

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>535023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>03/31/2026</b>
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NAME OF PROVIDER OR SUPPLIER <b>Weston County Health Services</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1124 Washington Blvd , Newcastle, Wyoming, 82701</b>
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(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
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F0000	<p><b>INITIAL COMMENTS</b></p> <p>A complaint survey was conducted by Healthcare Licensing and Surveys from 3/30/26 through 3/31/26.</p> <p>The following common abbreviations are used throughout this document:</p> <p>BIMS: Brief Interview for Mental Status</p> <p>NHA: Nursing Home Administrator</p> <p>Less commonly used abbreviations will be annotated within the deficiency.</p>	F0000		04/14/2026
F0602 SS = D	<p>Free from Misappropriation/Exploitation</p> <p>CFR(s): 483.12</p> <p>§483.12</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>This requirement was not met as evidenced by:</p> <p>Based on observation, resident trust account review, Amazon order review, medical record review and staff and resident representative interview, the facility failed to protect residents from misappropriation of resident property for 1 of 3 sampled residents (#2) reviewed for misappropriation of property. The findings were:</p> <p>1. Review of the 1/14/25 quarterly MDS assessment showed resident #2 had a BIMS score of 3 out of 15, which indicated severe cognitive impairment, and diagnoses which included dementia, non-traumatic brain dysfunction, and menière's disease. Further review showed the facility managed the resident's funds</p>	F0602	<p>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.</p> <p>Deficient Practice: The facility failed to ensure proper oversight and authorization of resident online purchases, creating the potential for misappropriation of resident funds.</p> <p>1. Corrective Action for Affected Resident(s): The identified resident's online purchase activity was immediately reviewed. All transactions were audited to ensure purchases were appropriate, for the residents' benefit, and reflected proper authorization. Documentation was updated to include resident consent and administrative review. No negative outcome was identified.</p> <p>2. Identification of Other Residents at Risk: An audit was conducted of all residents with managed personal funds and those who have utilized facility assistance for purchases within the past 30 days. This audit included review of documentation, receipts, and verification of appropriate authorization. Residents with cognitive impairment (as identified by BIMS scores and care plan documentation) were specifically reviewed to ensure appropriate involvement of the responsible party or Power of Attorney (POA). Any discrepancies</p>	03/31/2026

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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F0602 SS = D	<p>Continued from page 1 through a trust account. Attempts to interview the resident were unsuccessful due to cognitive debilities. The following concerns were identified:</p> <p>a. Review of the document titled "Business Order Information" provided by the NHA on 3/30/26 at 4:30 PM showed an Amazon order was placed for resident #2 on 2/10/25 which included 3 Meta Quest virtual reality headsets in the amount of \$399.99 per unit.</p> <p>b. Review of the document titled "Weston County Health Services Trust Transaction History" provided by the patient services coordinator on 3/31/26 at 11:12 AM showed a debit from the residents' trust account dated 2/10/25 in the amount of \$1,878.78 for Amazon purchases.</p> <p>c. Observation on 3/30/26 at 1:45 PM showed 3 Meta Quest virtual reality headsets in their original boxes (one opened) in the activities storage room located near the main dining room.</p> <p>d. Interview with the activities director on 3/30/26 at 1:46 PM revealed she did not know who the devices belonged to and they had been stored in the closet since February of 2025. She further revealed the devices required an internet source and she didn't know how to use them.</p> <p>e. Interview with the resident's responsible party on 3/31/26 at 10:15 AM revealed s/he knew nothing about the Meta Quest purchase. In addition, s/he did not believe the resident would have been capable of operating the virtual reality devices.</p> <p>f. Interview with the NHA on 3/31/26 at 10:30 AM revealed the resident was obligated to "spend down" his/her trust account as Medicaid requirement and 3 Meta Quest virtual reality headsets were ordered for the resident and possibly some friends to utilize.</p>	F0602	<p>Continued from page 1 identified were immediately corrected.</p> <p>3. Systemic Changes / Measures Put in Place:</p> <ul style="list-style-type: none"> <li>- The facility has implemented a formal Online Purchase Authorization Process to prevent misappropriation of resident funds.</li> <li>- Residents with decision-making capacity must sign an Online Purchase Authorization Form prior to any purchase, indicating approval of the item, cost, and reason for purchase.</li> <li>- Residents with cognitive impairment (as identified by BIMS score and/or care plan) will require authorization from the responsible party and/or POA prior to any purchase.</li> <li>- The Nursing Home Administrator (NHA) will review and sign off on each purchase after authorization is obtained and prior to final processing, ensuring appropriateness and oversight.</li> <li>- A standardized authorization form will be utilized for each transaction, including:                             <ul style="list-style-type: none"> <li>Resident name</li> <li>Item description</li> <li>Cost</li> <li>Reason for purchase</li> <li>Resident or responsible party/POA signature</li> <li>NHA review/signature</li> </ul> </li> <li>- Staff responsible for resident funds have been re-educated on misappropriation, resident rights, abuse prevention, and proper financial transaction procedures, including determining capacity and appropriate consent.</li> </ul> <p>4. Monitoring to Ensure Ongoing Compliance:</p> <ul style="list-style-type: none"> <li>- 100% of online purchases will include documented appropriate authorization (resident or POA) followed by NHA review and sign-off prior to completion.</li> <li>- A log of all online purchases will be maintained and reviewed for compliance.</li> </ul>	

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F0602 SS = D		F0602	Continued from page 2  <ul style="list-style-type: none"> <li>· The QAPI Committee will review online purchase activity monthly for 3 months, then quarterly thereafter, with focused review of purchases involving cognitively impaired residents.</li> <li>· Weekly audits will be conducted until 100% compliance is achieved for 4 consecutive months. Once achieved, monthly audits will be conducted thereafter to verify compliance with authorization and oversight requirements.</li> <li>· Any concerns identified will result in immediate corrective action and re-education of staff.</li> </ul> <p>5. Date of Compliance:</p> <ul style="list-style-type: none"> <li>· 3/31/2026</li> </ul>	