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 _____	**11/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	**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
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 11/7/2023 and 11/08/2023. Based on the findings of the survey, it was determined that the facility was in compliance with all requirements in accordance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 10/07/2023 and 10/08/2023. Requirements for Long Term Care Facilities Section 42 CFR 483.90, except as otherwise provided in this 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, one 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 a zoned fire alarm system. The facility had a capacity of 102 certified Medicare and Medicaid beds with a census of 63 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing	K 321		12/13/23

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

Electronically Signed | 11/21/2023

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K 321	Continued From page 1 system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous areas as required could result in injury or death due to fire spread. The deficiency affected two of numerous hazardous areas in the facility. The findings were: 1. Observation on 11/07/2023 at 2:34 PM revealed that when dropped with no initial motion, the mechanical room door inside the employee lounge failed to latch and close. Interview with the facility maintenance manager at	K 321	1. Maintenance Director has adjusted the closure on the mechanical room door located in the employee lounge area to close and latch when dropped with no initial motion. Maintenance Director has ordered a new door for the soiled utility room and will be installed immediately. 2. Maintenance Director was educated on the importance of doors located in hazardous areas closing and latching in accordance to 2012 NFPA 101. 3. Maintenance Director will complete a 100% audit of all doors in hazardous areas to ensure they close and latch	

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K 321	Continued From page 2 the time of observation acknowledged the deficiency, and indicated he was aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. 2. Observation on 11/07/2023 at 2:48 PM, revealed that when dropped with no initial motion, the soiled utility room door failed to latch and close. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Sections 19.3.2.1 and 19.3.2.1.3.	K 321	appropriately and adjust those that may need it to ensure they are in accordance with 2012 NFPA 101. Random audit to be conducted monthly for 3 months to ensure doors close and latch as required and follow TELS schedule thereafter. 4. Results of this audit will be reviewed at the Performance Improvement meetings monthly for three months or until the committee is able to determine the process in place is effective.	
K 345 SS=F	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	K 345	1. Maintenance Director has ordered a smoke detector sensitivity tester and	12/13/23

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K 345	Continued From page 3 alarm system in accordance with the 2012 NFPA 101, Life Safety Code, and 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm system could result in a failure of the system, resulting in injury or death in the event of a fire. The deficiencies affected the fire alarm system and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/08/2023 starting at 08:35 AM revealed that the facility failed to conduct all required fire alarm testing. No documentation was available at the time of the survey to demonstrate that the smoke detector sensitivity test was conducted in the last twenty four (24) months. The smoke detector sensitivity test shall be conducted once every 24 months. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.4.1, 9.6.1.3; 2010 NFPA 72 Table 14.5(15)(i)	K 345	testing will occur when item has been received. 2. Maintenance Director was educated on the importance of completing the smoke detector sensitivity test at least once within 24 months in accordance to 2012 NFPA 101 Life Safety Code and 2010 NFPA 72 National Fire Alarm and Signaling Code. 3. Maintenance Director will place schedule on TELS to ensure a smoke detector sensitivity test will be completed at least once in 24 months as required. 4. Results of testing will be reviewed at following Performance Improvement meeting.	