STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535039	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westview Health Care Center	**1990 West Loucks St , Sheridan, Wyoming, 82801**

(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 3/31/26 through 4/2/26. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nurse Aide DON: Director of Nursing NHA: Nursing Home Administrator RN: Registered Nurse Less commonly used abbreviations will be annotated within the deficiency.	F0000		04/24/2026
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, process improvement plan review, and staff interview, the facility failed to implement interventions to ensure residents were free from accident hazards in 1 of 3 sampled residents (#5) reviewed for accident hazards, which resulted in harm to the resident. The findings were: Based on medical record review, process	F0689	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual F0689 Free of Accident and Hazards 1. Res #5 no longer resides at the facility as of 10/26/2025. 2. All residents who have had a fall are at risk of intervention not being implemented. 3a) Education was provided to all Nursing staff on 11/19/25, 11/25/25 and 01/15/26 to provide necessary information regarding verification of fall interventions and reviewing the process surrounding falls, communication as well as documenting and	04/29/2026

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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F0689 SS = G	Continued from page 1 improvement plan review, and staff interview, the facility failed to implement interventions to ensure residents were free from accident hazards in 1 of 3 sampled residents (#5) reviewed for accident hazards, which resulted in harm to the resident. The findings were: 1. Review of the 10/14/25 quarterly MDS assessment showed resident #5 had a BIMS score of 6 out of 15, which indicated severe cognitive impairment, and had diagnoses which included hemiplegia, difficulty walking, renal insufficiency, heart failure, coronary artery disease, and a history of a cerebrovascular accident (stroke). Further review showed the resident was dependent for all transfers, required substantial assistance with standing from a seated position, and his/her primary mode of mobility was a wheelchair. Review of the care plan dated 4/11/25 showed the resident was a high fall risk. Revision on 4/24/25 showed interventions which included "…Mat on floor for safety." Additionally, medical record review showed the resident had sustained a fall on 10/26/25, and was sent to the hospital on 10/30/25 at 7:09 PM, where s/he was diagnosed with fractures to the left humerus and the 9th through 12th ribs, and pneumonia. The resident was pronounced deceased on 11/1/25 at 4:15 PM. The following concerns were identified: a. Review of the progress note dated 10/26/25 and timed 3:40 PM showed "…Resident was found laying face first next to bed on the floor…Resident did not have floor mat in place upon fall…Intervention for fall is to make sure resident's floor mat is placed on floor at all times when resident is laying in bed to comfort fall." b. Interview with the DON on 4/1/26 at 4:39 PM confirmed there was no floor mat next to the resident's bed at the time of the fall, further stating "This is why we put the PIP and other interventions in place." c. Review of the resident pain level summary showed the resident experienced pain on 11 different occasions following the fall between 10/26/25 through 10/30/25. d. Review of the emergency room physician note dated 10/30/25 showed the resident complained of left arm pain and shortness of breath. Further review showed he/she was diagnosed with pneumonia. e. Review of the chest x-ray report dated 10/30/25 and timed 7:52 PM showed…"1….Pneumonia…2… displaced fracture of the proximal left humerus,	F0689	Continued from page 1 updating interventions in the care plan and Kardex, and how to access the Kardex. Facility reviewed all residents who have had falls within the last 6 months with Regional Team. b). Interventions put in place to increase communication and verification of interventions were implemented on 11/24/25. These included utilizing the white board in the CNA room that includes residents who have had a recent fall or are considered at high risk and listed interventions which is updated as needed. A list of recent falls and interventions to be placed at nurses station for 72 hour charting, interventions listed on "Special Care" section of residents chart in Point Click Care (PCC) and magnets to be placed on the inside of res doors to help remind staff to check if interventions are in place. c). Discussion of recent falls and interventions during daily grand rounds with the Internal Disciplinary Team (IDT), Completion of fall huddles at time of the incident and documentation within risk management tool. 4. A 100% audit of all residents who have fall interventions in place was conducted on 4/2/26. Audit results indicated that all res had interventions in place. Weekly audits to be conducted by DON or designee on residents who have fallen in the last 6 months to ensure interventions remain in place for a period of 3 months or until substantial compliance has been achieved. Weekly Risk management meeting with IDT to review current falls and interventions. 5. Fall information reviewed at each Quality Assurance Performance Improvement (QAPI) meeting on 11/25/25, 12/30/2025 and 1/27/2026, 2/25/2026. DON or designee will track and trend falls and interventions, review audits and report findings to QAPI monthly for review and feedback for a period of three months or until substantial compliance has been achieved.	04/29/2026

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F0689 SS = G	Continued from page 2 correlate for recent trauma and point tenderness." f. Review of the CT angiography of the chest dated 10/30/25 and timed 9:36 PM showed fractures of the 9 th through 12 th ribs. 2. Review of the document titled "Quality Assurance & Performance Improvement plan (PIP)" dated 11/24/25 showed "…The DON will track/trend falls and interventions, as well as review weekly audits and report findings to monthly QAPI for review and feedback for 90 days or until substantial compliance is achieved." Review of intervention audit forms provided by the NHA on 4/1/26 at 12:40 PM were blank. 3. Interview with the DON and NHA on 4/1/26 at 4:19 PM revealed there was no evidence the audits were completed. 4. Review of the document titled "Fall Management" last revised 9/25/25 provided by the DON on 4/2/26 at 10 AM showed "…3. Implement Interventions…consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and if not, reduce the risk of an accident."	F0689		04/29/2026