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

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 _____	09/22/2009

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

(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 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 built in 1965. The building was equipped with a supervised automatic wet sprinkler system with an addressable fire alarm system. The facility has a capacity of 54 dually certified Medicare and Medicaid beds.	K 000	POC ACCEPTED W/ JoANN FARNSWORTH, NHA, ON 10/26/09.	
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 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 record review the facility failed to ensure 1 of 2 smoke barrier doors was smoke resistant. The findings were: Observation on 9/22/09 at 8:54 AM showed one smoke barrier door would not fully latch into its frame with three attempts. At the time of	K 027	Door openings in smoke barriers will have at least a 20 minute fire protection rating or be at least 1 ¾ thick solid bonded wood core. This will be accomplished by: a. Maintenance manager has generated a work order for the correction to be completed by maintenance department. b. maintenance manager will monitor this deficiency through monthly safety inspections and report to PI Committee.	10/30/9

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/22/9

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

RECEIVED
Wyoming Dept of Health
OCT 23 2009
Office of Healthcare Licensing and Surveys

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10/24/09

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K 027	Continued From page 1 observation the maintenance manager verified the door's failure to latch and reported smoke barrier doors were inspected monthly.	K 027		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ 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 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure hazardous areas were smoke resistant in 2 of 3 smoke compartments. The findings were: 1. Observation on 9/22/09 at 9:16 AM showed a kiln used to fire ceramic handcraft located in a basement room. The room was not equipped with a corridor door and had four unsealed pipe penetrations. The largest gap was 1/2-inch larger than the pipe. At the time of the observation the maintenance manager state he was unaware the room required a corridor door and automatic-closing device. 2. Observation on 9/22/09 at 10:16 AM showed the air handling room off of the main dining room had one unsealed pipe penetration. The gap was	K 029	One hour fire rated construction will protect hazardous areas. This will be accomplished by: 1a. WCHS maintenance will relocate the kiln into the mechanical room on the other side of wall where it is fire-rated, and all penetrations will be sealed with fire caulk. 1b. WCHS maintenance manager will monitor the completion of this deficiency 2a.. Maintenance manager will generate a work order for correction of the unsealed pipe. 2b. Maintenance manager will monitor this deficiency through monthly inspections and report to PI.	10/30/9 10/9/9

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10/26/09

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K 029	Continued From page 2 3/4-inch larger than the pipe. At the time of observation the maintenance manager reported all rooms were inspected monthly. He stated the unsealed pipe should have been noted during a monthly inspection.	K 029		
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 record review and staff interview the facility failed to ensure the fire alarm system was activated during 1 of the past 12 months. The findings were: Review of the fire alarm system testing records documented the system had not been activated during June 2009. On 9/22/09 at 11:20 AM the maintenance manager confirmed the fire alarm system had not been tested during the aforementioned month.	K 052	A fire alarm system required for life safety is installed and tested and maintained in accordance with NFPA 72. a. Maintenance manager will review all drills and log's in our fire alarm book and reassure that the fire alarms will be sounded and tested every month even after a silent drill has occurred. b. WCHS maintenance manager will monitor the correction of this discrepancy and report to PI monthly.	10/30/9
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested	K 062		

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K 062	Continued From page 3 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 and staff interview the facility failed to ensure sprinklers were not obstructed in 2 of 3 smoke compartments and failed to ensure the facility had adequate spare sprinkler heads. The findings were: 1. Observation on 9/22/09 between 8:30 AM and 10 AM showed the sprinkler heads under the SCU (Special Care Unit) canopy and the south exit canopy did not have the required 1- inch clearance between the deflectors and the ceilings. The gaps between the deflectors and the ceilings was only 1/4-inch. At the time of observation the maintenance manager reported the annual sprinkler inspection was conducted by an outside contractor and no spacing issues were noted on the last inspection. 2. Observation on 9/22/09 between 10 AM and 10:30 AM showed the sprinkler installed in the SCU dining room was a 165 degree pendant extended coverage head. Further review showed the two sprinkler heads installed in the activities storeroom were 212 degree upright heads. Review of the spare sprinkler cabinet showed the facility did not have the required minimum of two spare sprinkler heads for each of the installed types of heads.	K 062	Required automatic sprinkler systems will be continuously maintained in reliable operating condition and will be inspected and tested periodically. This will be accomplished by: 1a. Maintenance manager has contacted Western States Fire and has ordered longer dry heads to install under canopies. 1b. WCHS maintenance manager will oversee the completion of this discrepancy. 1c. Maintenance manager will randomly monitor compliance and report to PI quarterly. 2. a) Western States Fire Protection, Inc. has been contacted by maintenance manager to have the sprinkler head relocated to meet code requirements. b) Maintenance manager has ordered enough sprinkler heads to have two spare head stored for back-up. b) Maintenance manager will monitor that spare sprinkler heads are in stock at all times and report to PI monthly.	11/8/9
K 074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health	K 074		

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K 074	Continued From page 4 care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure curtains were flame retardant in 1 of 3 smoke comparments. the findings were: Observation on 9/22/09 at 10:20 AM showed the windows in the main dining room were covered with eight valances. that were not labeled with flame retardant documentation. Review of the facility's flame retardant documentation with the maintenance manager at 11:20 AM showed the facility did not have any flame retardant documentation for the aforementioned curtains.	K 074	Draperies, curtains, including cubical curtains, and other loose hanging fabrics will be maintained in accordance with 10.3.1 Maintenance manager has placed an order for Flame retardant spray compliant with NFPA 13 to be applied to the eight valances in the Manor dining room. WCHS maintenance manager will maintain documentation the flame spread treatment application.	10/30/9
K 141 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2.	K 141		

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K 141	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure no smoking signs were posted on oxygen storeroom doors in 1 of 3 smoke compartments. The findings were: Observation on 9/22/09 at 9:34 AM showed the corridor door to the oxygen storeroom was not posted with a no smoking sign. At the time of observation the maintenance manager reported he was not aware of the signage requirement.	K 141	Non-smoking and no smoking signs are placed in areas where oxygen is used or stored. This will be accomplished by: a. Maintenance manager will purchase no smoking signs. b. Maintenance department will place no smoking signs on the doors to the oxygen room. WCHS maintenance manager will oversee the completion of this deficiency	10/30/9
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by:	K 143	Transferring of oxygen WCHS maintenance is responsible for the correction a. Maintenance has moved the 100 lbs containers into the oxygen delivery room All transfers will take place in this room b. WCHS maintenance will monitor this transfer room in monthly safety Inspections and report to PI	10/30/9

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K 143	Continued From page 6 Based on observation and staff interview the facility failed to ensure 1 of 2 liquid oxygen transfer rooms had adequate safety equipment. The findings were: Observation on 9/22/09 at 9:36 AM showed liquid oxygen was being transferred from 100 pound containers into portable containers in the oxygen storeroom. The floor of the room was not ceramic or bare concrete as required. The floor was noted to be covered with linoleum. Further review showed the room was not equipped with a mechanical ventilation as required. At the time of observation the maintenance manager reported he was unaware of the flooring requirements for this type of room.	K 143		