STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535034	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westward Heights Care Center	**150 Caring Way , LANDER, Wyoming, 82520**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint investigation was conducted on 5/19/26 through 5/20/26. The survey was prompted by complaint intakes 2982761 and 2986671. The following abbreviations are used throughout this document: EMS: Emergency Medical Services ER: Emergency Room IDT: Interdisciplinary Team MDS: Minimum Data Set NHA: Nursing Home Administrator UA: Urinalysis Less commonly used abbreviations will be annotated in each deficiency.	F0000		
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is	F0627	PLAN OF CORRECTION – F627 (Inappropriate Discharge) Tag: F627 1. How the facility will correct the deficiency for the resident(s) affected: Resident #1's situation was reviewed by the Interdisciplinary Team (IDT), including the Administrator, Director of Nursing (DON), and Social Services on 5/22/2026 to identify process and documentation gaps. Facility leadership, including the Administrator, DON, and Social Services, received re-education on transfer and discharge regulations, including resident rights, appeal protections, and reassessment requirements on 6/11/2026 by the Director of Social Work & Admissions.	06/29/2026

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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F0627 SS = D	Continued from page 1 endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §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. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i)	F0627	Continued from page 1 The facility reviewed Resident #1's status to ensure compliance with federal regulations related to discharge, including physician documentation, IDT involvement, and appropriate discharge criteria. The facility implemented a revised process requiring clinical reassessment of hospitalized residents prior to any discharge determination to ensure the resident continues to meet Skilled Nursing Facility (SNF) level of care criteria and regulatory requirements. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: A 100% audit of all hospital transfers and facility-initiated discharges within the past 90 days was completed on 6/11/2026 by the Director of Nursing and Social Services. The audit included review of: Discharge notice compliance Resident right to return Physician documentation supporting discharge decisions IDT participation and evidence of reassessment Audit results were reviewed by the Administrator on 6/11/2026. No additional concerns identified. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility implemented the following systemic changes: Policy Revision: Clarified requirements for discharge, including prohibition of immediate	06/29/2026

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F0627 SS = D	Continued from page 2 of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.	F0627	Continued from page 2 discharge from hospital status, required physician documentation, and defined criteria for discharge decisions. IDT Process: Mandatory IDT review for all involuntary discharges, including documentation of interventions, reassessment, and clinical considerations. Hospital reassessment protocol implemented. Notice & Appeals: Social Services to ensure timely notice, appeal rights, and Ombudsman notification. Discharge Planning: Strengthened to ensure resident-centered planning, confirmed placement, and coordination. Education: Staff trained on F627 requirements, discharge regulations, hospital coordination, behavioral health, and documentation standards by Director of Social Work & Admissions on 6/11/2026. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The facility will conduct ongoing audits of all hospital transfers and involuntary discharges as follows: Weekly audits for 4 weeks beginning 6/8/2026. Monthly audits for 2 additional months thereafter Audits will be conducted by the Director of Nursing and Social Services and will include: Verification of discharge reason Physician documentation IDT review and involvement Compliance with notice requirements	06/29/2026

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F0627 SS = D	Continued from page 3 §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to	F0627	Continued from page 3 Evidence of reassessment prior to discharge Audit results will be reviewed at the facility's Quality Assurance and Performance Improvement (QAPI) meetings by the Administrator, DON, and IDT. Any identified noncompliance will result in: Immediate corrective action Staff re-education Progressive discipline as indicated 5. By what date the corrective action will be completed: Completion Date: June 29, 2026	06/29/2026

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F0627 SS = D	Continued from page 4 not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §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: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, resident representative, hospital staff, and staff interview, the facility failed to ensure residents were allowed to return following acute hospitalization for 1 of 4 sample residents (#1) reviewed for transfer and discharge. The findings were: 1. Review of a discharge MDS assessment dated 4/10/26 showed resident #1 admitted to the facility	F0627		06/29/2026

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F0627 SS = D	Continued from page 5 on 6/14/22 and had an unplanned hospital discharge return not anticipated on 4/10/26. Review of progress notes dated 4/10/26 and timed 7:50 AM, 8/24 AM, and 1:01 PM showed at approximately 6 am the resident had increased agitation with behaviors. Further review showed the resident had an elevated blood glucose, was administered insulin per a sliding scale, and was transferred via EMS for evaluation and treatment. The following concerns were identified: a. Review of a progress note dated 4/10/26 and timed 1:28 showed “LATE ENTRY Note Text: IDT team met with Westward Height’s management company. That meeting included Director of Facility Operations, Director of Clinical Services, Social Worker, and Director of Revenue Services. Given the background of situation and current status of theresident [sic], the team discission was to issue an involuntary discharge notice d/t: The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; and it is necessary for resident’s welfare, and [his/her] needs cannot be met in the facility. Call was then placed to ER to notify of immediate discharge of facility at 11:17 AM. ER supervisor [Name] stated that resident did not qualify for admission or psych stay stating " denying suicidal or homicidal ideation.” Call then placed to [name] state ombudsmen to notify of situation. Ombudsmen recommended placement at a psychiatric skilled nursing facility in Utah that has had good results in the past for a similar situation. IDT placed call to Utah facility called [Name of facility] in SLC. They stated they have open beds at this time and information given to provide referral via fax. Call then placed by IDT team back to ER director, the information was passed to ER director for [Name of facility] information. ER director stated that no case management was in ER, it was not her responsibility to send the referral, and the ER is not able to send referrals. Then IDT placed phone call to [name], the resident’s [spouse] notifying [him/her] of [Name of facility] aspotential [sic] option for safe placement. [Spouse] was also notified of involuntary discharge d/t [due to] level of care and safety and health of the individual in facility due from the Administrator and IDT team. [Spouse] was in agreement with no return to Westward Heights d/t concerns listed above that [Name of facility] would be a better fit for [him/her] right now. [Spouse] was going to make [his/her] way to the hospital and discuss this with ER staff. [Spouse] then called IDT team back and stated ER was ready to discharge [him/her] and [s/he]was [sic] ready for pickup and please coordinate with hospital in regard to plan moving forward. [Spouse] did state at this time that	F0627		06/29/2026

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F0627 SS = D	Continued from page 6 [s/he] was willing to help with anything that needed to be coordinated but would be unable to provide facility with any 1:1 resident support needed for [his/her] return. IDT then called to discuss with management company and give update on current situation. Management company re-irritated to IDT that it was unsafe to take resident back d/t suicidal ideation and safety and health of individuals in the facility. Nurse manager then called IDT team back again and stated resident discharged from ER and WHCC staff needed to work on transport. IDT team then again re-iterated involuntary discharge was issued and was no longer a resident effectiveimmediately [sic] on 4/10/26 d/t health and well being [sic] of others and suicidal ideation. IDT then placed a phone call to Westward Height's Medical Director to notify of situation at hand. Medical Director in agreement with discharge of resident. She placedcall [sic] to ER and discussed the situation with the ER. ER provider refused to speak with Westward Height's Medical Director. Medical Director spoke with the nurse manager explaining the discharge and asked questions regarding the psych evaluation. Medical Director returned call to DON and notified DON that she was waiting on call from psychiatrist to discuss the severity of resident's mental health. After Medical Director spoke with psychiatrist at hospital, he was in agreement to make an addendumto [sic] his recommendation that [s/he] was unsafe to return to WHCC and required placement in memory care. [Name], the ER nurse manager then called facility and asked IDT if they have received records in attempt again to make arrangements for transport, IDT team re-iterated again that involuntary notice has been issued and [s/he] is no longer a resident of this facility. The nurse manager then asked if family had been notified. IDT was able to confirm that family was also notified of discharge. [Name] then informed IDT that [s/he] would be discharged from ER and would need to return home with family. [Name] [spouse] then placed phone call to IDT team stating the hospital was discharging [him/her] with an unsafe plan and he was unable to care for [him/her] at home. IDT team then againexplained [sic] that we could not accept back due to safety of individual and the safety of all residents in facility. Following this phone call Social Services called [Name of facility] in SLC and asked if we could send a referral on behalf of hospital. [Name] at [Name of facility] reviewed referral however, did recommend WHCC excuse themselves from referral process as it needs to come from the hospital. Call then placed to [spouse] to notify [him/her] of referral was placed to [name of facility]. [Name]was appreciative of this call and had since calmed down from previous	F0627		06/29/2026

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F0627 SS = D	Continued from page 7 conversation and stated the hospital admitted her since he is unable to care for her at his home. DON then placed a phone call to primary care provider to be aware of situation. Primary care stated he has talked with ER and agreed that [Name of facility] would be in [his/her] best option for a transition. Provider was thankful for phone called placed with no further questions or concerns." b. Review of a "Social Services Transfer/Discharge Plan and Notice to Resident" dated 4/13/26 and timed 9:30 AM showed the resident was transferred on 4/10/26 to the hospital, and the reason for transfer was "Suicidal ideation/ combative." Further review showed the notice was provided to the resident/representative by mail on 4/13/26. c. Review of a hospital "Psychiatry Consul Note" dated 4/10/26 and timed 10:21 AM showed "…Discussed treatment options with the patient. The patient does not need inpatient psychiatric treatment at this time. [S/he] can be discharged if [s/he] is medically stable…" d. Review of an addendum to hospital "Psychiatry Consul Note dated" 4/10/26 and timed 3:21 PM showed "[His/her] current facility does not want to accept [him/her] because of [his/her] recent behavioral changes. They do not feel safe to keep [him/her]. The patient is unable to take care of [him/herself]. [S/he] will not be safe to be discharged without any placement. At this time I recommend to transfer [him/her] to a memory care unit..." e. Review of a hospital note dated 4/11/26 showed "…Patient with dementia that has been somewhat increased since [s/he] had changed blood pressure medications about a week ago and [s/he] has had some increased confusion. [S/he] had been sent up here from the nursing home and they would NOT take [him/her] back and discharged [him/her] from their facility declining to allow [him/her] back into their facility today. The ER had done a workup and planned to send [him/her] back however they would not take [him/her]. Administration here was notified and request to me to place patient in hospital. Patient will be placed in the hospital with supportive care. Ordered a one-to-one staff. Working on getting the patient to facility that will be most supportive for [him/her] with memory Care ideally. Will work on controlling [his/her] anxiety as well here. [S/he] was seen by tele psychiatry has [sic] it was reported from the facility that [s/he] was suicidal however [s/he] has not been suicidal at all and the psychiatrist did not feel like [s/he] was suicidal..."	F0627		06/29/2026

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F0627 SS = D	Continued from page 8 f. Review of the hospital notes showed the resident received 1-to-1 from hospital staff on 4/10/26 and 4/11/26, and had been removed from 1-to-1 on 4/12/26 at 7:15 AM. g. Review of a hospital note dated 4/15/26 and timed 5:24 AM showed "…No new issues reported overnight. Patient overall does not have any specific new complaints or problems. [S/he] is calm and pleasant this morning…" h. Review of a hospital note dated 4/16/26 and timed 5:58 AM showed "…Patient slept well overnight. There are no new issues reported. [S/he] is calm and pleasant…" i. Review of a hospital note dated 4/17/26 and timed 10:14 AM showed "…pt very chatty today, a little stream of conscious. pleasant...waiting on placement…" m. Review of a hospital discharge summary dated 4/17/26 and timed 12:52 PM showed "…1. Dementia, w overlying acute metabolic encephalopathy likely due to acute respiratory infection, possible clonidine use. Reportedly worsening dementia. Possibly in part due to recent initiation of clonidine contributing, though appears may have been longer in history. UA and other workup for other causes of worsened dementia were negative. [S/he] had been sent up here from the nursing home and they would NOT take [him/her] back and discharged [him/her] from their facility – declining to allow [him/her] back into their facility…[His/her] mental status after being taken off Clonidine has seemed to have improved some…Has been appropriate and cooperative here. Per family did have improvement in the acute confusion and seemed back to [his/her] baseline…" j. Interview with the resident's representative on 5/19/26 at 2:42 PM revealed the resident had been on a 1-to-1 at the hospital for 24 hours, and had stabilized within a day after medication changes had been made. Further interview revealed the resident had been moved to a long term care facility 2 and a half hours away, and did not require memory care. k. Interview hospital staff #1 on 5/19/26 at 3:14 PM revealed facility staff did not reassess the resident at the hospital. l. Interview with the NHA and DON on 5/20/26 at 10 AM revealed the facility could not provide mental health services or 1-to-1 supervision for the resident, and an emergent discharge had been	F0627		06/29/2026

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F0627 SS = D	Continued from page 9 issued for the resident's safety and the safety of other residents in the facility based on his/her behaviors at the time of discharge. Further interview confirmed the resident had not been assessed because s/he had already been discharged as a resident from the facility. m. Interview with the DON on 5/20/26 at 1:14 PM revealed the resident had been provided with a 1-to-1 on for approximately 1 1/2 hours prior to being discharged to the hospital. Further interview revealed the resident had never been involved in any resident-to-resident altercations.	F0627		06/29/2026