

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 Westview Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1990 West Loucks St Sheridan, WY 82801	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [DATE] 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 [DATE] showed the resident was a high fall risk. Revision on [DATE] showed interventions which included .Mat on floor for safety. Additionally, medical record review showed the resident had sustained a fall on [DATE], and was sent to the hospital on [DATE] 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 [DATE] at 4:15 PM. The following concerns were identified: a. Review of the progress note dated [DATE] 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 [DATE] 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 [DATE] through [DATE]. d. Review of the emergency room physician note dated [DATE] 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 [DATE] and timed 7:52 PM showed. 1. Pneumonia. 2. displaced fracture of the proximal left humerus, correlate for recent trauma and point tenderness. f. Review of the CT angiography of the chest dated [DATE] 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 [DATE] 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 [DATE] at 12:40 PM were blank. 3. Interview with the DON and NHA on [DATE] at 4:19 PM revealed there was no evidence the audits were completed. 4. Review of the document titled Fall Management last revised [DATE] provided by the DON on [DATE] 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.</p>

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 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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