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 _____	03/02/2011

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

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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. 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	The facility will ensure that there is no impediment to the closing of a corridor door. 1) Pioneer Bath door closure was adjusted on 3/2/11 prior to end of survey. 2) The Maintenance Director will check all corridor doors monthly to ensure all doors close completely within their frames and will be maintained according to life safety code 101 19.3.6.3.6 and 19.3.6.3 3) A quality-measuring tool will be used by the Maintenance Director to complete monthly audits and the results will be reported monthly at the Performance Improvement meeting for a period of three months or until substantial compliance is met.	4/19/11

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

Doug M — Executive Director — 3-28-11

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 and plans of correction 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.

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Wyoming Department of Health
Office of Healthcare Licensing and Surveys

Revised/approved ē changes on page 5 a/4e T.C. ē exec.DIR on 4/22@2P

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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 resistant to the passage of smoke in 1 of 5 smoke compartments. The findings were: Observation on 3/2/11 at 10:48 AM revealed corridor door to the Pioneer Bath #1 did not close completely in its frame, with three separate attempts. A self closure device was attached to the door. Interview with the maintenance manager at the time of the observation confirmed the finding.	K 018		
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 3 hazardous areas were separated from patient use areas in 2 of 5 smoke compartments. The findings were: Observation on 3/2/11 at 10:18 AM revealed the housekeeping closet in the entry hallway south of the main nurse's station did not have a self closure device attached to the door. In addition,	K 029	K.029 The facility will ensure hazardous areas are separated from patient use areas. 1) A closing device has been installed on the housekeeping closet door on 3/8/11 and the two doors behind the Saddle Ridge nurses' station (a copy room and a staff room) with the door holding devices were removed on 3/15/11.	4/18/11

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K 029	Continued From page 2 two doors behind the Saddle Ridge nurse's station (a copy room and a staff room) both had self-closure devices attached to their doors. However, both doors were noted to be held open with hooks attached to the wall. Interview with the maintenance manager at the time of the observation confirmed the findings.	K 029		
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 one exit access was unobstructed in 1 of 5 smoke compartments. The findings were: Observation on 3/2/11 at 12:48 AM revealed a water cooler was blocking the exit key pad at the North Fork entrance. Interview with the maintenance manager at the time of the observation confirmed this finding.	K 038	K038 The facility will ensure access to all exits are accessible at all times. 1) Culligan water dispenser was removed at the North Forty (Saddle Ridge) entrance in the therapy department. 2) Maintenance Director will check all exits monthly to ensure they are accessible at all times and will be maintained according to Life Safety Code 101 7.1 and 19.2.1 3) A quality-measuring tool will be used to ensure all exits are unobstructed. The results of these audits will be reported monthly at the Performance Improvement meeting for a period of three months or until substantial compliance has been met.	4/18/11
K 050 SS=F	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	K 050	K50 The facility will ensure staged fire drills will be conducted in the correct manner in accordance with Life Safety Code 101 19.7.1.2 1) The battery backup was removed for the PA system and the Maintenance Director on 3/11/11 placed the PA system directly into the emergency outlet. 2) The maintenance director will audit the PA system monthly for three months then quarterly thereafter during fire drills to ensure it is functioning properly.	4/18/11

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K 050	Continued From page 3 alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to conduct a staged fire drill in the correct manner. The findings were: During a fire drill conducted on 3/2/11 at 1:48 PM, observation revealed a faulty public address (PA) system. Nursing staff announced the existence of a fire over the PA system however the system did not broadcast the announcement throughout the nursing home. The nurse corporate consultant confirmed the PA system did not work during the drill.	K 050	3) A quality-measuring tool will be used to audit the PA system. The results will be reported monthly at the Performance Improvement meeting for a period of three months or until substantial compliance is met.	
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 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	K 051	K51 The facility will ensure all fire alarm pull stations are accessible in accordance with Life Safety Code 101 19.3.4 1) The Maintenance Director removed all obstruction from in front of the pull station in the kitchen. 2) The Maintenance Director will maintain all pull stations in facility monthly and ensure they are visible and clear of obstruction. If the pull stations are blocked immediate in-servicing and/or corrective action will occur. 3) A quality-measuring tool will be completed to ensure pull stations are not blocked. The results will be reported monthly at the Performance Improvement meeting for a period of three months or until substantial compliance is met.	4/18/11

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K 051	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 of 17 fire alarm pull stations was accessible. The findings were: Observation on 3/2/11 at 10:11 AM revealed the fire alarm pull station near the kitchen exit was obstructed by coffee making supplies. Interview with the maintenance manager at the time of the observation confirmed the findings.	K 051		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure smoke detector sensitivity was tested on 93 of 93 smoke detectors during the previous two years. The findings were:	K 052	K052 The facility will ensure smoke detector sensitivity testing is completed in accordance with Life Safe Code 101 9.6.1.4 1) Sensitivity testing was performed at this facility on 3/9/11 2) The Maintenance Director will maintain records and follow through with contractor to ensure sensitivity testing is performed ~~at least~~ annually. 3) The Maintenance Director will use a quality-measuring tool to ensure the tests were completed. Results of this audit will be reported in the performance improvement meeting following the next date due for sensitivity testing.	4/18/11

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K 052	Continued From page 6 Review of fire alarm records on 3/2/11 at 8:48 PM revealed a fire alarm consultant company (Comtronix Inc.) inspected the fire alarm system on 10/27/10. However, further record review revealed none of the 93 smoke detectors had been tested for sensitivity at that time. Nor were the detectors tested the previous year. The maintenance manager reviewed maintenance records, but was unable to find any records indicating when the last smoke detector sensitivity testing was done.	K 052		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	K66 The facility will ensure smoking regulations are enforced in accordance with NFPA 101 19.7.4 1) The Executive Director spoke with the resident who smokes to remind him of the specific areas designated for smoking and the importance of the use of the ashtray provided. This resident was apologetic and assured ED he would dispose of his smoking materials appropriately and only smoke in the designated areas. 1) The administrative staff will continue to remind our one resident who is a smoker of the designated smoking areas and ensure ashtrays are provided and maintained in those specific areas.	4/18/11

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K 066	Continued From page 6 This STANDARD is not met as evidenced by: Based upon observation and staff interview the facility failed to enforce smoking regulations that include the minimal provisions outlined in NFPA 101 Section 19.7.4. The findings were: Observation on 3/2/11 at 9:02 AM revealed a resident coming into the dining room in a wheelchair from an outdoor patio. Interview with the resident at the time revealed s/he had been outside smoking a cigarette. Additional observation at the time revealed there was no approved metallic cigarette butt container on the patio. There was, however, a plastic garbage container on the patio. Several cigarette butts were noted on the ground in front of the container, and cigarette ashes and burns were noted on the top edge of the container. Interview with the administrator at the time of the observation revealed the resident was the only smoker in the facility. The administrator also stated there were designated smoking areas outside other facility exits, but this particular area was not a designated smoking area and was not equipped with an ashtray or a metal container with a self-closing cover.	K 066	2) The Executive Director and Maintenance Director will continue to complete monthly audits of smoking areas to ensure the proper containers are available for use and maintained appropriately as well as ensuring the resident continues to comply with facility's smoking policy. The results will be reported monthly at the Performance improvement meeting for a period of three months or until substantial compliance is met.	
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 one of one kitchen observation and staff interview the facility failed to ensure cooking equipment was properly maintained. The findings were:	K 069	K069 The facility will ensure cooking equipment is properly maintained in accordance with Life Safety Code 101 9.2.3 and 19.3.2.6 1) Pilot light has been repaired on stove 3/14/11. 2) Dietary staff will monitor the pilot light on the stove daily to ensure it is lit and will report findings to the Maintenance Director.	4/18/11

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K 069	Continued From page 7 Observation on 3/2/11 at 10:10 AM revealed an odor of natural gas coming from the kitchen range. Further observation revealed the pilot lights for two of six burners had gone out. Interview with the dietary supervisor at the time of the observation revealed the night cook had stated the pilot light goes out "a couple times a week." Interview with the maintenance manager, also at the time of the observation, revealed air updraft from the overhead range air vents was probably responsible for the pilot lights going out. He also stated he did not know if a thermocouple was attached to the gas line.	K 069	3) The Dietary Manager will use a quality-measuring tool to complete a daily audit of the pilot light for a period of a month. The findings will be reported at the performance improvement meeting following the completion of the audit.	
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3	K 074	K074 The facility will ensure facility decorations are flame retardant in accordance with Life Safety Code 101 10.3.1 and NFPA 13. 1) Scarecrow was removed from room #209 immediately upon notification on 3/2/11. 2) All other wall hangings will be sprayed with flame retardant spray by 3/31/11 and the Maintenance Director will keep records/logs accordingly. The report will be reviewed at the following performance improvement meeting in April. The Maintenance Director will ensure any new decorative items introduced into facility will meet this standard.	4/19/11

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K 074	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure facility decorations were flame retardant in 2 of 5 smoke compartments. The findings were: Observation on 3/2/11 between 9 AM and 11 AM revealed several wall hangings, including a bear rug, in the dining room and a large quilt in the facility recreation room, did not have documentation that indicated whether or not they were flame retardant. In addition, a four foot high decorative dry grass scarecrow was noted in resident room #209. Interview with the maintenance manager at the time of the observation revealed documentation was unavailable for flame retandantcy of the items.	K 074		
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 This STANDARD is not met as evidenced by: Based upon observation and staff interview the facility failed to ensure the electrical system was properly maintained in 1 of 5 smoke compartments. The findings were: Observation on 3/2/11 at 11:49 AM revealed an electrical light switch cover plate in the staff room was cracked. Interview with the maintenance manager at the time of the observation confirmed the damage to the wall plate and it was in need of replacing.	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 maintenance director prior to the end of survey replaced the cracked light switch cover plate in the staff room.	4/18/11