STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH007	A. BUILDING: _____ B. WING _____	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF SHERIDAN	561 AVOCA AVENUE SHERIDAN, WY 82801

(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) COMPLETE DATE
S 000	General Comments A Life Safety Code survey was conducted by Healthcare Licensing and Surveys from April 17th, 2024 through June 13, 2024. The facility was a single story, fully sprinklered building of Type V(000) construction built in 1999. The building was equipped with a supervised, automatic wet 13R sprinkler system and a zoned fire alarm system. The facility has a capacity of 15 licensed beds with a census of 10 residents. Wyoming Department of Health, Rules and Regulations for Licensure of Boarding Homes, Chapter 7, Section 6 Building and Physical Plant. (o) Facilities Licensed prior to the effective date of these rules shall meet the Life Safety Code of the National Fire Protection Association that was in effect at the time the facility was licensed as a boarding home. All references are based on the requirements of NFPA 101 Life Safety Code, New Board and Care, 1994 Edition, unless otherwise noted.	S 000		
S8012	NFPA Life Safety - Nfpa Emergency Lighting NFPA 101 Emergency Lighting This State Rule and Regulation is not met as evidenced by: Based on document review, observation, and staff interview, the facility failed to test and maintain emergency egress lighting in accordance with the 1994 NFPA 101, Life Safety Code. Failure to properly test and maintain emergency egress lighting could result in delayed evacuation of the building in the event of an emergency, resulting in injury or death. The	S8012		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: President (X6) DATE: 6/18/24

POC approved via email to willowcreekofsheridan@gmail.com on 09/20/24 at 1:36PM. Martha Shawnana

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S8012	Continued From page 1 deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 04/17/24 starting at 1:00 PM revealed the facility had not conducted the required testing of emergency egress lighting. No documentation was available at the time of the survey to demonstrate that the facility had conducted the monthly, or yearly, testing of the emergency egress lighting in the past twelve (12) months. Observation at the time of the survey revealed six (6) battery-powered emergency lights located in the facility's corridors. Testing of the lights was conducted during the survey using the test switches and buttons located on the lights. The lights did not activate when tested. Interview with the house manager at the time of exit confirmed the deficiency. The house manager was asked by the surveyor to provide documentation demonstrating compliance by end of day 04/22/24. No information was provided to demonstrate compliance when the report was submitted to the facility on 05/07/24. A phone call with the facility owner on 06/04/24 took place with HLS administration regarding the submitted POC, which stated that evidence of compliance was provided to the surveyor before the 05/07/24 date. The facility administrator was asked to provide that evidence again, as it was not received by HLS, and was given until 06/12/24 to submit it. No evidence of compliance was provided as of 06/13/24. Ref: 1994 NFPA 101 22-3.2.9, 5-9.3, 31-1.3.7	S8012	Eun 6/18/24	

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S8017	NFPA Life Safety - Nfpa Det, Alarm & Comm Systems NFPA 101 Detection, Alarm and Communication Systems This State Rule and Regulation is not met as evidenced by: Based on document review, observation, and staff interview, the facility failed to properly test and maintain the fire alarm system in accordance with the 1994 NFPA 101, Life Safety Code and 1993 NFPA 72, National Fire Alarm Code. Failure to properly test and maintain the fire alarm system could result in malfunction or failure of the system, resulting in injury or death in the event of a fire. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 04/17/24 starting at 1:00 PM revealed the facility failed to conduct all required annual and semi-annual testing of the fire alarm system. No documentation was available at the time of the survey to demonstrate that the annual testing of the fire alarm system had been completed, or that the semi-annual inspection and testing of the fire alarm system batteries had been completed in the past twelve (12) months. Observation revealed that, at the time of the survey, the fire alarm panel was in a trouble mode listed as "Charger Fault". Interview with the house manager revealed that the panel had been in a trouble mode for approximately six (6) months. Interview with the house manager at the time of exit confirmed the deficiency.	S8017	Em 4/18/24	

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S8017	Continued From page 3 The house manager was asked by the surveyor to provide documentation demonstrating compliance by end of day 04/22/24. No information was provided to demonstrate compliance when the report was submitted to the facility on 05/07/24. A phone call with the facility owner on 06/04/24 took place with HLS administration regarding the submitted POC, which stated that evidence of compliance was provided to the surveyor before the 05/07/24 date. The facility administrator was asked to provide that evidence again, as it was not received by HLS, and was given until 06/12/24 to submit it. No evidence of compliance was provided as of 06/13/24. Ref: 1994 NFPA 101 22-3.3.4.1, 7-6.1.4; 1993 NFPA 72 Table 7-3.2, 7-5	S8017		
S8018	NFPA Life Safety - Nfpa Extinguishment Req NFPA 101 Extinguishment Requirements This State Rule and Regulation is not met as evidenced by: Based on document review, and staff interview, the facility failed to properly test and maintain the fire sprinkler system in accordance with the 1994 NFPA 101, Life Safety Code and 1992 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to properly test and maintain the fire sprinkler system could result in malfunction or failure of the system, resulting in injury or death in the event of a fire. The deficiency has the potential to affect all residents, staff, and visitors.	S8018	Sum 6/18/24	

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S8018	Continued From page 4 The findings were: 1) Document review on 04/17/24 starting at 1:00 PM revealed the facility failed to conduct all required quarterly fire sprinkler system testing. Documentation revealed that the quarterly testing of the water flow alarm device was conducted only once in the past twelve months. No additional documentation was available to demonstrate that testing of the water flow alarm device had been performed for the other three (3) quarters of the past twelve (12) months. Interview with the house manager at the time of exit confirmed the deficiency. The house manager was asked by the surveyor to provide documentation demonstrating compliance by end of day 04/22/24. No information was provided to demonstrate compliance when the report was submitted to the facility on 05/07/24. A phone call with the facility owner on 06/04/24 took place with HLS administration regarding the submitted POC, which stated that evidence of compliance was provided to the surveyor before the 05/07/24 date. The facility administrator was asked to provide that evidence again, as it was not received by HLS, and was given until 06/12/24 to submit it. No evidence of compliance was provided as of 06/13/24. Ref: 1994 NFPA 101 22-3.3.5.1; 7-7.5; 1992 NFPA 25 Table 2-1, 2-1.3, 1-8 2) Document review on 04/17/24 starting at 1:00 PM revealed the facility failed to conduct all	S8018	Em 6/18/24	

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S8018	Continued From page 5 required tests and inspections of the fire sprinkler system testing. Additional documentation received on 04/24/24 revealed that an annual inspection and testing of the fire sprinkler system was conducted in May of 2023. The contractor inspection report noted multiple deficiencies. The deficiencies noted included the gauges not having been replaced or recalibrated in the last five (5) years, not having extra sprinkler heads available on the premises or the appropriate head wrench, dry sprinkler heads 10 years or older that have not been replaced or sample tested, not having conducted an internal inspection in the last 5 years, and that the fire alarm panel was not free of alarm or trouble signals upon arrival nor upon departure. No documentation was available to demonstrate that any of the noted deficient items had been corrected since the inspection was conducted. Ref: 1994 NFPA 101 22-3.3.5.1; 7-7.5; 1992 NFPA 25 Table 2-1, 2-1.3, 1-8	S8018		
S8019	NFPA Life Safety - Nfpa Portable Fire Extinguisher NFPA 101 Portable Fire Extinguishers This State Rule and Regulation is not met as evidenced by: Based on document review, observation, and staff interview, the facility failed to properly inspect and maintain portable fire extinguishers in accordance with the 1994 NFPA 101, Life Safety Code, and 1994 NFPA 10, Standard for Portable Fire Extinguishers. Failure to properly inspect and maintain portable fire extinguishers could result in malfunction or failure of the	S8019	Evan 6/18/24	

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S8019	Continued From page 6 extinguishers, resulting in injury or death in the event of a fire. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Observation on 04/17/24 starting at 12:00 PM and throughout the survey revealed that the facility failed to conduct all required monthly and annual inspections and maintenance of the portable fire extinguishers. Observation of the portable fire extinguishers in the facility revealed that they were tagged as having last been maintained in 2022. Observation of the portable extinguisher tags revealed that they had last been inspected in January of 2024. No documentation was available at the time of the survey to demonstrate that additional testing or inspections had been completed. Portable fire extinguishers shall be inspected monthly, and shall have a maintenance examination conducted annually. Interview with the house manager at the time of exit confirmed the deficiency. The house manager was asked by the surveyor to provide documentation to demonstrate compliance by end of day 04/22/24. No information was provided to demonstrate compliance when the report was submitted to the facility on 05/07/24. A phone call with the facility owner on 06/04/24 took place with HLS administration regarding the submitted POC, which stated that evidence of compliance was provided to the surveyor before the 05/07/24 date. The facility administrator was asked to provide that evidence again, as it was not received by HLS, and was given until 06/12/24 to submit it. No evidence of compliance	S8019	Em 6/18/24	

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S8019	Continued From page 7 was provided as of 06/13/24. Ref: 1994 NFPA 101 22-3.3.5.3, 7-7.4.1; 1994 NFPA 10 4-4.1	S8019		
S8025	NFPA Life Safety - Nfpa Emergency Plan NFPA 101 Emergency Plan This State Rule and Regulation is not met as evidenced by: Based on document review and staff interview, the facility failed to train staff on the emergency plan in accordance with the 1994 NFPA 101, Life Safety Code, and Wyoming Department of Health (WDH) Ch 8: Program Administration for Boarding Homes. Failure to properly train staff on the emergency plan could result in delayed or improper evacuation, resulting in injury or death in the event of a fire. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 04/17/24 starting at 1:00 PM revealed the facility failed to train staff on the facility's emergency plan. No documentation was available at the time of the survey to demonstrate that the facility had provided training to staff on the emergency plan. All employees shall be trained when they begin work at the facility, and at least once every twelve (12) months to keep informed with respect to their duties and responsibilities under the plan. Such instruction shall be reviewed by the staff at least every two months. Interview with the house manager at the time of	S8025	6/18/24	

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S8025	Continued From page 8 exit confirmed the deficiency. The house manager was asked by the surveyor to provide documentation demonstrating compliance by end of day 04/22/24. No information was provided to demonstrate compliance when the report was submitted to the facility on 05/07/24. A phone call with the facility owner on 06/04/24 took place with HLS administration regarding the submitted POC, which stated that evidence of compliance was provided to the surveyor before the 05/07/24 date. The facility administrator was asked to provide that evidence again, as it was not received by HLS, and was given until 06/12/24 to submit it. No evidence of compliance was provided as of 06/13/24. Ref: 1994 NFPA 101 22-7.1; WDH Ch. 8 Section 14(b)(i)(B)	S8025		
S8026	NFPA Life Safety - Nfpa Resident Training NFPA 101 Resident Training This State Rule and Regulation Is not met as evidenced by: Based on document review and staff interview, the facility failed to train residents on the emergency plan in accordance with the 1994 NFPA 101, Life Safety Code, and Wyoming Department of Health (WDH) Ch 8: Program Administration for Boarding Homes. Failure to properly train residents on the emergency plan could result in delayed or improper evacuation, resulting in injury or death in the event of a fire. The deficiency has the potential to affect all	S8026	6/18/24	

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S8026	Continued From page 9 residents, staff, and visitors. The findings were: Document review on 04/17/24 starting at 1:00 PM revealed the facility failed to train residents on the facility's emergency plan. No documentation was available at the time of the survey to demonstrate that the facility had provided training to residents on the emergency plan. All residents shall be trained in the proper actions to be taken in the event of a fire. Residents shall be trained on the emergency plan at the time of their admission. Interview with the house manager at the time of exit confirmed the deficiency. The house manager was asked by the surveyor to provide documentation demonstrating compliance by end of day 04/22/24. No information was provided to demonstrate compliance when the report was submitted to the facility on 05/07/24. A phone call with the facility owner on 06/04/24 took place with HLS administration regarding the submitted POC, which stated that evidence of compliance was provided to the surveyor before the 05/07/24 date. The facility administrator was asked to provide that evidence again, as it was not received by HLS, and was given until 06/12/24 to submit it. No evidence of compliance was provided as of 06/13/24. Ref: 1994 NFPA 101 22-7.2; WDH Ch. 8 Section 14(c)(iii)(B) and (C)	S8026	Ewm 6/18/24	

Willow Creek
ElderCare Communities

Sheridan

Survey Date: March 27th, 2024

Corporate office Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by Willow Creek Community, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. The POC shall only be a required effort to respond to the unsubstantiated and subjectively biased allegations alleged in the survey document. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by Willow Creek Community of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Prefix Tag

S8012 NFPA Life Safety – Nfpa Emergency Lighting

1. Corporate officer will order new batteries for the emergency lights as cited and have the facility manager replace them. We will additionally order a spare to have on hand in the event that another needs to be replaced.
2. QA including emergency lighting will occur by 6/25/2024.
3. Corporate officer or manager will inspect emergency lights in 1 month.
4. Date of compliance 6/22/2024.

S8017 NFPA Life Safety – Nfpa Det, Alarm & Comm System

1. Manager will print our current year 2024 Fire Inspection test documentation and place it with all our previous years documentation.
2. Manager will coordinate with the Fire system testing agency and electrician will inspect and review trouble light on fire panel.
3. Manager will have documentation of system testing available for future surveys.
4. Manager will have a staff meeting and QA to inform staff where the location of required documentation is located.
5. Date of compliance: 6/22/2024

Willow Creek
ElderCare Communities

S8018 NFPA Life Safety – Nfpa Extinguishment Req

1. Facility manager and corporate officer will review the quarterly testing forms and ensure they are located along with the annual fire system inspection reports. These files will remain secure, but available when requested.
2. The facility manager will ensure all of the future quarterly water flow tests are completed and stored with the other pertinent documentation.
3. Corporate officer will reach out to testing contractor to ensure that they have provided the suggested supplies or repair items as they are required to provide as per their contract.
4. Manager will verify any necessary repairs have been corrected or documentation amended to appropriately resolve any perceived deficiencies.
5. Manager will have a staff meeting & QA meeting so all staff are aware of the procedures and policies relating to the life safety documentation & requirements.
6. Corporate officer or manager will ask for written confirmation that future surveyors have received all documentation requested to their satisfaction.
7. Date of compliance: 6/22/2024

S8019 NFPA Life Safety – Nfpa Portable Fire extinguisher

1. Manager will ensure that the new extinguisher tags are placed on the extinguishers and documentation is of inspection is placed with the other files.
2. Manager will print the new fire system inspection documentation and have it available for future surveys.
3. Manager will have a staff meeting and QA to inform staff where the location of required documentation is located.
4. Date of compliance: 6/22/2024

S8025 NFPA Life Safety – Nfpa Emergency Plan

1. Manager will conduct a new training to go along with our previous emergency training documentation.
2. Manager will provide or send all documentation in a timely manor to future surveyors.
3. Manager will call and verify that any documentation that has been sent is received and satisfies the request of the surveyor. An email or other document will ask for to certify in writing to validate the completion of the request for our records.

Willow Creek
ElderCare Communities

4. Manager will hold a staff meeting to inform & train staff where all important documentation is located and stored by 6/22/24.
5. QA including annual testing documentation occur by 6/22/2024.
6. Date of compliance 6//22/24.

S8026 NFPA Life Safety – Nfpa Resident Training

1. The facility manager hold a new resident emergency training to accompany our current monthly fire drills.
2. Manager will call and verify that any documentation that has been sent is received and satisfies the request of the surveyor. An email or other document will ask for to certify in writing to validate the completion of the request for our records.
3. Manager will hold a staff meeting to inform & train staff where all important documentation is located and stored by 6/22/24.
4. QA including resident emergency training will occur by 6/22/2024.
5. Date of compliance 6//22/24.

Eric McMillan, President

9/19/24 for 6/18/24
Date