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 _____	06/16/2011

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 This survey used the 2000 edition of NFPA 101, Life Safery Code, Chapter 19 Existing Health Care Occupancies, in compliance with 42 CFR 483.70 (a) This facility has Type VIII construction.	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 violation occurred.	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: On 06/16/2011 at approximately 1:20 PM in the afternoon a 1 inch penetration was found above the B Hall Smoke Barrier Wall. This penetration above the double doors would allow smoke to travel through to the other side without interference. This area of concern was observed by the facility maintaince supervisor.	K 012	K012 7/27/2011 1. The 1 inch penetration in the B Hall smoke barrier wall was closed on June 16, 2011 2. All smoke barrier walls have been inspected for sealing of wall penetrations. 3. The Maintenance Supervisor or designee will inspect smoke barrier walls each month to assure penetrations are appropriately sealed. 4. Audits of wall penetrations will be reviewed monthly by the Quality Assurance Committee each month to assure continued compliance and direct further corrective action as needed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: x Donna Schultz
TITLE: x Administrator
(X6) DATE: x 07/01/11

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 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.

JUL 22 2011