

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/10/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535039	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2019
NAME OF PROVIDER OR SUPPLIER WESTVIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1990 WEST LOUCKS STREET SHERIDAN, WY 82801		
(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 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 08/07/2019. 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 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility is a fully sprinklered single story building of Type V (111) construction built in 1988. The building is 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 70 residents.	K 000			
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain means of egress could result in injury or death in the event of an emergency. The deficiency affected one (1) of	K 211	1. Residents occupying room 108 were notified of the deficient practice and Ombudsman was contacted as well. 2. Room 108 was cleared of storage and excess furniture to allow a means of egress 48 inches in clear width or greater.		9/13/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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(X6) DATE

Electronically Signed

08/30/2019

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 211	Continued From page 1 five (5) smoke compartments. The findings were: Observation on 08/07/19 at 12:20 PM revealed that resident room 108 had storage and furniture that obstructed the exit access from the room to the corridor. Any aisle serving as a means of egress from a patient sleeping room shall be not less than 48 inches in clear width. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 Section 19.2.3.4	K 211	3. Maintenance director will complete a random monthly audit to ensure resident rooms including room 108 are free of storage and excess furniture. 4. Results of these audits will be reviewed during the monthly Performance Improvement meetings for 3 months or until the committee is able to determine the process in place is effective.		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.	K 372			9/9/19

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K 372	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain smoke barriers could result in injury or death in the event of a fire. The deficiency affected two (2) of five (5) smoke compartments. The findings were: Observation on 08/07/19 at 2:31 PM revealed the smoke barrier adjacent to the South Fork Wing had unprotected penetrations of fire sprinkler lines above the ceiling in resident room 101. All penetration of a smoke barrier shall protected by a system or material capable of restricting the transfer of smoke. Interview with the facilities manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.3.7.3, 8.5.6.2	K 372	1. Fire calk was applied to affected area in the smoke barrier sealing any unprotected penetration around the fire sprinkler lines. 2. Maintenance Director will complete a 100% audit of all smoke barriers to ensure there are no unprotected penetrations in those smoke barriers in accordance with NFPA 101. 3. Results of this audits will be reviewed during the monthly Performance Improvement meetings to determine the process in place was effective.		

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E 000	Initial Comments	E 000			
E 037 SS=F	An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 08/07/2019. EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness	E 037		9/20/19	

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E 037	Continued From page 1 policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually.	E 037			

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E 037	Continued From page 2 (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at	E 037			

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E 037	Continued From page 3 least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide an Emergency Preparedness Training Program. The findings were: Document review of the Emergency Preparedness Plan on 08/07/19 at 3:25 PM revealed the facility did not provide a written Emergency Preparedness Training Program. Interview with the facility administrator revealed that training was being conducted for new and existing staff on an annual basis, and at new employee orientation.	E 037	1. Training policy as well as the facility training/testing schedule and sample orientation plan was located in the Emergency Preparedness Manual which addresses the training and testing requirements. 2. There is only one Emergency Preparedness Manual in the facility. 3. Executive Director and Maintenance Director were educated on the importance of maintaining the the training and testing schedules as outlined in the policy manual. 4. Testing and training schedule will be discussed at the next Performance Improvement meeting to ensure the facility is in compliance with federal regulation.		
E 039	EP Testing Requirements	E 039			9/20/19

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E 039 SS=F	Continued From page 4 CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the	E 039			

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E 039	Continued From page 5 [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct exercises to test the emergency plan. The findings were: Document review of the Emergency Preparedness Plan on 08/07/19 at 3:25 PM revealed the facility failed to conduct the required annual full-scale exercise and the second full-scale or tabletop exercise. Interview with the facility administrator revealed that the emergency plan was activated for an emergency event. However, documentation of the incident including an analysis of the facility's response was not available.	E 039	1. The facility will participate in the next community wide full scale exercise. Facility will also participate in the next community table top exercise through the Public health agency meeting which is held monthly. Documentation was received regarding the activation of the emergency management plan and the analysis of the response. 2. There is only one emergency management manual in the facility. 3. maintenance director and executive director will be educated on the importance of participating in full scale exercises and ensuring the required documentation of drills is available in accordance with federal regulation and facility policy.		

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E 039	Continued From page 6	E 039	4. Policy and emergency preparedness plan will be discussed at the next Performance Improvement meeting to ensure the facility is in compliance with federal regulation.		