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 _____	**04/13/2023**

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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Licensing and Surveys on 04/13/2023. Based upon the findings, it was determined the facility was in compliance with all requirements of 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 04/13/2023. Requirements for Long Term Care Facilities Section 42 CFR 483.90 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 an addressable fire alarm system. The facility had a capacity of 58 certified Medicare and Medicaid beds with a census of 37 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
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	K 223		5/1/23

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

Electronically Signed | 05/02/2023

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K 223	Continued From page 1 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 provide a self-closing door that latched in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide a latching and self-closing door as required could delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of numerous doors in the facility. The findings were: Observation on 04/13/2023 at 9:49 AM of the rated fire door at the 2-hour separation between the CAH and the Long Term Care facility, revealed that the door was equipped with a self-closing device, but failed to latch when dropped with no initial motion. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 7.2.1.8.2	K 223	1. WCHS maintenance is responsible for the correction of this deficiency 2. WCHS maintenance will adjust this door located between the CAH and the Long-Term Care Facility 3. WCHS maintenance will monitor this during monthly safety walk through and report all findings during our monthly QA meetings 4. This will be complete by 5/1/2023	
K 255 SS=D	Suite Separation, Hazardous Content, and Subd CFR(s): NFPA 101	K 255		5/1/23

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K 255	Continued From page 2 Suite Separation, Hazardous Content, and Subdivision All suites are separated from the remainder of the building (including from other suites) by construction meeting the separation provisions for corridor construction (18.3.6.2-18.3.6.5 or 19.3.6.2-19.3.6.5). Existing approved barriers shall be allowed to continue to be used provided they limit the transfer of smoke. Intervening rooms have no hazardous areas and hazardous areas within suites comply with 18/19.2.5.7.1.3. Subdivision of suites shall be by noncombustible or limited-combustible construction. 18.2.5.7.1.2 through 18.2.5.7.1.4, 19.2.5.7.1.2, 19.2.5.7.1.3, 19.2.5.7.1.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor separations in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain corridor separations as required could result in injury or death due in an emergency. The deficiency affected one (1) smoke compartment in the facility. The findings were: Observation on 04/13/2023 at 8:21 AM in the corridor by social services revealed that the ceiling tile near the informational display bar had an oversized hole where wires protrude from the annular space above where by smoke could bypass the ceiling and enter the annular space above. 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	K 255	1. WCHS maintenance is responsible for the correction of this deficiency 2. WCHS maintenance will fill this oversized hole with Fire Rate caulking 3. WCHS maintenance will monitor this deficiency during monthly safety walk throughs and report findings during our monthly QA meetings. This will be completed by 5/1/2023	

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K 255	Continued From page 3 of exit acknowledged the deficiency. Ref: NFPA 101 19.3.6.2.4	K 255		
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a level means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide a level means of egress as required could delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of numerous egress routes in the facility. The findings were: Observation on 04/13/2023 at 8:28 AM at the exit outside the special care area found that the concrete walkway had an approximate 1 1/2" offset between two segments of the walkway. Interview with the maintenance director at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Sections 19.2.1, 7.1.6.2	K 271	1. WCHS maintenance is responsible for the correction of this deficiency. 2. WCHS maintenance will hire a contractor to come in and remove a section of this sidewalk and have the concrete repaired for a smooth transition from the exit discharge to the main pathway. 3. This will be a permanent fix and there will be no monthly monitoring thereafter. 4. Completion date dependent on contractor.	6/30/23

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K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to seal penetrations in a hazardous area in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly seal penetrations in a hazardous area could result in injury or death during an emergency. The deficiency affected the	K 321	1.WCHS maintenance is responsible for the correction of this deficiency. 2. WCHS maintenance will repair the drywall in the basement activities storage area and use drywall mud and approve fire rated caulking around plumbing	5/1/23

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K 321	Continued From page 5 one (1) of multiple storage rooms. The findings were: Observation on 04/13/2023 at 8:55 AM in the basement activities storage revealed a large section of the ceiling that had been removed for plumbing repairs. As such, the ceiling did not provide a continuous membrane to resist the passage of smoke. Interview with the maintenance manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref.: 2012 NFPA 101, Sections: 19.3.2.1, 19.3.2.1.2, 8.4.1	K 321	penetration. 3. This correction will be a permanent fix and there will be no monthly monitoring or reporting to our QA department. 4. Complete by 5/1/20203	
K 345 SS=D	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. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm Code. Failure to maintain fire detection systems	K 345	1. WCHS maintenance is responsible for the correction of this deficiency. 2. WCHS maintenance will update Underwriter's Laboratory (UL) certification and will be added to the list from the	5/1/23

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K 345	Continued From page 6 as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous requirements for the fire alarm system. The findings were: Observation on 04/13/2023 at 8:59 AM at the fire annunciator panel revealed that the Underwriter's Laboratory (UL) certification for the fire alarm was expired. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA Sections 19.3.4.1; 9.6.1.3 2010 NFPA 72 Section 26.3.4.3	K 345	Company that company that conducts our annual Fire Alarm Inspection and reports, to renew this annually. 3. WCHS maintenance supervisor will monitor that this is done on an annual basis. 4. This will be complete by 5/1/2023	
K 351 SS=E	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	K 351		5/1/23

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K 351	Continued From page 7 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: 1. Based on observation and staff interview, the facility failed to to maintain the fire sprinkler 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 multiple spaces within the facility. The findings were: Observation on 04/13/2023 at 8:42 AM at the entrance of room 10LR revealed a fire sprinkler head with the escutcheon missing, exposing the annular space. Additional observation on 04/13/2023 at 9:14 AM in the bathroom 22LR, 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. REF: 2010 NFPA 13, Sections: 6.2.7.1 2. 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	K 351	1. WCHS maintenance is responsible for the correction of this deficiency. 2. WCHS maintenance will replace the two escutcheon rings that were missing in room 10LR and in room 22 LR bathroom. 3. WCHS will monitor these findings during the monthly safety walk through and report all findings to our QA committee monthly meetings. 4. This will be completed by 5/1/2023	

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K 351	Continued From page 8 maintain sprinkler systems as required could result in injury or death during an emergency. The deficiency affected two (2) of multiple storage areas throughout the facility. The findings were: Observation on 04/13/2023 at 8:53 AM in the basement storage revealed objects stacked close to the ceiling within several inches of the sprinkler head. Additional observation on 04/13/2023 at 9:41 AM in the activities room revealed objects stacked close to the ceiling within several inches of the sprinkler head. Interview with the facility manager at the time of observation acknowledged the deficiency, and indicated they were aware 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 2011 NFPA 25, Section 5.2.1.2	K 351		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are	K 761		5/1/23

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K 761	Continued From page 9 maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to perform annual inspections of fire doors in accordance with the 2012 NFPA 101, Life Safety Code and 2010 NFPA 80. The failure to perform annual inspections of fire doors as required could result in injury or death due to an increased risk of fire spread throughout the facility, as well as possible delays to egress due to malfunctioning doors. The deficiency affected the entire facility facility. The findings were: Document review on 04/13/23 at 10:46 AM revealed that the facility had not developed their inventory of fire doors. Interview with the facility manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Section 19.7.6, 8.3.3.1 2010 NFPA 80, Sections 5.2, 5.2.3	K 761	1. WCHS maintenance is responsible for the correction of this deficiency. 2. WCHS maintenance will generate a detailed map of fire doors that need to be inspected annually and a numbered check list of each door. This will be kept on file and added to our computer work order system to regenerate annually. 3. This will be a procedure in place on our computer work order system as a recurring event on an annual basis on the first Tuesday of every May. No monitoring necessary.	