STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535034	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	150 CARING WAY LANDER, WY 82520

(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 (111) construction built in 1976. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze branch and an addressable fire alarm system.	K 000	Submission of the plan of correction shall not be construed as a waiver of this provider's right to contest any and all deficiencies, nor is such submission an admission that the facts ~~are as alleged~~ or ~~that any~~ regulatory violations occurred. **K018** 1. The dish cart was removed from obstructing the kitchen serving door. The wedge obstructing the dishwashing room was discarded. 2. All doors with automatic closures were inspected to assure that wedges or equipment are not being used to prevent the door from closing. Staff will be inserviced on keeping the doors closed and to not obstruct doors with wedges or equipment. 3. Random weekly observations will be made by the Maintenance Supervisor for the next 90 days to assure that doors with automatic closures are not being obstructed from closing. 4. The Quality Assurance committee will review the random	3/10/08
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.	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/29/08

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.

FAC Accepts w/ Donna Schultz, NTH 03/10/08

MAR 03 2008

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to ensure all corridor doors were smoke resistant in 1 of 3 smoke compartments. The findings were: 1. Observation on 2/13/08 between 2:30 PM and 3 PM revealed the following doors were equipped with self-closing devices and obstructed from closing: a. The kitchen serving door was obstructed by a dish cart. b. The dish room door was obstructed by a wedge. 2. Interview with the maintenance director on 2/13/08 at 2:48 PM revealed staff had been instructed not to prop any doors open.	K 018	weekly audits to assure continued compliance and direct further corrective action as needed. **K025** 1. The conduit penetration in the smoke barrier wall near the television lounge was filled with drywall compound on 2-19-08. 2. All walls will be inspected by the maintenance staff to assure that wall penetrations are appropriately sealed. Housekeepers will be inserviced to be observant of the integrity of walls and to report to maintenance any areas in need of repair. 3. The maintenance staff will conduct random weekly inspection of walls to assure wall integrity. 4. The results of random weekly audits will be reviewed by the Quality Assurance Committee for continued compliance and direct further corrective action as needed.	3/20/08
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 3 smoke barrier walls were smoke resistant. The findings were:	K 025		

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K 025	Continued From page 2 Observation on 2/13/08 at 3:45 PM revealed the smoke barrier wall near the television lounge had one unsealed conduit penetration. Interview with the maintenance director at the time of observations revealed the walls had been inspected quarterly.	K 025	**K029** 1. The latch of the door to the clean linen room was adjusted on 2-14-08 so that the door will latch into the frame. 2. All doors will be inspected by the maintenance staff to assure proper latching. Repairs and adjustments will be made as needed. 3. Housekeeping staff will be inserviced to be observant of door closure and to alert the maintenance department of needed repairs. The maintenance staff will do random weekly checks of door closures and correct latching. 4. The Quality Assurance committee will review random weekly audits to assure continued compliance and direct further corrective action as needed. **K050** 1. Staff will be inserviced on the steps to take in the event of fire or	3/20/08
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 observation and staff interview the facility failed to ensure hazardous areas were separated from use areas by smoke resistant partitions in 1 of 3 smoke compartments. The findings were: Observation on 2/13/08 at 3:20 PM revealed the clean linen room near resident room #103 had one of two doors that would not latch into its frame. Interview with the maintenance director revealed hazardous areas were routinely inspected quarterly.	K 029		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

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K 050	Continued From page 3 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure staff members were familiar with actions required under various elements of the fire drill procedure. The findings were: Observation of the fire drill on 2/13/08 at 4 PM revealed the first responder found the "fire" light, turned it off, and then asked another staff member what the light was for. When she was told it represented a fire, the responder still did not announce "Code Red," as indicated in the facility emergency policy. The responder did not activate the fire alarm system until instructed to do so by other staff members. Interview with the first responder at the time of the observation revealed she had not been in-serviced on what the "fire" light represented.	K 050	when finding the "fire light" for a staff training fire drill. 2. Training for new employees on fire procedures will be provided by the Maintenance supervisor. 3. Additional fire drills will be scheduled for the next 90 days to assure staff knowledge of proper procedures. The Safety Committee will review monthly the critiques of staff performance during fire drills. 4. The Quality assurance committee will review staff performance during fire drills to assure continued compliance and direct further corrective action as needed. **K051** 1. The batteries in the annunciator panel and the three heat detectors were tested on 2-14-08. 2. Testing of these devices will be added to the annual testing schedule.	3/10/08
K 051 SS=E	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	K 051		

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K 051	Continued From page 4 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 record review and staff interview the facility failed to ensure 2 of 9 fire alarm system components were properly tested. The findings were: 1. Review of the fire alarm system testing records revealed the batteries in the annunciator panel had not been tested in the past year. The system was last tested on 9/25/07 and the batteries had not been tested. 2. Review of the fire alarm system testing records revealed the three heat detectors had also not been tested in the past year. The system was last tested on 9/25/07. Interview with the maintenance director revealed he was unaware heat detectors	K 051	**K051 (cont)** 3. The Safety committee will review monthly the calendar of testing so that Fire Alarm system components are tested timely. 4. Quality Assurance committee will review testing schedules and reports for continued compliance and direct further corrective action as needed.	

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K 051	Continued From page 5 were installed in the building.	K 051		
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure the fire protection system over the commercial cooking equipment was tested semi-annually. The findings were: 1. Review of the commercial cooking equipment fire protection system testing records revealed the system had not been tested in the past 6 months. The system was last tested on January 18, 2007. 2. Interview with the maintenance director on 2/14/08 at 8 AM confirmed that the system had not been tested in the past 6 months.	K 069	**K069** 1. The fire protection system over the commercial cooking equipment was tested and inspected on 2-27-08. 2. The fire protection system over the commercial cooking equipment will be tested semi-annually. The Maintenance Supervisor will contact the testing vendor the last week of July 2008 to schedule testing in August 2008 and semi-annually thereafter. 3. The Safety committee will review monthly the schedule of required testing to assure that required testing has been completed as scheduled.	3/20/08
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to ensure the automatic transfer switch (ATS) for the emergency generator was equipped with an emergency battery light. The findings were: Observation on 2/13/08 at 2:46 PM revealed the ATS in the boiler room was not equipped with an emergency battery light. Interview with the maintenance director at the time of observation	K 147	**K147** 1. The boiler room is currently equipped with an emergency battery	3/20/08

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K 147	Continued From page 6 revealed he was unaware the battery light was required.	K 147	K147 (cont) Light. An additional battery light will be added to the boiler room to shine directly on the ATS. 2. The Preventative Maintenance checklist will be revised to include this additional light to be tested at the correct interval and time duration. 3. The Quality Assurance committee will review the preventative maintenance checklist quarterly for appropriate completion.	