DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2010
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	01/28/2010

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
K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered single story building of Type V(III) construction built in 1988. The building was equipped with a supervised automatic wet sprinkler system with a dry branch and an addressable fire alarm system.	K 000		
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:	K 018	K018 The facility will ensure that there is no impediment to the closing of a corridor door. 1) The door to room 220 was fixed prior to the end of survey. 2) The maintenance director will check all corridor doors on a regular schedule to ensure they close in their frame with 5 foot pounds of pressure or less applied. 3) Members of the Performance Improvement Team will use a quality-monitoring tool to ensure that all corridor doors close in their frames with the correct amount of pressure applied. The results of the audits will be reported monthly at the Performance Improvement Meeting for a period of three months or until substantial compliance is met.	3/10/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cynthia L. Rankin RN CRRN, NHA — TITLE — (X6) DATE: 2-21-10

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.

RECEIVED
Wyoming Dept of Health

Approved without changes on 3/3/10 @ 2:30 pm —

FEB 22 2010

Office of Healthcare Licensing and Surveys

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K 018	Continued From page 1 Based on observation and staff interview, the facility failed to ensure one corridor door was able to resist the passage of smoke in 1 of 6 smoke compartments. The findings were: Observation on 1/27/10 at 1:18 PM revealed the corridor door to resident room #220 did not close in its frame unless force in excess of 5 foot pounds of pressure was applied. The maintenance manager confirmed the observation at the time.	K 018		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure facility exit access was unobstructed in 1 of 5 smoke compartments. The findings were: Observation on 1/25/10 at 7:33 PM and then again on 1/26/10 at 3:48 PM revealed a snow drift approximately 12 inches high blocking the south hall east exit sidewalk. The drift allowed the door to open approximately fourteen inches. Interview with the maintenance manager on 1/27/10 at 2 PM confirmed the snowdrift interfered with the swing of the exit door. The manager also stated the drift had been removed the previous evening after the surveyor's observations.	K 038	K038 The facility will ensure that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1) The snow drift blocking the south hall east exit sidewalk was removed prior to the end of survey. 2) The maintenance director will check all exits regularly to ensure that all are unobstructed. 3) Members of the Performance Improvement Team will use a quality-monitoring tool to ensure that all exits are unobstructed. The results of the audits will be reported monthly at the Performance Improvement Meeting for a period of three months or until substantial compliance is met.	3/10/10
K 130 SS=F	NFPA 101 MISCELLANEOUS	K 130		

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K 130	Continued From page 2 OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure a renovation project received plan approval from the Wyoming Department of Health as required. The findings were: Observation on 1/25/10 at 7:53 PM revealed the facility had constructed an eight foot high wall in the vaulted ceiling saddle ridge rehabilitation (rehab) area within the previous year. No electrical outlets or plumbing fixtures were observed in the wall. In addition, the wall did not interfere with the vaulted ceiling's sprinkler head spray pattern. The wall separated the resident dining area from the rehab area. Entry into the dining area from the rehab area was through a six foot wide arched doorway. Exit from the dining area was either through the aforementioned archway or through an exterior exit on the opposite wall. It was noted that the exit door did have a self closure device, and a pull station was attached to the wall next to the exit. However, the exterior exit was not labeled as an emergency exit. A large enclosed grass area approximately one acre in size was visible from the exit door. Interview with the administrator on 1/28/10 at 4:30 PM revealed the above mentioned projects had not received plan approval.	K 130	K130 The facility will ensure that future renovation projects receive plan approval from the Wyoming Department of Health as required. 1) An exit sign was installed to label the identified door as an exit into the courtyard.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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K 147	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure compliance with the National Electrical Code in 2 of 5 smoke compartments. The following concerns were identified: 1. Observation on 1/27/10 at 11:49 AM revealed a resident whirlpool tub in the Pioneer bathroom #1. Electric current to the tub was provided through a wire originating at a wall switch directly behind the tub. Next to the wall switch were the hot and cold water faucets. Projecting out from the wall switch was an exposed copper ground wire that was attached (grounded) to the wall mounted hot and cold water faucets. 2. Observation on 1/27/10 at 1:38 PM revealed an electrical juncture box attached to the saddle ridge smoke barrier wall. The cover plate on the box was hanging by only one screw exposing the electrical wires in the box. 3. Observation on 1/27/10 between 11 AM and 1 PM revealed the required work space in front of electrical panels was not maintained at the following locations: a. A paper shredder was located in front of the panels at the central nurses' station. b. The panels in the housekeeping closet at the saddle ridge nurses' station were blocked by floor cleaning appliances (mop, vacuum cleaner). c. The panels in the laundry room were blocked by several laundry carts. Interview with the facility maintenance manager at the times identified above confirmed the observations.	K 147	K147 The facility will ensure that electrical wiring and equipment is in accordance with NFPA 70, National Electric Code 9.1.2 1) The copper ground wire formerly attached to the wall mounted hot and cold water faucets has been moved and is no longer exposed. The cover plate on the electrical juncture box attached to the Saddle Ridge smoke barrier wall has been replaced. There are no longer exposed electrical wires. The work spaces in front of the electric panels at the central nurses' station, the housekeeping closet next to the Saddle Ridge nurses' station, and in the laundry room have been marked to keep the work spaces clear of objects. 2) The maintenance director will randomly check the work space in front of the aforementioned areas to ensure that there are no objects blocking the electrical panels. If the electrical panels are blocked, immediate in-servicing and or corrective action will occur. 3) The ED will educate the staff regarding not blocking the work space in front of electrical panels anywhere in the facility. The education will be conducted on or before March 10, 2010. 4) Members of the Performance Improvement Team will use a quality-improvement monitoring tool to ensure that the work space in front of electrical panels is not blocked. The results of the audits will be reported monthly at the Performance Improvement Meeting for a period of three months or until substantial compliance is met.	3/10/10

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K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure alcohol based hand rub (ABHR) dispensers were not installed over ignition sources in 2 of 5 smoke compartments. The findings were: Observation on 1/27/10 at between 12:11 PM and 1:03 PM revealed ABHR dispensers attached to the wall over the light switches in the following three locations: a. the soiled utility rooms by the central nurses' station b. in the north hall c. in the housekeeping closet at the saddle ridge nurses' station. Interview with the facility maintenance manager at the time confirmed the observations.	K 211	K211 The facility will ensure that alcohol based hand rub (ABHR) dispensers are not installed over ignition sources. 1) All the mentioned ABHR dispensers were moved prior to the end of survey.	3/10/10

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