PRINTED: 08/24/2007
FORM APPROVED
OMB NO. 0938-0391

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

RECEIVED
SEP 27 2007
Wyoming Dept of Health
Licensing and Surveys

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 B. WING	R 08/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER	1108 BIRCH STREET DOUGLAS, WY 82633

(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}	INITIAL COMMENTS	{K 000}	K 038	
{K 038} SS=D	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 observations the facility failed to maintain 1 of 6 delayed egress locks. The finding was: Observation on 8/09/07 at 10:50 AM revealed the delayed egress lock on the northwest exit door did not emit an audible alarm in the vicinity of the door with the initiation of the release process.	{K 038}	This facility strives to maintain that all exits are readily accessible at all times in accordance with section 7.1.19.21. An audible egress ~~lock~~ has ~~been placed~~ on the northwest exit and does emit an audible alarm with the initiation of the release process. Maintenance supervisor will monitor on daily rounds and repair and replace as needed. Results will be reviewed by the QA committee ~~quarterly~~.	7/18/07 8/29/07
{K 052} SS=F	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 RECEIVED SEP 27 2007 Wyoming Dept of Health Licensing and Surveys This STANDARD is not met as evidenced by: Based on record review and staff interview the	{K 052}	K.052 The facility strives to maintain three of nine alarm systems in accordance with regulations. The fire panel was checked by a qualified professional and a report will be sent to the State. Due to the fact that the facility will be re-modeling and ~~building on~~, the facility will request a waiver of compliance on tag 052. Maintenance and Administration	7/18/07

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

Patricia Ann Miller | NHA | 9-26-07

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.

POC accepted w/ Pat Miller, NHA, on 9/28/07

PRINTED: 08/24/2007
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	R 08/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER	1108 BIRCH STREET DOUGLAS, WY 82633

(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)	COMPLETION DATE
{K 052}	Continued From page 1 facility failed to maintain 3 of 9 fire alarm system components. The findings were: 1. Review of the fire drill inspection records revealed the annunciator panel was not equipped with a ground fault indicator or a battery failure indicator. 2. Review of the fire drill inspection records revealed the was not equipped with a supervisory signal trouble alarm to monitor the tampering of the fire sprinkler system. 3. Review of the fire drill inspection records revealed two smoke detectors in the basement did not indicate a trouble signal when removed from the circuit. 4. Interview with the administrator on 8/09/07 at 12:15 PM revealed she was aware the system did not meet code, but did not want to fix each issue as a new system has already been designed to replace the current system.	{K 052}	Will monitor waiver dates and complete. QA to review on a quarterly basis. Submit electrician plans 11-4-07 Approval of plans - 2-4-08 Building slated to begin - 4-20-08 Final inspection - 10-30-08 9/4/07	
K 130	NFPA 101 MISCELLANEOUS	K 130	This facility strives to ensure quality monitoring by the Quality Assurance committee to maintain safety devices as required by code.	
SS=D	OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation, the facility did not ensure quality monitoring by its quality assurance committee in order to maintain safety devices as required by the Code. Findings were: Refer to K038 for details regarding the nonfunctional alarm for the delayed egress lock on the northwest exit door. According to the plan of correction submitted by the facility for the same issue cited on the recertification survey of 6/13/07, this was a quality issue that would be reviewed by the quality assurance committee to		The non-functional ALARM identified in K038 has been replaced and is working according to code. A new mtn. person was hired effective 9-10-07 and is maintaining a daily check list to include monitoring Door ALARMS.	

PRINTED: 08/24/2007
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	R 08/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER	1108 BIRCH STREET DOUGLAS, WY 82633

(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 130	Continued From page 2 ensure compliance.	K 130	The check list is reviewed weekly by Administrator monthly by QA committee + Safety committee for 3 months and then At quarterly QA Meetings. Employee NON-compliance will result in 1-1- counseling Adm. to monitor.	
{K 147} SS=D	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 observations the facility failed to provide an emergency battery light at 1 of 1 Automatic Transfer Switch (ATS) for the emergency generator. The finding was: Observation on 8/09/07 at 11:41 AM revealed the automatic transfer switch (ATS) was not equipped with an emergency battery light.	{K 147}	K147 The facility strives to meet the regulations to provide emergency battery lights at one of one ATS for our emergency generators. The electrician has evaluated the situation and will ~~complete work~~, ~~however the facility will request a~~ waiver of compliance for K147 based on time constraints for implementation. Administrator will monitor progress of waiver and completion. of work. QA to monitor at the quarterly meeting. INSTALL A BATTERY LIGHT @ THE ATS. Electricians plan - 8-9-07 Approval - 11-9-07 Installation - 1-9-08 Approval - 2-9-08	7/18/07 9-4-07 9-4-07

ELECTRICAL PLANS SUBMITTED TO STATE OF WYOMING 8/9/07
ESTIMATED PLAN APPROVAL 11/9/07
INSTALLATION OF BATTERY LIGHT 1/9/08
FINAL INSPECTION BY STATE OF WYOMING 2/9/08.

Department of Health and Human Services
Centers For Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535040	A. Building 01 - MAIN BUILDING 01 B. Wing	08/09/2007

Name of Facility	Street Address, City, State, Zip Code
DOUGLAS CARE CENTER	1108 BIRCH STREET DOUGLAS, WY 82633

This report is completed by a qualified State surveyor for the Medicare Medicaid and/or Clinical Laboratory Improvement Amendments program to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed 07/18/2007	ID Prefix	Correction Completed 07/18/2007	ID Prefix	Correction Completed 07/18/2007
Reg. # NFPA 101 LSC K0018		Reg. # NFPA 101 LSC K0020		Reg. # NFPA 101 LSC K0027	
ID Prefix	Correction Completed 07/18/2007	ID Prefix	Correction Completed 07/18/2007	ID Prefix	Correction Completed 07/18/2007
Reg. # NFPA 101 LSC K0029		Reg. # NFPA 101 LSC K0045		Reg. # NFPA 101 LSC K0046	
ID Prefix	Correction Completed 07/18/2007	ID Prefix	Correction Completed 07/18/2007	ID Prefix	Correction Completed 07/18/2007
Reg. # NFPA 101 LSC K0048		Reg. # NFPA 101 LSC K0050		Reg. # NFPA 101 LSC K0062	
ID Prefix	Correction Completed 07/18/2007	ID Prefix	Correction Completed 07/18/2007	ID Prefix	Correction Completed 07/18/2007
Reg. # NFPA 101 LSC K0076		Reg. # NFPA 101 LSC K0144		Reg. # NFPA 101 LSC K0154	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:		Date:
	TS	10/12/07			8/9/07
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**		

Followup to Survey Completed on 06/13/2007

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO