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

PRINTED: 09/09/2010
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
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1109 BIRCH STREET DOUGLAS, WY 82633

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K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in this section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association (NFPA). The facility was a fully sprinkled, single story building with a basement of Type V (111) construction built in 1967, 2010. The building was equipped with a supervised automatic wet sprinkler system with a combination zoned and addressable fire alarm system while under renovations. The facility had a capacity of 60 certified Medicare and Medicaid beds.	K 000		
K 018 SS=E	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, or 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 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	The corridor doors in rooms B11, B15 and B16 have all been adjusted so that they do not require more than 15#'s of force. The doors were adjusted so that they do not require more than 15#'s of force; this was done by Fisher Construction. To ensure that the doors do not require more than 15#'s of force, DCC maintenance or designee will monitor on a quarterly basis and brought to QA on quarterly basis.	8/30/10 all facility

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

[signature], NHA — NHA — 10/7/10

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.

Revised/approved ~ changes on pages 1, 5, 8, 9, 10
a/t a Telephone Call ~ Kelli (Adm) on 10/12 at 2:48 PM

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure corridor door latches did not require excessive force in 1 of 4 smoke compartments. The findings were: Observation of the corridor doors on 8/24/10 between 9 AM and 11 AM showed the corridor door latches for resident room #B-11, #B-15, and #B-16 required excessive force to release. At 11:10 AM the administrator confirmed the door latches required excessive force to open. Interview with the day shift registered nurse (RN) revealed she had been locked in a resident room because of the amount of force required to release the latch. The RN confirmed one resident had complained about this issue. The administrator confirmed the latches had not been adjusted since the resident filed the complaint.	K 018		
K 020 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 1 vertical opening was sealed. The findings were: Observation of the laundry elevator shaft on 8/24/10 at 10:02 AM showed the top of the shaft	K 020	The top of the elevator shaft located in the clean utility room has now been sealed this was done by maintained and was and will be monitored by NHA or designee. This will be monitored by maintenance or designee and brought to QA on a quarterly basis. It is DCC policy that we ensure 1 of 1 vertical opening is sealed. 8/24/10	

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K 020	Continued From page 2 was located in the clean utility room. Further review showed an unsealed 18 inch by 18 inch hole at the top of the shaft. At the time of observation the maintenance director and administrator were unsure how long the hole had been present.	K 020		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure egress doors had proper headroom in 1 of 4 smoke compartments. The findings were: Observation of the egress system on 8/24/10 at 9:07 AM showed the double egress doors leading to the special care unit were equipped with magnetic locks. Further review showed the bottom of the egress locks were not the required 6 foot 8 inches above the floor. The maintenance director measured the bottom of the locks at 6 feet 5 inches. The administrator reported she was aware of the 6 foot 8 inch requirement. She further reported the locks were supposed to be replaced, but did not know when.	K 038	Egress doors will have proper headroom with 7' frames and 6'8" from the bottom of the magnetic locks going into the special care unit. It is DCC's policy to ensure egress doors have proper headroom in smoke compartments. Fisher Construction is responsible for this and it will be monitored by NHA or designee. This is scheduled to be changed in the construction process; however it will not be done by 10/8/10, so I will have to ask for a waiver.	10/8/10
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine.	K 050		

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K 050	Continued From page 3 Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure fire drills were held on a quarterly basis on 2 of 3 nursing shifts. The findings were: Review of the fire drill records showed the second schedule was 1:45 PM to 10:15 PM, and the third shift schedule was 10 PM to 6:30 AM. According to the records a fire drill was not conducted on the second shift during the third quarter of 2009. Review also showed a fire drill was not conducted on the third shift during the fourth quarter of 2009. On 8/24/10 at 2 PM the maintenance director was not aware that he had missed the above mentioned fire drills.	K 050	The facility will ensure that fire drills are held on a quarterly basis on appropriate shifts according to facilities scheduled shifts, DCC maintenance or designee will conduct the fire drills and will be monitored by NHA or designee. We have an excel spreadsheet that tracks what fire drill is due for each month, and brought to QA on a quarterly basis by maintenance or designee. It is DCC's policy that to ensure fire drills are held on a quarterly basis.	9/30/10
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		

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K 052	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure smoke detectors were operational in 1 of 4 smoke compartments. The findings were: Observation of the fire alarm system on 8/24/10 at 10:05 AM showed the sensing chamber for the smoke detector at the nurses' station was filled with dust. Observation revealed the detector was located within 36 inches of the air vent diffuser. Observation also showed the power indicator light on the detector was inactive. At the time of observation the administrator reported the smoke detectors in this smoke compartment were all replaced one month prior to the survey. She stated she did not know why this particular detector had been missed.	K 052	The smoke detector in the nurse's station will be replaced and maintained. The detector will be replaced by H&H Electric and monitored on an annual basis with our annual fire inspections conducted by Rapid Fire & Protection and reviewed on an annual basis at QA. all facility smoke detectors will be 9/30/10	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056		

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K 056	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the sprinkler system provided complete coverage in 2 of 4 smoke compartments. The findings were: 1. Observation of the sprinkler system on 8/24/10 at 8:58 AM showed the corridor sprinkler head located near the special care unit corridor doors was located 10 feet 4 inches from the doors. At the time of observation the maintenance director was aware the spacing requirement was not to exceed 7 feet. He also reported the egress double doors had been installed three months earlier. 2. Observation of the sprinkler system on 8/24/10 at 12:05 PM showed the corridor sprinkler head located 13 feet from the doors. At the time of observation the maintenance director reported the sprinkler system was inspected annually by an outside contractor. He further reported the last inspection report failed to identify this spacing problem.	K 056	There was a new sprinkler head placed within 7' of the special care unit corridor. This was done by Rapid Fire and Protection and will be monitored by maintenance or designee. An audit of sprinkler head placements will be done on an annual basis, and brought to QA the month the audit is done. It is DCC's policy that the sprinkler system provides complete coverage. The sprinkler head add was in the plan that has had approval for our construction process.	9/30/10
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 the facility failed to ensure sprinkler heads were unobstructed in 1 of 4 smoke compartments and	K 062	K 56 The sprinkler head that is 13' from the door will have the doors moved back in the construction process this will be done by Fisher Construction and monitored by NHA or designee and continually brought to QA on a quarterly basis until the doors are moved. This will require a waiver to be done, since it won't be done by 9/8/10.	10/8/10

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K 062	Continued From page 6 failed to ensure the facility had adequate spare sprinkler heads. The findings were: 1. Observation of the sprinkler system on 8/24/10 at 9:47 AM revealed the sprinkler head located in the beauty shop was obstructed by the ceiling-mounted fluorescent light. The sprinkler was located 2 inches away from and 1-inch above the bottom of the light. At the time of the observation the administrator reported she was aware of the spacing requirement. She stated she did not know why this obstruction had not been identified and corrected. 2. Observation of the sprinkler system on 8/24/10 at 10:48 AM showed the sprinkler heads installed under the kitchen exterior canopy were 212 degree Fahrenheit dry cylinder sidewall sprinklers. Review of the spare sprinkler cabinet showed a spare sprinkler head was not available for this type of sprinkler heads. At the time of observation the administrator reported she was not aware of the above mentioned requirement. 3. Observation of the sprinkler system on 8/24/10 at 10:52 AM showed the sprinkler head installed in the B wing vestibule was a 165 degree sidewall sprinkler. Observation of the spare sprinkler cabinet showed a spare was not available for this type of sprinkler. At the time of observation the maintenance director was aware of the requirement for two spare heads for each type of sprinkler head installed. He could not explain why the facility did not have the required spare heads.	K 062	The ceiling mounted fluorescent light in the beauty shop was moved, so the sprinkler head is no longer obstructed. This was done by DCC maintenance and will be monitored by maintenance or designee and reported to QA on an annual basis. It is DCC's policy that we require our automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested.	8/24/10
			There is now a spare sprinkler head for a 212 degree Fahrenheit dry cylinder sidewall sprinkler. This was done by rapid Fire & Protection and will be monitored by maintenance or designee and will be monitored on an annual basis or as needed when a sprinkler head is used; and will be reported to QA on annual basis or as needed.	9/3/10
			There is now a spare sprinkler head for 165 degree sidewall sprinkler. This was done by Rapid Fire & Protection and will be monitored by maintenance or designee and will be monitored on an annual basis or as needed when a sprinkler head is used; and will be reported to QA on annual basis or as needed.	9/3/10
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064		

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K 084	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure portable fire extinguishers were properly maintained in 1 of 4 smoke compartments. The findings were: Observation of the portable fire extinguisher on 8/24/10 at 10:15 AM showed the hose for the K type fire extinguisher in the kitchen was leaking fluid from the hose was leaking fluid. At the time of the observation the maintenance director reported the extinguisher had been hydrostatically inspected during June 2010 because the pressure gage indicator was low.	K 084	The portable K type fire extinguisher in the kitchen has been fixed. This was done by Tri-County Fire & Protection and will be monitored by maintenance or designee on a monthly basis, and reported to QA on a quarterly basis. It is not DCC's policy to ensure portable fire extinguishers are properly maintained.	9/30/10
K 141 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure oxygen storage and use locations were posted with "No Smoking" signs in 2 of 4 smoke compartments. The findings were: 1. Observation of the oxygen storeroom on 8/24/10 at 10:40 AM showed the corridor was not posted with a No Smoking sign or Oxygen Storage sign. At the time of observation the administrator reported she was not aware of the signage requirement.	K 141	The facility has ordered signs to be placed on the oxygen storeroom door. This was ordered through Direct Supply and will be monitored by maintenance or designee. This will be monitored on an ~~annual~~ quarterly basis and brought to QA on an ~~annual~~ basis. It is DCC's policy to ensure oxygen storage and use locations are posted with "No Smoking" signs.	9/30/10

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K 141	Continued From page 8 2. Observation of resident rooms on 8/24/10 between 11 AM through 11:30 AM showed oxygen was in use in resident rooms #21, #B-10A, #B-14A, and B-15A. Further observation showed the corridor doors were not posted with "No Smoking" signs. At 11:25 AM the administrator state she did not know why the rooms lacked the required signage.	K 141	Douglas Care Center policy on oxygen will be changed to state there is no need to have signs placed on resident doors when oxygen is in use. Facility will notify fire department to assume all resident rooms have oxygen. This was done by NHA and will be monitored by NHA and reviewed on an annual basis and reported to QA annually.	10/1/10
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure electrical outlets in wet locations were protected with ground fault circuit interrupt (GFCI) protection and failed to ensure temporary wiring did not replace permanent fixed wiring in 2 of 4 smoke compartments. The findings were: 1. Observation on 8/24/10 at 9:40 AM showed two electrical outlets in the beauty shop were located less than 6 feet from the sink. The nearest outlet was only 60 inches away from the sink. At the time of this observation the maintenance director reported he was aware of the spacing requirement. However, he stated he did not know why the outlets had not been replaced. 2. Observation of the electrical system on 8/24/10 at 1:10 PM showed the computer in the housekeeping office was plugged into a surge protector, which was, itself, plugged into another surge protector. At the time of observation the	K 147	The electrical outlets in the beauty shop have been replaced with GFCI. This was done by maintenance and will be monitored by maintenance or designee. There will be an annual GFCI audit done and reported to QA on an annual basis. It is DCC's policy to ensure electrical outlets in wet locations are protected with ground fault circuit interrupt (GFCI) protection. The housekeeping office that had a surge protector plugged into another surge protector has been re-organized to ensure that there is no chaining of electrical appliances. This was done by housekeeping and will be monitored by maintenance on bi-annual basis and reported to QA on a bi-annual basis. It is DCC's policy to ensure that there is no chaining of electrical appliances.	8/24/10 8/24/10

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K 147	Continued From page 9 maintenance director reported he was aware that chaining electrical appliances was prohibited. He also reported offices were not routinely inspected for electrical compliance. 3. Observation of the electrical system on 8/24/10 at 1:12 PM showed the soda machine located in the courtyard was plugged into an extension cord which was plugged into a surge protector. At the time of observation the maintenance director was aware of the electrical configuration. He stated he was also aware it was prohibited.	K 147	The soda machine located in the courtyard will no longer be plugged into an extension cord, plugged into a surge protector. This will be done by maintenance and monitored by maintenance or designee. This will be monitored on an ~~annual~~ basis and reported to QA on an ~~annual~~ basis. This is due to move with construction but will not be done by 10/8/10, so we will have to ask for a waiver.	10/8/10

Guarderly