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 _____	03/10/2009

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

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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 (NFPA). The facility was a fully sprinkled 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 loop 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. The following is to be considered our Credible Allegation of Compliance	
K 025 SS=E	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 2 smoke barrier walls were smoke resistant. The findings were: Observation on 3/09/09 at 4:19 PM revealed the smoke barrier wall near resident room #101 had two unsealed pipe penetrations. The gaps around	K 025	**K025** **1.** The two pipe penetrations in the smoke barrier wall near the resident room #101 were filled with SpecSeal Fire Stop Putty on 3-20-08. **2.** All smoke barrier walls have been inspected by the maintenance staff to assure that wall penetrations are appropriately sealed. **3.** The maintenance staff will conduct random monthly inspection of smoke barrier walls to assure wall integrity. **4.** The results of random monthly audits will be reviewed by the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna Schultz — TITLE: Administrator — (X6) DATE: 3-28-09

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.

POC ACCEPTED W/ DONNA SCHULTZ, NHA, AD 4/01/09.

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K 025	Continued From page 1 the pipes were between 1/4 and 1/2 inch wide. Interview with the maintenance director at the time of observation revealed the smoke barrier walls were not checked routinely.	K 025	Quality Assurance Committee for continued compliance and direct further corrective action as needed.	
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure 2 of 12 emergency preparedness policies were organized in a usable and functional way. The findings were: 1. Review of the Building Evacuation policy revealed the relocation site for residents was Showboat Assisted Living Center. Interview with the maintenance director on 3/10/09 at 10:15 PM revealed this was no longer current, and the actual relocation site was the Wyoming Life Resource Center. 2. Review of the the entire disaster manual revealed it was difficult to navigate as non-contiguous pages were inserted between corresponding numbered pages. Pages 60 and above were referenced by several policies but were unable to be located until staff members spent several minutes looking for them. The pages were located in a different section of the manual and separated by an unmarked divider. 3. Interview with the administrator on 3/10/09 at 10:30 AM revealed the manual was last reviewed on 12/08/08. She further confirmed the manual	K 048	Date of Correction: 4-24-09 **K048** **1.** The Maintenance Supervisor will oversee the rewriting of the building evacuation plan to include current information of evacuation site. **2.** A Quality Assurance task force headed by the Maintenance Supervisor will review and rewrite all sections of the Emergency preparedness manual to include current information and to simplify the format and page numbering. **3.** The Safety Committee will review and approve any additions or corrections to be made to the Emergency Preparedness Manual (if any) on a monthly basis. **4.** The Quality Assurance Committee will review, modify	

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K 048 K 050 SS=F	Continued From page 2 was difficult to navigate. NFPA 101 LIFE SAFETY CODE STANDARD 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 emergency procedures on 1 of 3 shifts. The findings were: 1. Observation of a fire drill on 3/09/09 at 4:06 AM revealed the first responder left the "fire" room without calling a code red and the location. In addition, the first responder did not close the corridor door as indicated in the Fire Plan. The first responder was observed to ask a nurse what actions to take. The nurse walked to the front desk and announced "Code red; room #212." The announcement was made one minute and thirty seconds after the "fire" was found. Another staff member activated the fire alarm two minutes and ten seconds after the "fire" was found. A Hoyer lift was left in the corridor near the "fire" room throughout the drill. 2. Interview with the certified nurse aide (CNA) that first found the "fire" on 3/09/09 at 4:12 PM	K 048 K 050	and/or approve the Emergency Preparedness Manual annually. Date of Correction: ~~May 15, 2009~~ 4/24/09 **K050** 1. Staff will be inserviced on the steps to take in the event of fire or 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	

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K 050	Continued From page 3 revealed she had worked at the facility for three weeks. After questioning her on the procedure required in a fire it was revealed that she was not familiar with the needed steps. She further reported that she had not previously participated in a fire drill. She also reported that she had attended an orientation class that covered the fire procedures.	K 050	compliance and direct further corrective action as needed. Date of Correction: 4-24-09	
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure oxygen cylinders were properly stored in 1 of 3 smoke compartments. The findings were: 1. Observation on 3/09/09 between 3 PM and 5 PM revealed an oxygen storage cart was left in the service corridor. The cart held 20 "E" sized oxygen cylinders. 2. Observation on 3/10/09 at 9 AM revealed the cart was still in the corridor. Interview with a CNA	K 076	**K076** **1.** The oxygen storage cart was removed from the service corridor on 3-10-09. **2.** Oxygen E cylinders in excess of that which will fit in the designated oxygen storage room in the service hall will be kept in exterior storage until needed by staff. The Maintenance Supervisor will monitor the clearance of the service corridor. **3.** Staff will be inserviced on the correct storage of oxygen cylinders. The Housekeeping Supervisor (or designee) will make rounds 3 times a week for the next twelve weeks to ensure corridors are maintained free of equipment.	

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K 076	Continued From page 4 at the time of observation revealed the cart was usually left in the corridor. Interview with the maintenance director at the time of observation revealed he was aware oxygen cylinders were not approved to be stored in corridors.	K 076	4. The results of rounds made by Housekeeping Supervisor (or designee) will be made to the Quality Assurance Committee on a monthly basis for continued compliance. Date of Correction: 4-24-09	
K 211 SS=F	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 did not exceed 1.2 liters/40 fluid ounces in 3 of 3 smoke compartments. The findings were: Observation on 3/09/09 between 3 PM and 5 PM revealed each resident room was equipped with an ABHR dispenser as well as six locations in the corridor system. The ABHR insert in the dispenser near resident room #103 had a	K 211	**K211** 1. The Alcohol based hand rub (ABHR) dispenser inserts in the corridors which were 67 ounce capacity were replaced with 33 ounce capacity inserts. 2. All dispensers were checked for correct size insert, appropriate clearance from electrical outlets. And total capacity of the smoke compartment was tallied to not exceed 10 gallons. 3. Housekeepers will be inserviced on the size of inserts to be used in specific dispensers.	

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K 211	Continued From page 5 capacity of 67 fluid ounces. Review of the other dispensers in the corridor system revealed they all had 67-ounce inserts. Interview with the maintenance director at the time of observation revealed the facility only had 67-ounce inserts. He further revealed he was unaware the inserts could not exceed 40 ounces for resident rooms and corridor locations.	K 211	The Maintenance Supervisor (or designee) will inspect corridor dispensers for correct insert size monthly and report findings to the Safety Committee monthly. 4. The findings of monthly audits will be reported to the Quality Assurance Committee for continued compliance. Date of Correction: 4-24-09	