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 08/13/2026

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 complaint survey was conducted by Healthcare Licensing and Surveys from 8/11/26 through 8/13/26. The survey was prompted by complaint intakes #3008410, #3117687, #3108946, #3091259, #3091095, #3133625, #3091116, #3091128, #3020125, #3015135, #3013871, and #2990011. The following common abbreviates are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F0000		08/26/2026
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 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:	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. Corrective Action(s) Accomplished for Those Residents Found to Have Been Affected Resident #3 was immediately protected following the identified incident through separation from resident #4 and relocation to the secure unit. Resident #3 continues to be protected from further contact with resident #4. Resident #4's care plan has been reviewed and updated to identify the risk for inappropriate interactions with other residents and to include specific interventions related to supervision, appropriate boundaries, redirection, and resident safety. Resident #4 will not be left alone with female residents. Staff will provide supervision when	08/13/2026

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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F0600 SS = G	Continued from page 1 Based on medical record review, resident representative and staff interview, facility incident report review, plan of correction review, and policy and procedure review, the facility failed to protect the resident's right to be free from sexual abuse by a resident for 1 of 4 sample residents (#3) reviewed for abuse. This failure resulted in actual harm to resident #3. The findings were: 1. Review of the quarterly MDS assessment dated 5/19/26 showed resident #3 had severely impaired cognitive function and diagnoses which included cerebral palsy, anxiety disorder, anoxic brain damage, and unspecified disorder of adult personality and behavior. Further review showed the resident was non-verbal, non-ambulatory, impaired in both lower extremities, and wheelchair bound. In addition, the resident was dependent upon staff for all mobility, eating and hygiene activities, and required substantial to maximal assistance with upper and lower body dressing. Review of the quarterly MDS assessment dated 5/4/26 showed resident #4 had a BIMS score of 14 out of 15 and had diagnoses which included anemia, hypertension, and diabetes mellitus. Further review showed resident #4 ambulated with a walker and was independent with mobility. The following concerns were identified: a. Review of the facility incident report dated 7/1/26 and timed 12:48 PM showed CNA #1 observed resident #4 with his/her hand inside the shirt of resident #3 while in the solarium common area television room. Resident #4 then immediately removed his/her hand from the inside of resident #3’s shirt and left the solarium room. b. Interview with CNA #1 on 8/13/26 at 2:51 PM confirmed she had witnessed resident #4 with his/her hand down the shirt of resident #3. The CNA stated “…[his/her] left hand was down the front of [resident #3’s] shirt and appeared to be touching his/her [skin]...” She revealed resident #4 had removed his/her hand from resident #3’s shirt and had left the solarium room following the observation. She revealed "As soon as I got [resident #3] back to [his/her] room following the incident, the resident started flaying both arms around and leaning [his/her] head forward, which is what [s/he] does when anxious”. c. Interview with resident #3’s family representative on 8/13/26 at 1:34 PM revealed “…Resident #4 shouldn’t have touched resident #3 and resident #3 would have been fearful of resident #4…”	F0600	Continued from page 1 resident #4 is in common areas where interactions with female residents may occur. A behavioral agreement was implemented for resident #4 addressing appropriate interactions and physical boundaries with residents and staff. Increased monitoring, including hourly checks, has been implemented and will be documented. The interdisciplinary team will review both residents' care plans and make additional revisions as indicated by their individual needs, behaviors, or changes in condition. 2. Identification of Other Residents Who Have the Potential to Be Affected and Corrective Action The facility will identify residents who may have the potential to be affected by the same deficient practice by reviewing current residents for identified behavioral risks, previous allegations or incidents involving inappropriate resident-to-resident interactions, and residents who regularly interact with resident #4 in common areas. Residents identified as potentially affected will be assessed/interviewed, as appropriate to their cognitive and communication abilities, to determine whether they have experienced or witnessed inappropriate interactions or have concerns regarding their safety. Any resident identified with a concern will receive immediate assessment and appropriate protective interventions. The resident's care plan will be reviewed and updated to address any identified risk or need. The facility will also review incident reports and abuse/neglect reports to identify any additional concerns involving inappropriate resident-to-resident interactions and will address any findings accordingly. 3. Measures Put Into Place/Systemic Changes to Ensure the Deficient Practice Does Not Recur The facility has reviewed its process for ensuring that interventions implemented following an abuse allegation or other significant behavioral event are incorporated into the resident's care plan. The interdisciplinary team will be educated that when a new safety risk, behavioral concern, or abuse allegation is identified, the resident's care plan must be reviewed and updated to accurately reflect the	08/13/2026

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F0600 SS = G	Continued from page 2 d. Review of the document titled “Plan of Correction” dated 7/7/26 showed “…Systemic changes implemented…The care plans for both residents were reviewed and updated if required to reflect the identified risks, interventions, and monitoring needs…” e. Interview with the nursing home administrator on 8/13/26 at 3:57 PM revealed she was aware of the incident and she stated the facility had developed a plan of correction which included a behavioral contract with resident #4. She revealed the plan included supervision by staff when resident #4 was in common areas and hourly checks. She revealed resident #3 was relocated to the secure unit of the facility. f. Review of the care plan last revised 7/29/26 for resident #4 showed no identified risks, interventions, or monitoring had been documented. 2. Interview with the nursing home administrator on 8/13/26 at 4:10 PM confirmed the care plan for resident #4 had not been updated according to the facilities plan of correction. 3. Review of the document titled "Abuse/Neglect Policy" last revised 12/19 showed “…It is the policy of Weston County Manor that each resident will be free from abuse…”.	F0600	Continued from page 2 identified risk and all ongoing interventions. The facility will specifically verify that interventions being implemented by staff are reflected in the resident's care plan. Education will include: Abuse prevention and resident-to-resident abuse. Immediate protection and separation of residents following an allegation. Identification of residents at risk for inappropriate interactions. Appropriate supervision and monitoring. Appropriate resident boundaries. Timely care-plan review and updating. Ensuring staff are following the interventions identified in the care plan. Documentation of required monitoring and interventions. Reporting changes in resident condition or behavior to the interdisciplinary team. 4. Plan for Monitoring Corrective Actions to Ensure the Deficient Practice Is Corrected and Sustained The Nursing Home Administrator, or designee, will begin weekly audits upon implementation of corrective actions. Audits will be conducted for four consecutive weeks to validate continued compliance and effectiveness of the corrective actions. Any identified concerns will be immediately corrected, with additional education and/or care-plan revisions completed as indicated. The audits will verify: Identified risks are reflected in the resident's care	08/13/2026

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F0600 SS = G		F0600	Continued from page 3 plan. Care-plan interventions are specific and appropriate to the identified risk. Staff are implementing the interventions identified in the care plan. Required monitoring is completed and documented. Changes in resident condition or behavior are communicated to the interdisciplinary team. Care plans are revised when resident needs or risks change. Audit results will be reviewed by the Administrator and Director of Nursing. Any identified deficiency will be corrected immediately, and additional staff education will be provided as indicated. Results of the audits will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee. The QAPI Committee will review the results to determine whether the corrective actions are effective and sustained and whether additional system changes are necessary. After the initial four-week monitoring period, the facility will continue to monitor care-plan compliance through the facility's established QAPI process. Date of Compliance August 14, 2026	08/13/2026