of 23, which indicated s/he was at moderate risk for pressure sores. d. Review of a progress note dated 11/3/25 and timed 11:32 showed the risk management team met to review the incident, heel protector boots were initiated, and the wound nurse was contacted to evaluate the resident. e. Review of "Wound - Weekly Observation Tool" dated 11/6/25 and timed 2:17 PM showed wound #1 on the left heel was a deep tissue injury, and was measured as length 7.5 cm, width 7.5 cm. The description of the peri-wound tissue was "pink, intact" and the wound edges and shape were described as "irregular. f. Review of "Wound - Weekly Observation Tool" dated 11/6/25 and timed 2:17 PM showed wound #2 was a deep tissue injury, and was measured as length 3.5 cm, width 2.5 cm and depth 0 cm. The description of the peri-wound tissue was "pink, intact" and the wound edges and shape were "irregular." g. Review of "Head to Toe Skin Checks" dated 11/9/25 and timed 8:45 PM showed "…existing bruising, pressure areas to B/L heels with treatment plan in place, callous to bottom of L foot with treatment plan in place…" There was no evidence the wound size, progress, or treatment effectiveness was assessed. h. Review of "Head to Toe Skin Checks" dated 11/16/25 and timed 11:15 PM showed "…pressure areas to B/L heels with treatments in place and callous to bottom of L foot with treatment as ordered." There was no evidence the wound size, progress, or treatment effectiveness was assessed. i. Review of "Head to Toe Skin Checks" dated 11/23/25 and timed 8:41 PM showed "…calluses [sic] to bottom of L foot…blisters to B/L heels." There was no evidence the wound size, progress, or treatment effectiveness was assessed. j. Review of "Head to Toe Skin Checks" dated 11/30/25 and timed 8:30 PM showed "…calluses [sic] to bottom of	F0686	Continued from page 18 The Nursing Care Coordinator completed a facility-wide audit of all residents with: Pressure ulcers or injuries Skin breakdown High Braden Scale risk scores Medical records were reviewed to ensure: Weekly wound measurements were documented Wound progress and treatment effectiveness were evaluated Wound care was consistent with physician orders and facility policy Any identified gaps were corrected immediately, including updated wound assessments and care plans. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Nursing staff were re-educated on the facility's Identification, Treatment and Prevention of Pressure Ulcers policy, with emphasis on: Weekly wound measurements Accurate staging and documentation Ongoing evaluation of wound healing and treatment effectiveness Weekly risk meeting where residents are reviewed that are at risk of skin breakdown, weight loss, or are potential end of life. The wound assessment process was standardized to require:	

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F0686 SS = D	Continued from page 19 L foot new dressing…blisters to B/L heels new dressings." There was no evidence the wound size, progress, or treatment effectiveness was assessed. k. Review of progress note dated 11/14/25 and times 9:22 PM showed "Left heel began bleeding some after resident got [him/herself] into a sitting position on [his/her] bed and rubbed [his/her] foot along the edge of the bedframe. Cleansed and covered with dressing." There was no evidence the wound size, progress, or treatment effectiveness was assessed. 2. Observation on 12/10/25 at 12:45 PM showed LPN #3 measured and placed a bandage on the resident's left heel, and measured the right lateral heel. Interview with LPN #3 at that time revealed a scab fell off the resident's right heel, and she felt the wound would "heal up quickly." 4. Interview on 12/10/25 at 12:50 PM with RN #1 revealed the certified wound care nurse assessed the wound within the first week so she could stage it and complete a wound evaluation form. Following the first assessment, the wound care nurse had not completed any further assessment, and the floor nurses changed the dressings and visually assessed the wounds. 5. Interview on 12/11/25 at 1:13 PM with the DON revealed wound care progress was documented by nursing staff who completed weekly skin assessments, and the effectiveness of the wound care was evaluated by the nurse observation. Further interview confirmed measurements were not documented in the weekly skin assessments. 6. Review of the facility policy titled "Identification, Treatment and Prevention of Pressure Ulcers" last updated 10/2023 showed "...1. Document healing in chart and/or weekly skin review book..." and "IV. Staging and measuring wounds A. Use Briggs form for wound assessment and follow-up and stage as directed weekly and prn. B. Measure wound top to bottom and side to side..."	F0686	Continued from page 19 Weekly and PRN measurements documented by licensed nurses The Nurse Care Coordinator will conduct routine follow-up assessments for residents with active wounds. Leadership educated nursing staff expectations that visual assessment alone is insufficient without documented measurements and evaluation. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur The Nurse Care Coordinator will audit wound documentation: Weekly for 4 weeks Then monthly for 3 months, and thereafter as indicated until substantial compliance is met and achieved. Audits will verify: Presence of weekly wound measurements Documentation of wound progress and treatment effectiveness Consistency with care plans and physician orders Audit results will be reviewed during QA/QAPI meetings. Any noncompliance will result in immediate correction and additional staff education. 5. Responsible Party Director of Nursing Nurse Care Coordinator Charge Nurses 6. Date of Compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

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F0686 SS = D		F0686	Continued from page 20 1/5/2026	
F0725 SS = E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on resident, resident representative, and staff interview, grievance log review, call light log review, and policy and procedure review, the facility failed to ensure sufficient nursing staff was provided to ensure the highest practicable physical, mental and psychological well-being of 3 of 4 units (Four Corners, Mule Creek, Unit 6) reviewed for staffing. The findings were: 1. Review of the quarterly MDS assessment dated 10/30/25 showed resident #36 had a BIMS score of 15 out	F0725	The preparation and execution of this plan of correction is being done to comply with the requirements of federal and state laws and does not constitute an admission by the facility that any of the statements contained in this survey report or the conclusions drawn from these statements are accurate or true. 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice Residents identified in the survey findings, including resident #36 and resident #17, were immediately assessed by licensed nursing staff to ensure their needs were met and no ongoing unmet care needs existed. Nursing leadership ensured call lights were placed within reach and that residents received timely assistance with toileting, positioning, meals, and personal care. Staff were counseled regarding proper call-light management, including the prohibition of turning off call lights without resolving the resident's request or ensuring appropriate handoff. The facility educated on immediate response expectations and staff accountability to ensure resident dignity and safety. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice The Nurse Care Coordinator reviewed call-light response data facility-wide to identify residents experiencing prolonged wait times. Resident grievances and concerns related to staffing and response times were reviewed by Social Services, Director of Nursing, and Nurse Care Coordinators. All units (Four Corners, Mule Creek, Unit 6) were assessed for staffing patterns, resident acuity, and care needs.	01/05/2026

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F0725 SS = E	Continued from page 21 of 15, which indicated the resident was cognitively intact, and had diagnoses which included left foot drop, lumbago with sciatica, major depressive disorder, and pneumonia. Further review showed the resident was dependent for toilet transfers. The following concerns were identified: a. Interview with the resident on 12/9/25 at 8:27 AM revealed s/he had to wait a long time for the call light to be answered, and meal times were a longer wait time. b. Interview with the resident's representative on 12/9/25 at 11:31 AM revealed the resident would use his/her call light, staff would come in and turn it off and move the rolling table, and the resident was then unable to reach the call light or phone. They reported the resident has been left sitting in feces in his/her recliner due to the extended wait times. Further interview revealed the resident's roommate would often push his/her call light in order to get assistance for the resident because s/he could not reach the call light. c. Observation on 12/10/25 at 4:17 PM showed the resident was sitting in his/her recliner and crying, and reported the bedside table was not placed close enough in front of him/her to reach the call light and phone. d. Review of the facility grievance log showed a grievance was filed on 12/6/25 by the resident's family which stated the resident was found by a family member with his/her bedside table, call light and cell phone out of reach. Further, the resident's call light had been turned off by a CNA who had left to find help to assist him/her, and the CNA did not return to assist the resident while the family member was still in the room. 2. Interview with 7 residents during resident council on 12/9/25 at 10:04 AM revealed the residents were told the average response time for call lights was 7 minutes; however, they reported the call lights are turned off by staff, residents were told the staff will "be right back," and they "never see them again." 3. Interview with resident #17 on 12/9/25 at 10:15 AM revealed s/he waited 73 minutes for a call light to be answered. 4. Interview with staffing coordinator on 12/11/25 at 10:52 AM revealed there are usually 6 CNAs when the facility was fully staffed, unless staff called off,	F0725	Continued from page 21 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The facility implemented a call-light response policy establishing clear expectations for: Prompt response to call lights Proper handoff if assistance is needed Prohibition of silencing call lights without resolution Staffing patterns were reviewed and adjusted based on census, acuity, and resident needs in accordance with the facility assessment. Leadership strengthened contingency staffing plans, including: Increased use of PRN and agency staff On-call leadership support when staffing shortages occur Non-licensed staff were educated on appropriate interim assistance and escalation when clinical staff are needed. Staff education was completed on resident dignity, timely care, and communication. Call-light expectations were reinforced by Nurse Care Coordinator during shift huddles and staff meetings. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur The Director of Nursing or Nurse Care Coordinator will monitor call-light response times: Daily review for 2 weeks Then weekly for 4 weeks	

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F0725 SS = E	Continued from page 22 which happened frequently. 5. Interview with CNA #2 on 12/11/25 at 11:06 AM revealed the facility did not have enough staff to provide cares for residents at all times. Further interview revealed there were times when there was only 1 staff in the locked unit and 2 for the rest of the building. This resulted in residents who were “soaked” in the morning. She reported there have been times when 1 CNA has been responsible for 27 residents at night. 6. Interview with CNA #1 on 12/11/25 at 11:06 AM revealed there were times when there were only 2 CNAs at night, and the day staff stayed late to help residents so they could go to bed when they wanted, and not have to stay up until midnight because there was not enough staff to help. Further interview revealed she had seen call lights that had been on for over an hour. 7. Review of the call light log for resident #36 showed the call light wait times on 11/16/25 of 49 minutes at 8:37 AM, 11/18/25 of 69 minutes at 6:49 AM, 11/23/25 of 84 minutes at 8:21 PM, and 11/23/25 of 84 minutes at 9:46 PM. 8. Review of the call light log for resident #17 showed call light wait times on 11/23/25 of 35 minutes at 9:13 PM, 12/6/25 of 34 minutes at 8:23 PM, and 12/6/25 of 34 minutes at 8:58 PM. 9. Interview with the DON on 12/11/25 at 1:45 PM revealed she did not have an expected time frame for CNAs to answer call lights. She reported if non-clinical staff answered the light, they would leave it on for clinical staff. Further interview confirmed she has been “drilling” staff on call lights, and she currently had a contest for staff regarding call light times. Her expectation for staff during the day was to have 2 CNAs on each hall to partner and help each other out, and if staff called out, she would try to replace them and assist the direct care staff. She reported she did not have a facility policy on answering call lights.	F0725	Continued from page 22 Then monthly for 3 months, and thereafter as indicated until substantial compliance is met and achieved. Staffing levels will be reviewed daily to ensure adequate coverage on all shifts. Findings related to staffing adequacy, response times, and resident concerns will be reviewed during QA/QAPI meetings. Any identified noncompliance will result in immediate corrective action and additional staff education. 5. Responsible Party Director of Nursing Administrator Unit Scheduler Charge Nurses 6. Date of Compliance 1/5/2026	
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F0812	The preparation and execution of this plan of correction is being done to comply with the requirements of federal and state laws and does not constitute an admission by the facility that any of the statements contained in this survey report or the conclusions drawn from these statements are accurate or true.	01/05/2026

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F0812 SS = F	Continued from page 23 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, temperature log review, policy and procedure review, and 2022 Food Code review, the facility failed to ensure a professional standards for food service safety were followed in 1 of 1 kitchen. The census was 53. The findings were: Regarding dish machine temperature logs: 1. Observation on 12/8/25 at 3:22 PM showed the facility used a Hobart high temperature sanitizing dishwashing machine. The temperature of the wash and rinse cycles, were to be recorded at breakfast, lunch and dinner. The highest daily temperature was to be recorded one time per day. Review of the Hobart dishwashing machine manufacturer's instructions showed the minimum temperature of the wash cycle was 150 degrees Fahrenheit [F], and the minimum final rinse temperature was 180 degrees F. The following concerns were identified: a. Review of the October 2025 dish machine log sheet showed the required breakfast, lunch, and dinner temperatures, and daily temperature test was not documented on the form 51 out of 124 opportunities. Review of the November 2025 dish machine log sheet showed the required breakfast, lunch, and dinner temperatures, and daily temperature test was not documented on the form 77 out of 120 opportunities. b. The breakfast, lunch, dinner, and daily high temperature were missing on 10/23, 11/3, 11/14, 11/25,	F0812	Continued from page 23 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice Immediately upon identification of the deficient practices, dietary leadership reviewed food safety practices to ensure no unsafe food was served to residents. The dish machine was verified to be functioning by maintenance within manufacturer and FDA Food Code temperature requirements. Dietary staff were instructed to immediately begin completing all required temperature logs for: Dish machine wash and final rinse Freezer and refrigeration units Hot and cold food temperatures at each meal Beard restraints were provided and required for all dietary staff with facial hair while preparing or serving food. The dietary aide observed without a beard restraint was immediately educated and brought into compliance. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice The Dietary Manager completed a full review of: All dietary temperature logs Dish machine sanitation records Food temperature monitoring records A walk-through of the kitchen and food service areas was completed to verify: Proper food storage	

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F0812 SS = F	Continued from page 24 11/26, 11/28, 11/29, and 11/30. c. The breakfast and daily high temperature were missing on 10/12, 10/19, 10/20, 11/5, 11/9, 11/17, 11/18, and 11/27. d. The breakfast, lunch and daily high temperature were missing on 10/27, 10/28, 10/31, and 11/24. e. The lunch, dinner and daily high temperature were missing on 10/14, 10/16, 10/21, 10/26, 11/2, 11/6, 11/8, 11/10, 11/11, 11/12, and 11/13. f. The dinner and daily high temperature were missing on 10/7, 10/11, 10/15, 10/22, 10/23, 10/24, 10/25, and 10/26. g. The dinner temperature was missing on 10/6. h. The lunch and daily high temperature were missing on 10/29, 10/30, 11/22 and 11/23. i. The lunch and dinner temperature were missing on 11/1, 11/15, 11/16, and 11/20. j. The lunch temperature was missing on 11/19, and 11/21. k. The daily high temperature was missing on 10/8 and 11/7. 2. Interview with the dietary manager on 12/8/25 at 3:25 PM confirmed the temperature logs were incomplete. 3. Review of the facility policy titled “Daily Temperature Recording” last revised 1/2020 showed “…The AM cook will be responsible for monitoring and recording the temperatures of the freezer, and both walk-in refrigerator [sic] on the posted daily temperature record. 2. Obvious problems with temperatures in these areas will be reported to the supervisor immediately. 3. The temperatures of the above units will be monitored by staff on both shifts during the course of their work. 4. The dish machine wash and rinse temperatures will be monitored by dietary staff during each shift of dishwashing and recorded. 5. The Aide or Cook catching dishes will be responsible for recording the dish machine wash and rinse temperatures three times daily on the attached daily temperature record which is posted in the main kitchen…” 4. Review of the 2022 FDA Food Code showed "(A) The	F0812	Continued from page 24 Use of personal protective equipment (hair nets and beard restraints) Compliance with sanitation standards Any identified concerns were corrected immediately. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Dietary staff were re-educated on: FDA Food Code requirements Facility policies for temperature monitoring Importance of accurate and timely documentation Hair and beard restraint requirements Clear responsibility assignments were reinforced: AM, noon, and PM cooks are responsible for food temperature monitoring Dishwashing staff are responsible for documenting dish machine temperatures each shift Temperature logs were revised and simplified to improve compliance. The Dietary Manager implemented end-of-shift verification of all temperature logs. Signage was updated to explicitly include beard restraints in addition to hair nets. Facility policies related to food safety, temperature monitoring, and traffic control were reviewed and reinforced with staff. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur	

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F0812 SS = F	Continued from page 25 temperature of the wash solution in spray type warewashers that use hot water to SANITIZE may not be less than: (1) For a stationary rack, single temperature machine, 74 [degrees] C (165 [degrees] F); (2) For a stationary rack, dual temperature machine, 66 [degrees] C (150 [degrees] F); (3) For a single tank, conveyor, dual temperature machine, 71 [degrees] C (160 [degrees] F); or (4) For a multitank, conveyor, multitemperature machine, 66 [degrees] C (150 [degrees] F)." Regarding the Freezer, walk-in #1 and #2, reach in: 1. Review of the October and November 2025 daily temperature logs for the freezer, walk-in #1, walk in-in #2, and reach in showed the temperature was to be documented on both the morning and afternoon shifts. The expected temperature was 0 degrees Fahrenheit for the freezer, and 41 degrees Fahrenheit for refrigerators. The following concerns were identified: a. The walk-in freezer morning shift temperatures were missing on 10/20, 10/29, 10/31. b. The walk-in freezer, walk-in #1 and #2 refrigerators, and reach-in cooler afternoon shift temperatures were missing on 10/16, 10/17, 10/18, 10/19, 10/23, 10/24, 10/25, 10/26, 10/27, 10/28, 10/29, 10/31, 11/4, 11/5, 11/6, 11/7, 11/8, 11/9, 11/10, 11/11, 11/12, 11/13, 11/15, 11/16, 11/18, 11/19, 11/20, 11/21, 11/25, 11/26, 11/28, 11/29, and 11/30. c. The walk-in freezer, walk-in #1 and #2 refrigerators, and reach-in cooler morning and afternoon shift temperatures were missing on 10/29, 11/1, 11/2, 11/3, 11/14, 11/17, 11/22, 11/23, 11/24, and 11/27. 2. Interview with the dietary manager on 12/8/25 at 3:25 PM confirmed the temperature logs were incomplete. 3. Review of the facility policy titled “Daily Temperature Recording” last revised 1/2020 showed “…The AM cook will be responsible for monitoring and recording the temperatures of the freezer, and both walk-in refrigerator [sic] on the posted daily temperature record. 2. Obvious problems with temperatures in these areas will be reported to the supervisor immediately. 3. The temperatures of the above units will be monitored by staff on both shifts during the course of their work. 4. The dish machine wash and rinse temperatures will be monitored by dietary staff during each shift of dishwashing and recorded. 5. The Aide or Cook catching dishes will be	F0812	Continued from page 25 The Dietary Manager or Assistant Dietary Manager will audit: Dish machine temperature logs Refrigerator and freezer temperature logs Food temperature logs Use of hair and beard restraints Audits will occur: Daily for 2 weeks Then weekly for 4 weeks Then monthly for 3 months, and thereafter as indicated until substantial compliance is met and achieved. Audit findings will be reviewed during QA/QAPI meetings. Any missing documentation or noncompliance will result in immediate correction and staff re-education. 5. Responsible Party Dietary Manager Assistant Dietary Manager Administrator QA/QAPI Committee 6. Date of Compliance 1/5/2026	

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F0812 SS = F	Continued from page 26 responsible for recording the dish machine wash and rinse temperatures three times daily on the attached daily temperature record which is posted in the main kitchen…" Regarding food temperatures: 1. Review of the October and November 2025 Food temperature logs showed the temperature was to be logged at breakfast, lunch, and dinner. The following concerns were identified: a. No lunch temperatures were recorded on 10/23. b. No dinner temperatures were recorded on 10/12, 10/16, 10/18, 10/22, 10/26, 10/27, 10/28, 10/30, 11/1, 11/6, 11/10, and 11/21. c. No lunch and dinner temperatures were recorded on 10/15, 10/21, 11/2, 11/3, 11/5, 11/8, 11/9, 11/11, 11/12, 11/13, 11/14, 11/15, 11/16, 11/18, 11/19, 11/21, 11/25, 11/28, 11/29, and 11/30. d. No temperatures for breakfast, lunch, or dinner were recorded 11/17, 11/22, 11/23, 11/24, and 11/27. 2. Interview with the dietary manager on 12/8/25 at 3:25 PM confirmed the temperature logs were incomplete. 3. Review of the facility policy titled "Recording Food Temps" last revised 7/2025 showed "The temperatures of time-temperature controlled foods will be monitored each meal by dietary staff in a sanitary manner. Procedures. 1. The AM, noon and PM cooks will, check hot foot temperatures before placing hot foods into the portable steam table. All hot foods must be maintained in the steam table at least 140 degrees F. A temperature of 160 degrees prior to placing foods into the steam table is desirable…6. The cook for each meal is responsible for checking and maintaining proper temperatures during meal service. Temperatures should be checked with a thermometer at least two times during at breakfast and once at lunch and dinner…" 4. Review of the 2022 FDA Food Code showed "... Records must be maintained to verify that the critical limits required for food safety are being met. Records provide a check for both the operator and the regulator in determining that monitoring and corrective actions have taken place..." Regarding beard restraint: 1. Observation on 12/10/25 starting at 10:05 AM showed	F0812		

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F0812 SS = F	Continued from page 27 the dietary aide #1 washed dishes, prepared gravy, and served lunch from the tray line to residents. Further observation showed he had visible facial hair and did not wear a beard restraint. 2. Interview with the dietary manager on 12/10/25 at 12:30 PM revealed she was unaware the dietary staff with beards should wear a beard restraint. 3. Review of the facility policy titled “Traffic Control” last revised 8/2025 showed “…signs are posted on the door to the kitchen regarding the requirement of hair nets upon entrance…” 4. Review of the 2022 FDA Food Code showed "...2-402 Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. (B) This section does not apply to FOOD EMPLOYEES such as counter staff who only serve BEVERAGES and wrapped or PACKAGED FOODS, hostesses, and wait staff if they present a minimal RISK of contaminating exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES."	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing	F0880	The preparation and execution of this plan of correction is being done to comply with the requirements of federal and state laws and does not constitute an admission by the facility that any of the statements contained in this survey report or the conclusions drawn from these statements are accurate or true. 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice Immediately upon identification, resident #27’s urinary catheter collection bag was placed in a protective cover and positioned off the floor and below the level of the bladder. The resident was assessed by licensed nursing staff for any signs or symptoms of urinary tract infection or other complications, and none were noted. The resident’s care plan was reviewed and confirmed to	01/05/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Weston County Health Services	**1124 Washington Blvd , Newcastle, Wyoming, 82701**

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F0880 SS = D	Continued from page 28 services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F0880	Continued from page 28 include proper catheter care and infection-prevention interventions. Staff involved were counseled and re-educated on catheter bag placement, infection prevention expectations, and facility policy requirements. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice The Nurse Care Coordinator completed a facility-wide audit of all residents with indwelling urinary catheters to ensure: Catheter bags are covered Bags are positioned below bladder level Bags are not in contact with the floor Any identified concerns were corrected immediately and documented. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Nursing staff were re-educated by the Infection Control Nurse on infection prevention practices related to urinary catheter care, including: Proper placement and handling of collection bags Prevention of contamination Resident dignity and privacy Infection prevention expectations were re-educated during shift huddles and staff meetings. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur	

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F0880 SS = D	Continued from page 29 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure infection prevention practices were implemented for 1 of 2 sample residents (#27) reviewed for urinary catheters. The findings were: 1. Review of the quarterly MDS assessment dated 10/27/25 showed resident #27 had a BIMS score of 13 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included, renal insufficiency, neurogenic bladder, congestive heart failure and history of a stroke. The following concerns were identified. a. Observation on 12/10/25 at 8:57 AM showed resident #27 was in bed and his/her urinary catheter bag was on the floor and uncovered. b. Interview with the DON on 12/10/25 at 4:41 PM revealed that catheter bags were expected to be in covered bags, below the level of the resident's bladder, and shouldn't have been on the floor. c. Interview with CNA #1 on 12/11/25 at 10:56 AM revealed that catheter bag should have been in covers and not touching the floor. d. Interview with Infection Preventionist on 12/11/25 at 10:18 AM confirmed catheter bags should never touch the floor and should have been stored in bag covers to protect privacy and avoid contamination. Further interview revealed clinical staff were trained upon hire regarding infection prevention policies in relation to catheter bag placement. e. Review of facility policy titled “Care of Urinary Catheters” last revised 7/2025 showed “…Keep the collection bag off the floor...”	F0880	Continued from page 29 The Infection Preventionist or designee will conduct catheter care audits: Weekly for 4 weeks Then monthly for 3 months, and thereafter as indicated until substantial compliance is met and achieved. Audits will verify compliance with catheter bag placement, coverage, and infection prevention standards. Audit findings will be reviewed during QA/QAPI meetings. Any identified noncompliance will result in immediate correction and additional staff education. 5. Responsible Party Infection Preventionist Director of Nursing Nurse Care Coordinators Charge Nurses 6. Date of Compliance 1/5/2026	
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each	F0883	The preparation and execution of this plan of correction is being done to comply with the requirements of federal and state laws and does not constitute an admission by the facility that any of the statements contained in this survey report or the conclusions drawn from these statements are accurate or true. 1. How the corrective action will be accomplished for	01/05/2026

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F0883 SS = D	Continued from page 30 resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or	F0883	Continued from page 30 those residents found to have been affected by the deficient practice Resident #1 was reviewed immediately for current pneumococcal immunization eligibility based on CDC recommendations. The resident and/or resident representative was re-educated on the benefits and potential side effects of the pneumococcal vaccine, including updated CDC guidance regarding PCV20/PCV21. The pneumococcal vaccination was re-offered to the resident, and the resident's decision (acceptance or refusal) was documented in the medical record. Nursing and MDS staff were counseled regarding the requirement to re-offer pneumococcal vaccination even after a prior declination. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice The MDS Coordinator and Infection Control Nurse conducted a facility-wide review of all resident immunization records to ensure: Pneumococcal vaccines are offered in accordance with current CDC recommendations Education regarding benefits and potential side effects is documented Acceptance, refusal, or contraindication is clearly documented Any resident identified as eligible and not previously re-offered vaccination was immediately addressed. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Facility immunization policies were reviewed and reinforced to clarify that:	

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F0883 SS = D	Continued from page 31 refusal. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review and staff interview, the facility failed to offer and/or provide pneumococcal vaccination for 1 of 5 sample residents (#1) reviewed for immunization status. The findings were: 1. Review of the immunization record for resident #1 showed the resident received the pneumococcal PPSV 23 vaccine on 1/1/94 and the pneumococcal PCV 13 vaccine on 9/25/17. Review of the CDC pneumococcal vaccine recommendations showed the resident was recommended to receive the pneumococcal PCV20 or PCV21 5 years after s/he received the PCV 13 vaccine. The following concerns were identified: a. Review of the resident's medical record showed an annual pneumococcal vaccination was offered and declined in 2024; however, there was no evidence the resident was offered annually after the declination. 2. Interview with the MDS coordinator on 2/11/25 at 10:41 AM revealed she did not think the resident had been offered the pneumococcal vaccine since s/he declined in 2024.	F0883	Continued from page 31 Pneumococcal vaccination must be re-evaluated and re-offered when CDC recommendations change, eligibility criteria are met, regardless of prior declination or annually if indicated. Nursing and MDS staff received re-education on: Current CDC pneumococcal vaccine guidelines Documentation requirements for education, offering, acceptance, or refusal Immunization review was added to the routine quarterly MDS and care plan review process. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur The MDS Coordinator or designee will audit immunization records: Monthly for 3 months Then quarterly for ongoing compliance Audits will verify timely offering of influenza and pneumococcal vaccines, appropriate education, and complete documentation. Results will be reviewed through the QA/QAPI process, and corrective actions will be implemented as needed. 5. Responsible Party MDS Coordinator Director of Nursing Infection Preventionist Nurse Care Coordinators 6. Date of Compliance	

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F0883 SS = D		F0883	Continued from page 32 1/5/2025	