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

PRINTED: 05/05/2005
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 _____	04/19/2005

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 PRECEEDED 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 Surveyor #: 19186 The regulatory reference is 42 CFR 483.70 (a) except where a different regulation may be specifically referenced. K2: Building: Type V (111) with a complete wet sprinkler system with an anti-freeze branch in the New Wing. The building is one story with direct ground level access. K6: Date of Plan Approval: 1965 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=51;SNF/NF=51 K9: The facility meets the Life Safety Code standards based on acceptance of a plan of corrections "NFPA" National Fire Protection Association	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.3 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities as of March 19, 2006.	K 018	K018 The facility will provide doors with no impediment to closing and that will resist the passage of smoke. This will be accomplished by: 1. The kitchen housekeeping closet door will be repaired to fully latch in the frame. 2. The corridor door to resident room #39 will be repaired to fully latch in the frame.	6-3-05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/11/05

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.

ACCEPTANCE OF THIS POC WITH JOINT FINDINGS WORTH, WA. 05/25/05 @ 4 PM VIA TELECONFERENCE.

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations and staff interview on 4/19/05 between 1230 PM and 2 PM, the facility failed to protect 2 of 58 corridor door openings in accordance with NFPA 101 Section 19.3.6.3. The findings were: 1. The kitchen house keeping closet door was equipped with a self-closing device that was not able to fully latch the door into the door frame. 2. The corridor door for resident room #39 would latch into the door frame. The latch bolt would not insert into the strike plate. 3. Maintenance staff verified the above findings.	K 018	**All other doors will be inspected to seal and latch properly to resist the passage of smoke and provide no impediment to closing. The maintenance manager or designee will monitor compliance with this regulation.**	
K 027 SS=D	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 observations and staff interview on 4/19/05 between 1 PM and 2 PM, the facility	K 027	**K027** **The facility will maintain smoke barrier doors.** **This will be accomplished by:** **1. The solarium's East door will be repaired to fully latch into the doorframe. All other smoke barrier doors will be inspected for compliance. The maintenance manager or designee will monitor compliance and check doors during monthly fire drills.**	6-3-05

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K 027	Continued From page 2 failed to protect 1 of 4 smoke barriers in accordance with NFPA 101 Section 19.3.7.3 and 3.3.20. The findings were: 1. The solariums East doors were equipped with self-closing devices that did not fully latch the doors into the door frame. Maintenance staff verified the above finding.	K 027		
K 029 SS=D	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 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 on 4/19/05 between 230 PM and 3 PM, the facility failed to provide 1 of 6 hazardous areas with proper separation in accordance with NFPA 101 Section 19.3.2.1. The findings were: 1. The South tub was being used as a soiled linen room. The corridor door was not equipped with a self-closing device and was not fire rated as required by the Code. Maintenance staff verified the above finding.	K 029	**K029** **The facility will provide hazardous areas with proper separation. This will be accomplished by:** **1. The south tub room will not be used as a soiled linen room. The soiled linen will be stored in the dirty utility room. The other hazardous areas will be inspected for their proper use. The maintenance manager or designee will monitor compliance with the use of these areas.**	6-3-05
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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K 062	Continued From page 3 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested 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 on 4/19/05 between 2 PM and 3 PM, the facility failed to maintain the installed sprinkler system in accordance with NFPA 13 Section 56-.5.2.1. The findings were: 1. Several of the sprinkler heads in the attic crawl space above the North wing and the Southeast wing had insulation falling down from the rafters onto the sprinkler heads obstructing their spray patterns. Maintenance staff verified that above findings.	K 062	**K062** **The facility will ensure automatic sprinkler systems are continuously maintained in reliable operating condition. This will be accomplished by:** **1. The sprinkler heads in the North and Southeast wing will have the insulation removed that is obstructing their spray pattern. All other sprinkler heads will be inspected for obstructions. This will be monitored by the maintenance manager or designee during monthly fire drills.**	6-3-05
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and staff interview on 4/19/05 between 2 PM and 3 PM, the facility failed to provide an electrical system installed in accordance with NFPA 99 Section 3-5.2.2.3. The findings were: 1. The medication refrigerator in the medication room was not supplied by emergency power as required by the Code. Maintenance staff verified the above finding.	K 130	**K130** **The facility will provide and maintain an electrical system in accordance with NFPA99. This will be accomplished by:** **1. A policy will be written to address the problem of the medication refrigerator not being supplied by emergency power during a power failure. This will be monitored by Long Term Care Nurse Manager.**	6-3-05

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K 143 SS=D	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: Based on observation and staff interview on 4/19/05 between 1 PM and 2 PM, the facility failed to provide a liquid oxygen transferring area in accordance with NFPA 99 Section 4-5.1.1.2. The findings were: 1. The outdoor liquid oxygen transfer area was located closer than the allowed 25 ft. from the buildings windows. Maintenance staff verified the above finding.	K 143	K143 **This standard will be achieved by one of the following options. Weston County Manor will undergo major renovation. During this renovation there are plans to construct a room that meets all code requirements associated with the storage and use of liquid oxygen. We are requesting at least 1 month for plan design, another month for plan approval and an additional 4 months for the actual construction. Completion of this project will be by 11-30-05. The other option would be to construct a room either on site or within the facility that meets all code requirements associated with the storage and use of liquid oxygen. This option is not preferred by Weston County Manor due to a new liquid room is planned in the renovation, this option would be more costly. The maintenance manager or his designee will monitor the storage and use of liquid oxygen to insure compliance.**	6-3-05