

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

RECEIVED
WY Dept of Health

PRINTED: 08/15/2014
FORM APPROVED
OMB NO. 0938-0391

AUG 28 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535040	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, MAIN BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER DOUGLAS CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet applicable provisions of the 2000 Edition of the Life Safety Code, Existing and New Health Care, of the National Fire Protection Association. The facility was a fully sprinkled single story building of Type V (111) construction built in 1967 and 2010. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch and an addressable fire alarm system. The facility had a capacity of 60 certified Medicare and Medicaid beds with a census of 56 residents.	K 000	The facility will ensure that corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. A) The 3 of the 7 smoke compartments have been repaired. B) All of the sprinkler pipe escutcheons throughout the facility have been sealed in the ceiling(s). C) The facility maintenance or designee will audit all sprinkler pipe escutcheon on a quarterly basis until resolved and/or when there is work done in the attic near the sprinkler pipes.	8/29/14	
K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 via Phone Call with Kelli Rogge (Administrator) on 9/8/14 9:56am

Phil Wm 9/13/14

85

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

PRINTED: 08/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535040	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER DOUGLAS CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 017	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to ensure corridors were separated from use areas by walls or ceilings that resisted the passage of smoke in 3 of 7 smoke compartments. The findings were: Observation on 08/07/14 from 10:48 AM to 1:40 PM revealed multiple sprinkler pipe escutcheon's throughout the facility were loose causing unsealed penetrations in the ceiling. Interview with the Administrator and Maintenance Manager at the time of observations revealed that work had recently been completed in the attic near the sprinkler pipes and opined this caused the escutcheon's to become loose.	K 017			