STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING **01** B. WING _____	**03/04/2020**

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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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on March 4, 2020. Based on the findings of the survey team, it was determined that the facility was in compliance with all requirements.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on March 4, 2020. 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 was a fully sprinklered, single story building with a basement of Type II (111) construction built in 1968, 2006, and 2015. The building was equipped with a supervised automatic wet sprinkler system, and a addressable fire alarm system. The facility had a capacity of 58 certified Medicare and Medicaid beds with a census of 52 residents. .	K 000		
K 100 SS=D	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are	K 100		3/20/20

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

Electronically Signed | 07/28/2020

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K 100	Continued From page 1 deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to prevent the development and transmission of communicable diseases and infections in accordance with QSO-17-30-Hospitals/CAHs/NHs. Failure to maintain the facility free of decorative fountains as required could result in sickness or death. The deficiency affected one of numerous corridors in the facility. The findings were: Observation on 3/4/2020 at 3:00 PM in the corridor across from the activity directors office revealed an active decorative water fountain in the corridor. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated unawareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: S&C QSO-17-30-Hospitals/CAHs/NHs 42 CFR §483.80 .	K 100	1) Maintenance met with Activities Manager shortly after the findings of the water fountain display and explained the reason of not being able to have this in the facility. 2) Activities removed the water fountain on 03/04/2020. 3) Maintenance will monitor further displays in monthly safety inspections to assure we are in compliance and report findings in our monthly QA meeting. 4) This display was removed on 03/04/2020.	
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	K 211		7/31/20

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K 211	Continued From page 2 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 as required could delay egress resulting in injury or death during an emergency. The deficiency affected one of numerous exits from the facility. The findings were: Observation on 3/4/2020 at 3:06 PM in the staff dining room revealed an exterior exit door that when tested required more than 30 pounds of force to set the door in motion. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 7.2.1.4.5.1 .	K 211	1) WCHS maintenance is responsible for the correction of this deficiency. 2) Maintenance will make proper adjustments needed for this door to function correctly. 3) WCHS will monitor this door and all other exit doors during monthly safety inspections then report findings in our monthly QA meeting. 4) This will be completed on 07/31/2020.	
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT	K 222		3/31/20

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K 222	Continued From page 3 LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies	K 222		

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K 222	Continued From page 4 installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress from the facility resulting in injury or death during an emergency. The deficiency affected one of numerous exits from the facility. The findings were: Observation on 3/4/2020 at 2:21 PM at the exterior gate off the south special care unit exit, by the day room, revealed the gate door would not open without putting in a code. The area is not currently used as a secured unit, but as a standard care area. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101 Section 19.2.2.2.4	K 222	1) WCHS maintenance is responsible for the correction of this deficiency. 2) WCHS maintenance will add an emergency egress button to the inside of gate that will drop the mag hold when pushed. 3) This will be a permanent solution and WCHS maintenance will monitor its function during monthly safety inspections and report finding in our monthly QA meeting. 4) This was completed on 03/31/2020 pictures were sent to Wyoming Department of Health on 03/31/2020.	

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K 222	Continued From page 5 .	K 222		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain doors with self-closing devices in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain doors with self-closing devices as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous self-closing doors in the facility. The findings were: Observation on 3/4/2020 at 12:20 PM revealed the fire-rated self-closing door at the large pantry room failed to latch when tested. Interview with the facility maintenance manager at the time of observation acknowledged the door failed to latch, and indicated awareness of the	K 223	1) WCHS maintenance is responsible for the correction of this deficiency. 2) WCHS maintenance will make proper adjustments for this door to close properly. 3) WCHS maintenance will monitor this storage room door and all other storage room doors during monthly safety inspections and report the findings in our monthly QA meeting. 4) This will be completed on 07/31/2020.	7/31/20

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K 223	Continued From page 6 requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.2.2.2.7 .	K 223		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 324		3/11/20

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K 324	Continued From page 7 Based on observation and staff interview, the facility failed to maintain the oven/range switch in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous areas as required could result in injury or death during an emergency. The deficiency affected one (1) of three (3) oven/range switches in the facility. The findings were: Observation on 3/4/2020 at 3:06 PM of the residential range located within the dining room revealed that the key for the oven/range switch was left in the lock with the key turned to the on position with no staff supervision. When tested the range began heating. Additionally, combustibles were left on top of the range. Interview with the facility maintenance manager at the time of observation acknowledged the key in the switch in the on position, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.2.5.3(9)(b) .	K 324	1) WCHS maintenance is responsible for the correction of this deficiency. 2) WCHS maintenance spoke with Dietary manager and explained the importance and the reasoning of this deficiency. a. what the key lock switch was used for. b. importance of not leaving key in the on position while unattended. c. The Life Safety and Fire Hazard this put us at risk for. The Dietary manager then educated Dietary and other staff on 03/11/2020. A large key ring as a secondary reminder is attached to the key to help remind the staff of removing the key when work is completed. 3) WCHS maintenance will monitor this deficiency during monthly safety inspection and report finding in our monthly QA meetings. 4) This was completed on 03/11/2020.	
K 345 SS=E	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.	K 345		6/23/20

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K 345	Continued From page 8 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 maintain records of the location of horn and strobe notification inspections in accordance with the 2012 NFPA 101, Life Safety Code and 2010 NFPA 72, National Fire Alarm and Signal Code. Failure to maintain records of the location of horn and strobe functioning as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous testing records for the fire alarm system. The findings were: Document Review on 3/4/2020 at 5:00 PM revealed the facility could not verify that each horn and strobe notification device had passed visual and audible inspection during the previous 12 months. Interview with the facility maintenance manager at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Sections 19.3.4.1; 9.6.1.5 2010 NFPA 72 Sections 14.4.5(20); 14.6.2.4; Figure 14.6.2.4 page 11. .	K 345	1) WCHS maintenance is responsible for the corrections of this deficiency. 2) WCHS maintenance and device testing company mapped out and labeled all devices. 3) Testing company came in and conducted their annual testing and reports. Reports reflect new process of showing all devices were tested from this day forward. 4) Testing was conducted and completed on 06/23/2020.	
K 372 SS=D	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.	K 372		6/25/20

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K 372	Continued From page 9 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor walls in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain corridor walls as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous smoke barriers in the facility. The findings were: Observation on 3/4/2020 at 1:00 PM revealed penetrations in a required smoke barrier in the south corridor wall to the side of the south smoke doors. IT wires were observed to penetrate the wall with no fire rated sealant. Interview with the facility maintenance manager at the time of observation acknowledged the penetrations, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.6.2 .	K 372	1) WCHS maintenance is responsible for the correction of this deficiency. 2) WCHS maintenance will seal with approved fire rated caulking the entire portion of this smoke barrier. 3) WCHS maintenance will monitor the integrity of this smoke barrier during monthly safety inspections and report the findings in our monthly QA meeting. 4) This was completed on 06/25/2020	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		3/11/20

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K 920	Continued From page 10 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical equipment in accordance with the 2012 NFPA 101, Life Safety Code and 2011 NFPA 70, National Electrical Code. Failure to maintain electrical equipment as required could result in injury or death. The deficiency affected two (2) of numerous rooms in the facility. The findings were: Observation on 3/4/2020 at 12:40 PM in the alcove across from the main nurses desk revealed a power strip plugged into another	K 920	1) WCHS maintenance is responsible for the corrections of this deficiency including observation of power strips daisy chained in alcove across from nurse□s station as well as observations 1, 2, and 3. 2) These devices were removed in all 4 locations on 03/05/2020. 3) All Staff were educated on 03/11/2020 on the use of power strips. 4) WCHS maintenance will monitor these deficiencies during monthly safety inspections, we will try to inspect 35	

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K 920	Continued From page 11 power strip creating a daisy chain. Addititional observation found a second instance in the north secured unit. Interview with the maintenance manager at time of observation acknowledged the daisy chains, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 9.1.2 2011 NFPA 70, Section 400.8 Based on observation and staff interview, the facility failed to maintain electrical equipment in accordance with the 2012 NFPA 101, Life Safety Code, the 2012 NFPA 99, Health Care Facilities, and the 2011 NFPA 70, National Electrical Code. Failure to maintain electrical equipment as required could result in injury or death. The deficiencies affected three (3) of numerous rooms in the facility. The findings were: 1. Observation on 3/4/2020 at 1:18 PM revealed an extention cord in use in room 17LR. 2. Observation on 3/4/2020 at 2:05 PM in room 25LR revealed a non-UL approved power strip. 3. Observation on 3/4/2020 at 2:36 PM revealed that the south secured unit day room had two (2) power strips located within the patient care vicinity. The day room contained patient care related electrical equipment. Power strips cannot be located within the patient care vicinity that use patient care related electrical equipment.	K 920	rooms with a minimum of 25 with allowable access and report findings to the QA meetings. 5) This was completed on 03/11/2020.	

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K 920	Continued From page 12 Interview with the maintenance manager at time of observation acknowledged the deficiencies, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 9.1.2 2012 NFPA 99, Section 10.2.3.6 2011 NFPA 70, Section 400.8	K 920		
K 923 SS=E	. Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room,	K 923		7/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING **01** B. WING _____	**03/04/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 923	Continued From page 13 where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain oxygen storage in excess of 3,000 cubic feet in accordance with the 2012 NFPA 99, Health Care Facilities code. Failure to maintain oxygen storage as required could result in injury or death. The deficiency affected one (1) of two storage locations at the facility. The findings were: Observation on 3/4/2020 at 1:46 PM revealed that a liquid oxygen container greater than 3,000 cubic feet was stored outdoors against the building in a secured area with a gate. Further observation revealed that the exterior storage location was not separated from the wood-framed building by at least 50 feet as required by NFPA 99 and NFPA 55. Interview with the maintenance manager at time of observation acknowledged the deficiencies, and indicated awareness of the requirement. Interview with the facility administrator at the time	K 923	1) WCHS maintenance is responsible for the corrections of this deficiency. 2) WCHS maintenance will remove this storage area and return tank to supplier. 3) This will be a permanent resolution at this point. In the future if increased oxygen is needed we will take proper action and build a location to NFPA 99 standards. 4) This will be completed on 07/31/2020.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 923	Continued From page 14 of exit acknowledged the deficiency. REF: 2012 NFPA 99, Section 11.3.2.4; 5.1.3.5.12 and Annex A Figure A.5.1.3.5.12 (a)	K 923		