STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	**1990 WEST LOUCKS STREET SHERIDAN, WY 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
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 7/10/23 to 7/12/23. The survey was prompted by complaint intake WY000003626.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 580		8/21/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/02/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	**1990 WEST LOUCKS STREET SHERIDAN, WY 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
F 580	Continued From page 1 (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on resident, resident representative, and staff interviews, medical record review, and review of facility policy, the facility failed to notify the appropriate entities for 2 of 6 (#22, #28) sample residents reviewed for notification of changes. The findings were: 1. During an interview with resident #22 on 7/10/23 at 3:35 PM the resident stated 2 night shift staff threw the resident in a wheelchair and slapped his/her left cheek causing "a little stinging" to the cheek. The resident stated s/he reported it to "the head lady" and the facility did not tell the family representative about the event. a. Interview with the resident's representative on 7/10/23 at 3:41 PM revealed the resident notified him/her of the event however, s/he never heard anything from the facility about the event. b. Interview with nurse aide (NA) #3 on 7/11/23 at 3:20 PM revealed resident #22 did tell	F 580	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 1. Resident #28 and #22 remain in the facility. Families and resident representatives have been notified of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	**1990 WEST LOUCKS STREET SHERIDAN, WY 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
F 580	Continued From page 2 her in June 2023 about being thrown around, and NA #3 told the nurse but didn't remember who the nurse was. c. Interview with the DON on 7/10/23 at 1:30 PM revealed the facility did not have any reports and was unaware of the event. Further review failed to show the resident had been assessed or monitored. 2. Interview with the resident #28 on 7/11/23 at 2:30 PM revealed the resident had been slapped by a staff member on the shoulder after he pinched her bottom. a. Interview with staff #3 on 7/11/23 at 3:20 PM confirmed she had slapped the resident on the shoulder as a reaction on 6/25/23 after this resident pinched her bottom. The staff member herself notified the nurse on duty at that time. b. Interview with resident #28 representative on 7/11/23 at 5 PM revealed he had not been notified by the facility the resident was slapped by a staff member. c. Interview with the DON on 7/11/23 at 4:20 PM showed the facility did not start an investigation, notify the doctor, state agencies or the family because the NA slapped the resident with an open hand and did not cause an injury. Further review failed to show a thorough investigation, and no assessments or monitoring in the resident's record. d. Review of the facility policy titled "Protection of Residents: Reducing the Threat of Abuse & Neglect" last revised 1/21/19 showed; "2. All associates are mandated to immediately report suspected resident abuse and/or neglect to their immediate supervisor and/ or facility representative. 3. All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin (e.g.,bruising and skin	F 580	occurrences with both residents. No negative outcomes have resulted in the families not being notified. 2. All residents involved in allegations of abuse, neglect, exploitation and mistreatment are at risk of staff failing to notify the incident to the responsible parties. 3. ED will provide education to all staff regarding the importance of notifying the resident's responsible party of any alleged incident immediately and appropriately. A checklist implemented to ensure all notifications to resident responsible parties are being completed for each allegation of abuse/neglect/exploitation/or mistreatment. 4. ED will complete a 100% audit of investigation log to ensure all allegations of abuse/neglect/exploitation or any mistreatment that are investigated also include notifying the resident responsible parties as required by federal regulation weekly for 4 weeks and monthly for 3 months. 5. Results of this audit will be reviewed at the Performance Improvement meetings monthly for three months or until the committee is able to determine the process in place is effective. Performance improvement meetings consisting of at a minimum the Executive Director, Director of Nursing, and Medical Director, and additional staff as needed. The Performance Improvement committee identifies issues with respect to which quality assessment, assurance activities are necessary and develops, and implements appropriate plans of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	**1990 WEST LOUCKS STREET SHERIDAN, WY 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
F 580	Continued From page 3 tears) will be immediately reported to the administrator and/or director of nursing. 4. when an incident of resident abuse is suspected, the incident must be reported to the supervisor regardless of the time lapse since the incident occurred. The supervisor notifies the director of nursing and the executive director of the alleged incident. ....6. the charge nurse will complete and sign the Incident Report and notify the physician and the resident's representative of the occurrence. ...8. The charge nurse will immediately assess the resident and offer medical attention, if necessary. Findings of the assessment and any treatment provided will be documented in the resident's medical record....11... Retaliation by staff is abuse, regardless of whether harm was intended, and must be cited....12. Facilities must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately.....and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Failure to do so will mean that the facility is not in compliance with the federal regulations."	F 580	action to correct identified quality deficiencies.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		8/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	**1990 WEST LOUCKS STREET SHERIDAN, WY 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
F 609	Continued From page 4 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, medical record review, and review of facility policy, the facility failed to report a reasonable suspicion of a crime against a resident for 1 of 2 (#28) sample residents reviewed for abuse allegations. The findings were: Review of the quarterly minimum data set (MDS) assessment the 6/5/23 for resident #28 showed the resident had a brief interview for mental status (BIMS) score of 3 out of 15, which indicated severe cognitive impairment and diagnoses which included diabetes mellitus, hypertension, and post traumatic stress disorder. Interview with the resident on 7/11/23 at 2:30 PM	F 609	1. Resident #28 remains in the facility. Incident was reported through state portal. No negative outcomes have resulted in the incident not being reported. Staff member was immediately provided education following the incident. 2. All residents involved in allegations of abuse, neglect, exploitation and mistreatment are at risk of staff failing to report the incident to the appropriate entities. 3. ED will provide education to all staff regarding the importance of reporting an alleged incident immediately and appropriately. Staff will discuss any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	**1990 WEST LOUCKS STREET SHERIDAN, WY 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
F 609	Continued From page 5 revealed the resident had been slapped by a staff member on the shoulder after s/he pinched the staff member's bottom. The following concerns were identified: 1. Interview with NA (non-certified nursing assistant) #3 on 7/11/23 at 3:20 PM confirmed s/he had slapped the resident on the shoulder on 6/23/25 as a reaction after this resident pinched his/her bottom. The staff member notified the nurse on duty at that time. a. Interview with the DON on 7/11/23 at 4:20 PM confirmed the facility did not start a risk management report, or report the incident to the state agency. The DON verbalized the resident was slapped by a staff member with an open hand which did not cause an injury. b. Review of the Wyoming Department of Healthcare Licensing and Survey incident data base showed no incidents of staff-to-resident abuse had been reported by the facility from 1/1/23 to 7/5/23. c. Review of the facility list of incident reports from 1/1/23 to 7/10/23 failed to show any reports created for resident #28 on 6/23/23. d. Interview with the Executive Director and Director of Nursing on 7/12/23 at 1:35 PM confirmed the incident was not reported to the state survey agency as required because the resident admitted to pinching the staff member's bottom and no injury occurred. d. Review of the facility policy titled "Protection of Residents: Reducing the Threat of Abuse & Neglect" last revised 1/21/19 showed; " 3. All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin (e.g.,bruising and skin tears) will be immediately reported to the administrator and/or director of nursing...12. Facilities must ensure	F 609	occurrences or issues of concern with residents during daily rounds. Regional Vice President will provide education to Executive Director, Social Service Director and Director of Nursing regarding the reporting requirement to the state survey agency for any allegation of abuse/neglect/exploitation/or mistreatment. 4. ED will complete a 100% audit of investigation log to ensure all allegations of abuse/neglect/exploitation or any mistreatment that are investigated are also reported to the state survey as required by federal regulation weekly for 4 weeks and monthly for 3 months. 5. Results of these audits will be reviewed during the Performance Improvement meetings for three months or until the committee is able to determine the process in place is effective.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	**1990 WEST LOUCKS STREET SHERIDAN, WY 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
F 609	Continued From page 6 that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately.....and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Failure to do so will mean that the facility is not in compliance with the federal regulations."	F 609		