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

PRINTED: 11/17/2011
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTON COUNTY HEALTH SERVICES	1124 WASHINGTON BLVD NEWCASTLE, WY 82701

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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 this 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 (NFPA). The facility was a fully sprinkled single story building with a basement of Type V (111) construction with plan approval in 1965. The building was equipped with a supervised automatic wet sprinkler system and with an addressable fire alarm system. The facility had a capacity of 54 certified Medicare and Medicaid beds with a census of 53 residents.	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the fire barrier was smoke resistant. The findings were: Observation of the hospital fire barrier on 11/1/11 at 10:44 AM showed two unsealed conduit penetrations. The largest gap was 1/2 inch wider than the conduit. At the time of observation the	K 011	WCHS will ensure the smoke barrier wall is smoke resistant. This will be accomplished by: 1. WCHS Maintenance will seal the smoke barrier in the link hallway connecting the hospital to the Manor. 2. Maintenance will perform monthly inspections and report to PI	12/17/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 11/23/11

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.

POC Modified & Accepted w/ Joann Farnsworth, ON

NOV 23 2011

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 1JSW21 Facility ID: WY0034 If continuation sheet Page 1 of 9

12/6/11 [signature]

Office of Healthcare Licensing and Surveys

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K 011	Continued From page 1 maintenance director could not explain why the penetrations had not been noticed and repaired during the quarterly inspections.	K 011		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully dueled heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the smoke barrier wall was smoke resistant. The findings were: Observation of the attic smoke barrier wall on 11/1/11 at 10:50 AM showed two unsealed penetrations. The largest gap measured 2 inches by 6 inches. At the time of observation the maintenance director could not explain why the penetrations had not been noticed and repaired during the quarterly inspections.	K025	WCHS maintenance department will ensure a smoke-resistant fire barrier is present when there is a common wall in the building. This will be accomplished by: 1. Maintenance will install 5/8" sheet rock covering all gaps and edges to make a tight seal on the fire barrier around the pent house. 3. Maintenance manager will monitor with monthly safety inspections and report to PI	12/17/11
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches	K 027		

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K 027	Continued From page 2 from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 3 smoke barrier doors closed automatically. The findings were: Observation of the attic smoke barrier door on 11/1/11 at 10:52 AM showed the self-closing device was a spring, but it was not attached to an opposing wall. At the time of observation the maintenance director could not explain why the spring had been disconnected and why this had not been noticed and repaired during the quarterly inspections.	K 027	WCHS will ensure that maintenance will maintain proper closures through fire walls. This will be accomplished by: 1. WCHS maintenance will secure a spring on the doorway hatch that will maintain a positive pressure to ensure door closure. 2. This will be a permanent fixture. 3. THE ATTIC SMOKE BARRIER DOOR WILL BE INSPECTED QUARTERLY TO ENSURE PROPER FUNCTIONALITY & REPORT TO PI.	12/17/2011
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with% 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	K 029	WCHS maintenance department will ensure that hazardous areas are separated from use areas. This will be accomplished by: 1. Maintenance will seal around pipes with fire caulking in the air handler room off of the Manor dining room. 2. Maintenance will monitor monthly and report to PI	12/17/2011

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K 029	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure hazardous areas were separated from use areas in 1 of 3 smoke compartments. The findings were: Observation of the dining room air handling room on 11/1/11 at8:53 AM showed a 2 inch unsealed pipe penetration. Atthe time of observation the maintenance director reported the area had recently been worked on, he could not explain why the gap had not been re-sealed after the work was completed.	K029		
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 alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure fire drills were held at varying times on 1 of 3 shifts. The findings were: Review of the fire drill records showed the second shift occurred between 2 PM and 10 PM. Further review showed the drills held on the second shift	K050	WCHS will ensure that fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. This will be accomplished by: 1. WCHS maintenance department will conduct fire drills on second shift at varying times to include times frames after 6 pm. 2. WCHS maintenance manager will monitor and report to PI monthly.	12/17/11

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K 050	Continued From page 4 over the past four quarters have all occurred between 3 PM and 4:36PM. On 11/1/11 at 12 PM the maintenance director confirmed he was aware drill times were required to be varied. He also reported the maintenance staff conducted the drills at these times due to convenience as their shift finished at 5 PM.	K 050		
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 observation and staff interview the facility failed to ensure smoke detectors were properly installed in 2 of 3 smoke compartments. The findings were: Observation of the fire alarm system on 11/1/11 between 9 AM and 11 AM showed the smoke detectors in the corridor near resident room #4 and the dining room entrance corridor were both installed closer than 36 inches from ventilation diffusers. At 9:15AM the maintenance director reported he was unaware of the spacing requirement and assumed the fire alarm	K 052	WCHS will ensure smoke detectors are properly installed in all smoke compartments. This will be insured by: 1. WCHS maintenance will install deflectors that will attach to the diffuser. These deflectors will block the air flow from blowing on the smoke detectors that are located within 3 feet of the diffusers. 2. Maintenance manager will inspect these deflectors monthly to assure they remain in place, & Report To P.I.	12/17/11

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K 052	Continued From page 5 contractor would inspect for proper spacing. Reference: NFPA 101, 2000 Edition,19.3.4.1, 9.6.1.4; NFPA 72, 1999 Edition; 5.7.4.1* In spaces served by air-handling systems, detectors shall not be located where airflow prevents operation of the detectors. A 5.7.4.1 Detectors should not be located in a direct airflow or closer than 1 m (3 ft) from an air supply diffuser or return air opening ...	K 052		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, records review, staff interview and review of previous Life Safety Surveys, the facility failed to ensure sprinklers were unobstructed in 2 of 3 smoke compartments. The findings were: 1. Observation of the corridor system on 11/1/11 between 9 AM and 10:30 AM showed the corridor lights hung down 14 inches from the ceiling. Further review showed the sprinkler heads near the special care unit (SCU) corridor door, near resident room #2, #15, #12, near the liquid oxygen storeroom and near the nurses station were all located less than the required 48 inches from the lights. Review of the 10/11/10 Life Safety Code survey showed this issue was addressed	K 062		

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K 062	Continued From page 6 during that survey. At 9:31 AM the maintenance director could not explain why the entire sprinkler system had not been inspected and obstructed sprinkler heads modified. 2. Observation of the sprinkler system on 11/1/11 between 9:30AM and 10 AM showed two sprinkler heads in the SCU bath suite and two heads in the SCU soiled utility room were located less than 12 inches from ceiling mounted lights and the lights were 2 inches below the sprinkler deflectors. 3. Review of the sprinkler system testing records showed the waterflow device and supervisory signal had not been tested during the third quarterly of2011. On 11/1/11 at 12 PM the maintenance director confirmed he was aware of the quarterly testing requirement. He also reported that he had a contract with a sprinkler contractor and expected them to test the system quarterly. Reference; NFPA 101,2000 Edition, 19.3.5.1, 9.7.5; NFPA 13, 1999 Edition. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (Standard Spray Upright/Standard Spray Pendent) Distance from sprinkler to side of obstruction — Maximum allowable distance from deflector above bottom of obstruction Less than 1 ft .....0 1 ft to less than 1 ft 6 in.....2 Y, 1 ft 6 in. to less than 2 ft .....3 Y,	K 062	WCHS will ensure that sprinklers are unobstructed. This will be accomplished by: 1. WCHS maintenance has contacted Western States Fire Protection. They will come to WCHS and measure all sprinkler heads for proper clearance. Any and all sprinkler heads that do not meet the regulatory guidelines (NFPA 101) will be extended or relocated to the correct standard. 2. Maintenance manger will oversee this project and completion. 3. Changes will be documented on the final mapping of the building. 4. ALL SPRINKLER HEADS WILL TEST INSPECTED ANNUALLY & REPORT FINDINGS TO F.I.	12/17/11

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K 062	Continued From page 7 2ft to less than 2ft 6 in.....5% 2ft 6 in. to less than 3ft .....?% 3 ft to less than 3 ft 6 in .....9 % 3 lt 6 in. to less than 4 lt .....12 4 lt to less than 4ft 6 in.....14 NFPA 25, 1998 Edition; 9-2.7 Waterflow alarm. All waterflow alarms shall be tested quarterly in accordance with manufacture's instructions. NFPA 72, 1999 Edition. Table 7-3.2 Testing Frequencies. 15. Initiating Devices j. Supervisory Signal Devices,.....quarterly k. Waterflow Devices,.....quarterly	K 062		
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 on observation and staff interview the facility failed to repair or remove damaged electrical equipment in 1 of 3 smoke compartments. The findings were: Observation of resident room #7 on 11/1/11 at 9:27AM showed the power cord to bed "B" had the outer sheath pulled back and the inner wires were exposed at the plug. At the time of observation the maintenance director could not explain why this cord had not been noticed during the last monthly electrical inspection and replaced.	K 147	See next pg.	

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K 147	Continued From page 8 Reference; NFPA 101,2000 Edition,19.5.1, 9.1.2; NFPA 70, 1999 Edition; 90-7 Examination of Equipment for Safety. ...It is the intent of this Code that factory-installed internal wiring or the construction of equipment need not be inspected at the time of installation of the equipment, except to detect alterations of damage .	K 147	WCHS will ensure electrical safety throughout the building. This will be accomplished by: 1. Maintenance will repair the power cord and plug-in to bed 7B. 2. WCHS will inspect all electrical cords monthly and report to PI	~~2/17/11~~ 12/17/11