CENTERS FOR MEDICARE & MEDIC SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

7/19/06

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
K 000	INITIAL COMMENTS Surveyor #: 18186 The regulatory reference is 42 CFR 483.70 (a) except where a different regulation may be specifically referenced. K3: Building: Type V (111) single story building with a supervised automatic wet sprinkler system with a dry branch and fire alarm system. K6: Date of Plan Approval: 1988 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=102;SNF/NF=102 K9: The facility meets the Life Safety Code standards based on an acceptance of a Plan of Correction. "NFPA" National Fire Protection Association	K 000	Need to check what year it is back to code during	
K 014 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide flame retardant interior wall finishes in accordance with NFPA 101 Section 19.3.3.2 and 10.2.3. The findings were: 1. Observation on 06/13/06 at 9:11 AM revealed the newly installed wall finish on the bottom 4 feet of the dining room was not class A. The newly installed pine half round logs were class C interior	K 014	POC ACCEPTED WITH DATES BAKER, MNTC DIRECTOR, ON 7/19/06 @ 10 AM.	

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

Director of Maintenance 7/19/06

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.

JUL 19 2006

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K 000	INITIAL COMMENTS Surveyor #: 18185 The regulatory reference is 42 CFR 483.70 (a) except where a different regulation may be specifically referenced. K3: Building: Type V (111) single story building with a supervised automatic wet sprinkler system with a dry branch and fire alarm system. K6: Date of Plan Approval: 1988 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=102;SNF/NF=102 K9: The facility meets the Life Safety Code standards based on an acceptance of a Plan of Correction. "NFPA" National Fire Protection Association	K 000	This plan of correction constitutes Westview Health Care Center's credible allegation compliance with the Life Safety Code Standard effective 07/10/06.	
K 014 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide flame retardant interior wall finishes in accordance with NFPA 101 Section 19.3.3.2 and 10.2.3. The findings were: 1. Observation on 06/13/06 at 9:11 AM revealed the newly installed wall finish on the bottom 4 feet of the dining room was not class A. The newly installed pine half round logs were class C interior	K 014	K014 The facility will ensure that interior finish for corridors and exit-ways have a flame spread rating of Class A or Class B. 1. At the time of installation, the wall finish on the bottom 4 feet of the dining room was treated with SHER-WOOD Water White Conversion Varnish which has a flame spread rating of Class A. 2. At the time of installation the wall finish in the lobby was treated with SHER-WOOD Water White Conversion Varnish which has a flame spread rating of Class A. 3. The Maintenance Director will conduct a facility wide audit to identify and repair all found problems by ~~09/10/06~~. This audit will be reported at Quality Assurance meeting for three months or until ongoing compliance is established	7/20/06

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

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ving 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

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WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

7/18/06

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K 014	Continued From page 1 finish. 2. Observation on 06/15/06 at 9:17 AM revealed The newly installed wall finish in the lobby was not class A as required in exit access corridors. The newly installed pine paneling covering approximately 25% of the room on the north wall was from floor to ceiling. Pine paneling is class C interior finish. 3. The maintenance director reported he was not aware that wall coverings had to meet any classification. He further reported he was not aware wall coverings needed plan approval from the office of Healthcare Licensing and Surveys.	K 014	K-14 4. PLANS WILL BE SUBMITTED TO THE OFFICE OF HEALTHCARE LICENSING & SURVEYS, ENGINEERS FOR APPROVAL OF NEWLY INSTALLED INTERIOR FINISH.	7/19/06

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JS 7/19/06

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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations the facility failed to protect the corridor system in accordance with NFPA 101 Section 19.3.6.3. The findings were: 1. Observation on 06/13/06 between 9 AM and 12 PM revealed the following corridor doors had gaps between the top edge of the doors and the door frames which were greater than the allowed 1/8 th of an inch. a. The conference room b. Resident room #202 c. Resident room #201	K 018	K018 The facility will ensure that the gaps between the edge of the doors and the door frames is within 1/8th of an inch. 1. Maintenance Director will repair each door accordingly. a. The conference room door will be repaired by ~~09/10/06~~ b. The door for room 202 will be repaired by ~~09/10/06~~ c. The door for room 201 will be repaired by ~~09/10/06~~ 2. Maintenance Director will conduct an audit to identify and repair all found problems. This audit will be reported at Quality Assurance meeting for three months or until on going compliance is established.	7/28/06

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K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations the facility failed to protect 4 of 16 smoke barrier doors in accordance with NFPA 101 Section 19.3.7.6 and 4.6.12.2. The findings were: 1. Observation on 06/13/06 between 10 AM and 11:30 AM revealed the following double smoke barrier doors were equipped with latching devices which were not able to secure the doors into the frames: a. The smoke barrier doors near resident room #119. b. The smoke barrier doors near resident room #213.	K 027	K027 The facility will ensure that smoke barrier doors are in accordance with NFPA 101 Section 19.3.7.6 and 4.6.12..2 1. Maintenance director adjusted the double smoke barrier doors to ensure they would latch secure into the frames. a. The smoke barrier doors near resident room #119 was repaired on 06/21/06 b. The smoke barrier doors near resident room #213 was repaired on 07/21/06 The maintenance director will conduct a facility wide audit that will be reported to the Quality Assurance meeting for three months or until ongoing compliance is achieved.	

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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to separate 3 of 12 hazardous areas from other spaces by smoke-resistant assemblies in accordance with NFPA 101 Section 19.3.2.1 and 19.3.6 respectfully. The findings were: 1. Observation on 06/13/06 between 9 AM and 11:30 AM revealed the following areas were storing combustible material and did not have 1-hour separation or a self-closing device on the door. a. The administration area copy room was storing 8 cardboard boxes full of paper files. b. Resident room #206 was storing 4 mattress and 6 upholstered chairs. 2. Observation on 06/13/06 at 9:36 AM revealed the corridor alcove near resident room #118 was storing numerous folded cardboard boxes. 3. Maintenance director reported he was aware combustible items were not to be stored in non-hazardous rooms. He further reported he had instructed the nursing staff to not store extra items in unoccupied resident rooms.	K 029	K-29 #4 PLANS WILL BE SUBMITTED TO THE OFFICE OF HEALTHCARE LICENSING & SURVEYS FOR APPROVAL BY THE ENGINEERS FOR CHANGE OF FINISH OF SPRINKLER K 029 The facility will ensure separation of hazardous areas from other spaces by smoke-resistant assemblies. 1. Maintenance director will ensure all appropriate areas will have self-closing devices on the doors. a. The copy room door will have a self-closing door installed by ~~09/10/06~~ 7/28/06. b. Resident room #206 will have the extra mattresses and chairs removed by ~~09/10/06~~. 2. The cardboard boxes have been removed from the alcove near resident room # 118. 3. Maintenance director will conduct a facility-wide audit and repair any found problems. This audit will be reported to the Quality Assurance meeting for three months or until ongoing compliance is achieved.	7/19/06 7/19/06 7/28/06

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K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observations the facility failed to install the fire alarm system in accordance with NFPA 72 Section 4-4.4.2.3. The finding was: 1. Observation on 06/13/06 at 12:58 PM during the fire drill revealed the central hall corridor had more than two strobes in the field of view spaced closer than the allowed 55 feet which were not synchronized. A pair of strobes were located at	K 051	V-256 1. PLANS WILL BE SUBMITTED TO THE OFFICE OF HEALTHCARE LICENSING & SURVEY FOR APPROVAL BY THE ENGINEERS FOR MODIFICATION OF THE FIRE ALARM SYSTEM. K 051 The facility will ensure that the installed fire alarm system is in accordance with NFPA 72 Section 4-4.4.2.3 1. Maintenance Director will be sure the strobes are appropriately spaced and synchronized by ~~09/10/06~~. Maintenance Director will conduct a facility wide audit repairing all found problems and reporting this to the Quality Assurance meeting for three months or until ongoing compliance is achieved.	7/19/06 7/28/06

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K 061	Continued From page 6 each end of the corridor spaced 10 feet from each other. The distance between the pair of strobes was 40 feet. The four strobes were not synchronized.	K 061		
K 075 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to limit the amount of soiled linen receptacles in non-hazardous areas in accordance with NFPA 101 Section 19.7.5.5. The finding was: 1. Observation on 06/13/06 at 9:42 AM revealed the special care unit shower room stored 2 soiled linen receptacles within 8 feet of each other. Maintenance staff reported he was unaware nursing staff was storing soiled linen receptacles in shower rooms. He further reported he was not aware that you could not store linen receptacles within 8 feet of each other.	K 075	K 075 The facility will limit the amount of soiled linen receptacles in non-hazardous areas in accordance with NFPA 101 Section 19.7.5.5. 1. Maintenance Director will remove soiled linen receptacles from the special care unit shower room and ensure they are appropriately stored in designated soiled utility rooms by 09/10/06. 2. Maintenance Director will conduct a facility wide audit and repair all findings. This audit will be reported to the Quality Assurance meeting or until on-going compliance is achieved.	7/28/06