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 _____	02/16/2016

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 the 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. The facility was a fully sprinklered, single story building of Type V (111) construction built in 1965 and 2006. The building was equipped with a supervised, automatic wet sprinkler system with a zoned fire alarm system. The facility had a capacity of 54 certified Medicare and Medicaid beds with a census of 51.	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to arrange exit access so that exits are readily accessible at all times in 1 of 9 exits. The findings were: 1. Observation on 02/16/16 at 2:10 PM of the doors to the secured unit revealed the doors were a required exit for the unsecured side. Further observation revealed the doors were equipped with a sensor and a push to exit button, however the senor did not function and would not release the magnetic lock. At the time of the observation the Facility Maintenance Manager acknowledged the door would not unlock when an occupant approached the door. 2. Observation on 02/16/16 at 2:10 PM of the	K 038	K038 The facility will maintain exits to be readily accessible at all times. This will be accomplished by: 1. A service call will be set up with outside Contractor ~~STANLEY SENIOR TECH~~ to correct the photo eye for the egress door to the secured unit. Safety inspections will occur on a regular month basis. 2. A service call will be placed with Outside Contractor ~~STANLEY SENIOR TECH~~ to make sure the wanderguard system is operating correctly. The system will be monitored through monthly safety inspections. 3. Proper door hardware will replace the door lock with the proper releasing function knob to permanently repair of the equipment.	3-25-16 gs 3/14/16 gs 3/14/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3/14/16

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.

RECEIVED
MAR 07 2016
Healthcare Licensing and Surveys

modified POC Accepted with Administrator JoANN Farnsworth on 3/14/16 @ 10:45AM 34354

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 _____	02/16/2016

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 038	Continued From page 1 North Secured Unit exit revealed the exit was a required exit for the unsecured facility. Further observation revealed the door was equipped with a wanderguard system, but the system did not function properly. A code was required to be entered to unlock the doors to the outside of the building. At the time of the observation the Facility Maintenance Manager acknowledged the wanderguard system was not working and the exit was locked. Ref: 2000 NFPA 101, Section 19.2.2.2.4 3. Observation on 02/16/16 at 2:26 PM of the facility exam room revealed the door required tight pinching, and more than one releasing operation to make the door operable. At the time of the observation the Facility Maintenance Manager acknowledged the door lock required more than one releasing operation. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.4	K 038	4. Maintenance Department will monitor monthly and report to QA.	