

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

PRINTED: 04/04/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 000	Initial Comments	E 000			
E 031 SS=F	An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on March 8, 2022. Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following:	E 031			3/8/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/24/2022

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.

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

PRINTED: 04/04/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 031	Continued From page 1 (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to develop and maintain the emergency preparedness contact information in accordance with §483.73(c). Failure to develop and maintain the emergency preparedness contact information could result in the supervising agency not being notified in an emergency. The deficiency affected the contact list in the emergency preparedness plan. The findings were: Document review on 3/8/2022 at 11:40 AM revealed that the contact list in the emergency preparedness plan was missing contact information for: The State Licensing and Certification Agency and the Office of the State Long-Term Care Ombudsman. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated she was unaware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	E 031	1. CEO added the required contact information for Federal, State and Denver Region Emergency Preparedness staff, State Licensing Agency, State Ombudsman to the Emergency Response and Communication Plan. 2. Facility will review all requirement for Emergency Preparedness to ensure all requirements are met. 3. Educated managers on 3/14/2022 and staff on 03/31/22 on the Emergency Response and Communication Plan additions. 4. Monitoring will be completed by CEO or designee for compliance and will report at monthly QA. 5. Completed 03/8/22.		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby	E 041			4/24/22

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

PRINTED: 04/04/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E 041	Continued From page 2 power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it	E 041			

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

PRINTED: 04/04/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E 041	Continued From page 3 evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011.	E 041			

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

PRINTED: 04/04/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E 041	Continued From page 4 (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: 1. Based on document review and staff interview, the facility failed to provide proof of fuel reliability in accordance with §483.73(a), 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) . Failure to verify the reliability of emergency fuel systems could result in the generator not functioning in an emergency. The deficiency affected planning for facility-wide power readiness in the event of an emergency. The findings were: Interview on 3/8/2022 at 11:00 AM with the maintenance manager revealed that no letter from the natural gas provider was available to provide proof of low probability of interruption and demonstrated reliability. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. 2. Based on document review and staff interview, the facility failed to record weekly generator tests in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Failure	E 041	1. Failure to provide proof of fuel reliability. a. WCHS Maintenance Department is responsible for this correction. b. WCHS Maintenance Manager will retrieve this document from the supplier and keep on hand for further review. c. WCHS Maintenance staff will obtain updated documents if supplier changes occur. 2. Failure to record weekly generator inspections. a. WCHS Maintenance is responsible for the correction of this deficiency. b. WCHS Maintenance will generate a weekly check sheet form NFPA110 Standard for Emergency and stand-by power systems. c. WCHS Maintenance will report monthly to QA Committee on the weekly checks. d. This will begin on 3/30/2022 and every Wednesday thereafter. 3. Completed 4/24/22.		

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

PRINTED: 04/04/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 041	Continued From page 5 to perform weekly generator tests as required could result in power loss during an emergency. The deficiency affected facility-wide reliability of the emergency power system. The findings were: Document review and interview with the director of plant operations on 3/8/2022 at 11:05 AM revealed that no record of weekly generator tests was available. Interview with the director of plant operations at the time of the observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.5.1, 9.1, and 9.1.3.1 2010 NFPA 110, Sections 8.4.1	E 041			
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on March 8, 2022. 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 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	K 000			

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

PRINTED: 04/04/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	Continued From page 6 automatic wet sprinkler system, and an addressable fire alarm system. The facility had a capacity of 58 certified Medicare and Medicaid beds with a census of 41 residents.	K 000			
K 223 SS=E	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 delay egress from the building during an emergency resulting in injury or death. The deficiency affected one (1) of many doors with self-closing devices throughout the facility. The findings were: Observation on 3/8/2022 at 9:32 AM at the storage area accessible from the dining area revealed that the door failed to latch when dropped from an open position with no initial	K 223	1. WCHS Maintenance is responsible for the correction of this deficiency. 2. WCHS Maintenance made adjustments to the door to make a positive latch on 3/11/22. 3. WCHS Maintenance will monitor this door for three months during Safety Inspections and will report findings monthly to QA Committee. 4. Completed 3/11/22.		3/11/22

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

PRINTED: 04/04/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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 223	Continued From page 7 movement. Interview with the maintenance manager at the time of observation acknowledged the door's inability to latch, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.3.2.1.3, 7.2.1.8	K 223			
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to to maintain the fire sprinkler	K 351	1. WCHS Maintenance is responsible for the correction of this deficiency.		3/11/22

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

PRINTED: 04/04/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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 351	Continued From page 8 system in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency affected one (1) of numerous sprinkler heads throughout the facility. The findings were: Observation on 3/8/2022 at 10:25 AM in the storage room by the main entrance revealed a fire sprinkler head with the escutcheon missing, exposing the annular space. Interview with the maintenance manager at the time of observations acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K 351	2. WCHS Maintenance installed the correct escutcheon ring is in place where indicated on 3/11/22. 3. WCHS Maintenance will this deficiency for three months during Safety Inspections and will report findings monthly to QA Committee. 4. Completed 3/11/22.		
K 353 SS=E	REF: 2010 NFPA 13, Section: 6.2.7.1 Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test	K 353		4/24/22	

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

PRINTED: 04/04/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 9 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain sprinkler systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 NFPA 25, Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems. The failure to maintain sprinkler systems as required could result in injury or death during an emergency. The deficiency affected the entire facility. The findings were: Observation on 3/8/2022 starting at 9:13 AM, and throughout the survey, revealed storage areas with obstructions to their sprinkler heads. Observation in the kitchen's storage area revealed objects stacked closely to the ceiling and within several inches of the sprinkler. This condition was also observed throughout the kitchen area. Additionally, storage areas throughout the facility were observed to have similar conditions with storage within the obstruction distance of sprinkler heads. 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, Sections 19.3.5.1; 9.7.5	K 353	1. WCHS Maintenance is responsible for the correction of this deficiency. 2. WCHS Maintenance will tape a reference line of 18 inches from ceiling in all storage areas to help direct staff of the requirement. 3. WCHS Maintenance will monitor storage compartments for three months during Safety Inspections and will report findings monthly to QA Committee. 4. Completed 4/24/22.		

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

PRINTED: 04/04/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 10 2011 NFPA 25, Section 5.2.1.2	K 353			
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide an operations placard at the K-type extinguisher in accordance with the 2012 NFPA 101, Life Safety Code, the 2010 NFPA 10, Standard for Portable Fire Extinguishers. Failure to provide operational information at emergency equipment could lead to inappropriate staff response during an emergency. The deficiency affected one (1) of one (1) kitchen K-type extinguishers for the facility. The findings were: Observation on 3/8/2022 at 9:21 AM in the kitchen revealed there was no placard conspicuously placed near the K-type extinguisher stating the kitchen hood fire protection system shall be actuated prior to using the fire extinguisher. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K 355	1. WCHS Maintenance is responsible for the correction of this deficiency. 2. WCHS Maintenance will acquire proper signage for the use of the K-Type extinguishers. The signage will be mounted on wall where the K-Type extinguishers are located. 3. Signs will be permanently in place therefore no monitoring of signage will be reported. 4. Completed 4/24/22.	4/24/22	

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

PRINTED: 04/04/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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 355	Continued From page 11	K 355			
K 911 SS=F	Ref: 2012 NFPA 101, Sections 19.3.5.12, 9.7.4.1 2010 NFPA 10, Section 5.5.5.3 Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to provide a letter of reliability in accordance with the 2012 NFPA 101, Life Safety Code, the 2012 NFPA 99, Healthcare Facilities Code, and NFPA 110, Standard for emergency and standby power systems. The failure to prove reliable access natural gas as required could result in injury or death due in an emergency. The deficiency affected one (1) of one (1) generator for the facility. The findings were: Records review on 3/8/2022 at 11:00 am with the maintenance manager revealed that no letter from the natural gas provider as available to provide proof of low probability of interruption and demonstrated reliability. 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	K 911	1. Failure to provide proof of fuel reliability. a. WCHS Maintenance Department is responsible for this correction. b. WCHS Maintenance Manager will retrieve this document from the supplier and keep on hand for further review. c. WCHS Maintenance staff will obtain updated documents if supplier changes occur. 2. Completed 4/24/22.	4/24/22	

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

PRINTED: 04/04/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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 911	Continued From page 12 of exit acknowledged the deficiency. Ref: NFPA 101, Sections 19.5.1, 9.1, 9.1.2, and 9.1.3.1 NFPA 99, Sections 6.4.1, 6.4.1.1, 6.4.1.1.1.2 and 6.4.1.1.4 NFPA 110, Section 5.1, 5.1.4	K 911			
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		4/24/22	

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

PRINTED: 04/04/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535023	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF PROVIDER OR SUPPLIER WESTON COUNTY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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 918	Continued From page 13 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to record weekly generator tests in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Failure to perform weekly generator tests as required could result in power loss during an emergency. The deficiency affected facility-wide reliability of the emergency power system. The findings were: Document review and interview with the director of plant operations on 3/8/2022 at 11:05 AM revealed that no record of weekly generator tests was available. Interview with the director of plant operations at the time of the observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.5.1, 9.1, and 9.1.3.1 2010 NFPA 110, Sections 8.4.1	K 918	1. WCHS Maintenance is responsible for the correction of this deficiency. 2. WCHS Maintenance will generate a weekly check sheet form NFPA110 Standard for Emergency and stand-by power systems. 3. WCHS Maintenance will report monthly to QA Committee on the weekly checks. 4. This will begin on 3/30/2022 and every Wednesday thereafter. 5. Completed 4/24/22		