STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING **01** B. WING _____	**08/29/2018**

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 A Life Safety Code survey was conducted on August 29, 2018 by Healthcare Licensing and Surveys. Requirements for Long Term Care Facilities Section 42 CFR 483.70 (2) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 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 1988. The building was equipped with a supervised automatic wet sprinkler system with a dry branch and an addressable fire alarm system. The facility had a capacity of 102 certified beds with a census of 69 residents.	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.	K 324		10/12/18

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

Electronically Signed | 09/21/2018

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.

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K 324	Continued From page 1 Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain cooking facilities in accordance with the 2011 NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Failure to maintain the cooking facilities could result in injury or death in the event of a fire. The deficiency affected one (1) of five (5) smoke compartments. The findings were: Document review on 08/29/18 at 3:30 PM revealed that the kitchen hood exhaust and ducting had been inspected once in the last twelve (12) months. The 2011 NFPA 96 requires that kitchen hood exhaust systems be inspected and, if necessary, cleaned once every six (6) months. Interview with the maintenance director at the time of document review acknowledged the deficiency, but indicated he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency.	K 324	1. Kitchen hood exhaust and ducting system inspection and cleaning was completed in August of 2018 and scheduled for March of 2019 and six months thereafter in accordance with NFPA 96. 2. Maintenance Director received letter of confirmation from contractor to stating kitchen hood exhaust and ducting system will be inspected and cleaned semi annually. 3. Maintenance Director will ensure service is completed as scheduled and in accordance with NFPA 96. Results of this checklist will be discussed at the following Performance Improvement meeting to ensure compliance with NFPA 96 and to determine the process in place is effective.	

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K 324	Continued From page 2 Reference: 2012 NFPA 101 19.3.2.5.3(10); 2011 NFPA 96 11.4	K 324		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire alarm system in accordance with the 2012 NFPA 72 National Fire Alarm and Signaling Code. Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency affected five (5) of five (5) smoke compartments. The findings were: Document review on 08/29/18 at 3:30 PM revealed that the alarm notification appliances had the annual testing done in February of 2018. The documentation provided for the annual testing of the alarm notification appliances did not include a breakdown of each device by type and location. The documentation provided simply noted the total number of alarm notification devices and the number that passed testing.	K 345	1. Fire alarm testing was completed on September 11th 2018 which included the testing of the alarm notification appliances and a breakdown of each device by type and location. 2. Maintenance Director implemented a checklist for each device which includes zone, type of device and location. These will be used during the testing of our fire alarm system to ensure compliance with NFPA 70 and 72. Maintenance Director will immediately update checklist to include changes in devices. 3. Results of this checklist will be discussed at the following Performance Improvement meeting to ensure compliance with NFPA 70 and 72 and to determine the process in place is effective.	10/12/18

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K 345	Continued From page 3 Interview with the maintenance director at the time of document review acknowledged the deficiency, but indicated he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2010 NFPA 72 Table 14.4.5(20), Figure 14.6.2.4 page 11	K 345		

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on August 29th, 2018.	E 000		
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for	E 015		10/12/18

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E 015	Continued From page 1 hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to address the subsistence needs for medical and pharmaceutical supplies. The findings were: Document review of the Emergency Preparedness Plan on 08/29/18 at 2:25 PM revealed that no policy or procedure was available that addressed the medical and pharmaceutical supply needs of staff and patients. Interview with the facility administrator acknowledged the deficiency, and revealed they were unaware that this requirement was missing from the plan.	E 015	1. Facility policy was located in Emergency Preparedness Manual which addresses the medical and pharmaceutical supply needs. 2. There is only one emergency preparedness manual in the facility. 3. Executive Director educated Maintenance Director and Director of Nursing of the location and the contents of this policy which states the medical and pharmaceutical supply needs of staff and residents during an emergency. 4. Policy and emergency preparedness plan will be discussed at next Performance improvement meeting to ensure facility is in compliance with federal regulation.	
E 026	Roles Under a Waiver Declared by Secretary	E 026		10/12/18

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E 026	Continued From page 2 CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to address roles under a waiver declared by the Secretary. The findings were: Document review of the Emergency Preparedness Plan on 08/29/18 at 2:25 PM revealed that no policy or procedure was available that addressed the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Social	E 026	1. Facility policy was located in Emergency Preparedness Manual which addresses facility role under waiver 1135 declared by the Secretary. 2. There is only one emergency preparedness manual in the facility. 3. Executive Director educated Maintenance Director and Director of Nursing of the location and the contents of this policy which states the facility role under waiver 1135 declared by the	

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E 026	Continued From page 3 Security Act. Interview with the facility administrator acknowledged the deficiency, and revealed they were unaware that this requirement was missing from the plan.	E 026	Secretary. 4. Policy and emergency preparedness plan will be discussed at next Performance improvement meeting to ensure facility is in compliance with federal regulation.	