PRINTED: 07/10/2009
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	06/24/2009

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 Requirements for the Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the 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. The facility was a fully sprinklered single story building of Type V (111) construction built in 1967. The building was equipped with a supervised automatic wet sprinkler system and fire alarm system	K 000	POC ACCEPTED W/ CHANGES W/ FEED STAPLETON, NHA, DON 7/30/09.	
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, 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. This STANDARD is not met as evidenced by:	K 018	K-018 Doors in room #5, 7, 8, and DON's office will be repaired to positively latch to resist the passage of smoke, to be completed by August 8, 2009. Will be monitored by Maintenance, QA committee will also monitor to make sure door closes properly (Monthly & PRN)	8-8-09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Adm — (X6) DATE: 7-30-09

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. Resubmitted 7-22-07

Adm — 7-30-09

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K 018	Continued From page 1 Based on observation and staff interview, the facility failed to ensure its non hazardous corridor doors could resist the passage of smoke in 2 of 3 smoke compartments. The findings were: Observation on 6/23/09 between the hours of 8:11 AM and 10:48 AM revealed corridor doors did not completely close in their frames at the following locations: a. Resident rooms #5, #7 and #8. b. The door to the director of nursing's office. Interview with the facility maintenance manager at the time of the observations revealed the doors would require an adjustment by maintenance staff in order to properly close.	K 018		
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. 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 observation, record review and staff interview the facility failed to respond to a fire in an organized manner and to ensure fire drills were conducted on each shift during 2 of 4 quarters. The findings were:	K 050	V-05 Fire drills will be conducted by the Maintenance Department at unexpected & varying conditions at least quarterly (all 3 shifts). A fire drill was held on July 2, 2009 at 1:25 a.m. and 11:45 a.m. An evacuation of residents was completed. A fire drill for afternoon shift will be scheduled in August. Maintenance department has developed an annual schedule for unexpected fire drills for the remaining of 2009 and in January 2010, a fire drill schedule will be scheduled for the 12 month period. This will be monitored by the QA committee.	7-24-09

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K 050	Continued From page 2 1. Observation on 6/24/09 at 1:50 PM revealed the maintenance manager was installing a light bulb in an exit sign in the basement when the sign's transformer overheated and started a fire. The facility's administrator announced over the public address system that residents were to be evacuated. The administrator then called 911. However the fire alarm system was not activated. Observation during the evacuation process revealed the following concerns: a. Staff was confused. They did not know if the PA announcement was genuine or if the state surveyor was conducting a fire drill and had decided not to initiate the fire alarm. b. Not all staff heard the public announcement. As a result, during observation of the evacuation, several staff did not seem to know what was happening and did not respond to the evacuation order until other staff members told them what to do. c. Residents were evacuated from several rooms; however, several of the doors were not closed behind them. d. The resident in room #2 was not evacuated, nor was the room door closed. The resident was observed lying on the bed during the entire evacuation procedure. Interview with the DON immediately after the procedure revealed they did not have the opportunity to get to that resident before the all clear announcement was made. 2. Review of the fire drill records showed the third shift had not conducted a drill during the first quarter of 2009. Review of the fire drill records also revealed the second and third shifts had not conducted drills during the third quarter of 2008. During an interview on 6/23/09 at 9:10 AM, the	K 050		

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K 050	Continued From page 3 maintenance director confirmed the fire drills had not been conducted.	K 050		
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 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 1 of 22 smoke detectors was installed correctly. The findings were: Review of facility records revealed a fire alarm inspection was last conducted on 3/4/09. Findings of that inspection revealed a "smoke detector in the basement did not go into the fire alarm." Interview with the facility's maintenance manager revealed he was unaware of the inspection findings and stated he would contact a consultant to correct the problem.	K 052	K-052 An inspection of the facilities' fire alarm system, ~~sprinkler heads, etc.,~~ will be conducted by August 8, 2009. (report will be faxed to Wyoming Health Department by 8-8-09) by ~~Rapid Fire Protection Inc., 1805 Sameo Road, Rapid City, SD 57702, phone number 605-348-2342.~~ This inspection will be completed yearly and report kept on file. Monitored by the QA committee.	8-8-09
K 062 SS=E	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	K 062		

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K 062	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the sprinkler system was inspected in accordance with NFPA 25. The findings were: Observation on 6/23/09 between the hours of 8:11 AM and 10:48 AM revealed the following concerns: a. No documentation was available indicating a thorough annual inspection of the facility's sprinkler system was conducted. The only documentation available indicated quarterly testing of the water flow switch and the main drain test was conducted. No evidence existed indicating, for example, that the tamper switch was inspected, the fire dept connections were in satisfactory condition, or sprinkler pipe hangers were in good condition. b. Sprinkler heads were not properly maintained in 1 of 3 smoke compartments as evidenced by 4 ceiling sprinkler head escutcheons in the front west hallway had come away from the ceiling approximately 1/2-inch. c. Duct tape that was being used to hold a ceiling vent in place in the small alcove in the main hallway had come away from the ceiling. As a result, both the vent and the tape dropped onto the sprinkler head directly beneath it. Interview with the facility's maintenance manager on 6/23/09 at 9:10 AM confirmed the above items were in need of repair.	K 062	K-062 Communicating Systems, Inc. (API Systems Integrators) did a smoke detector sensitivity test on all smoke detectors to make sure they functioned properly, see attached inspection report dated 7-7-09. This inspection will be done yearly and the report kept on file. Monitored by the QA committee. K-062 Rapid Fire Protection, Inc. will inspect and repair smoke compartments as evidenced by 4 ceiling sprinkler head escutcheons in the west hallway. Monitor by the QA committee. Duct tape hold on ceiling vent, removed. Vent properly attached. Monitor by QA committee.	7-7-09 8-8-09 7-24-09
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3, 19.3.2.6, NFPA 96	K 069		

API Systems Integrators

Douglas Care Center
Sensitivity test
7-7-09

RANGE

Location in bldg.	Device Type	Device Number	Sensitivity
Outside room 25	Ion	A1	3.65
Outside room 27	Ion	A2	2.08
Closest to main panel	Ion	A3	2.26
Main entry vestibule	Photo	A4	2.38
Outside utility room	Ion	A5	2.30
Outside room 3	Ion	A6	2.14
SW Exit outside room 5	Ion	A7	2.14
Between rooms 22,23	Photo	B1	2.90
Between rooms 20,21	Photo	B2	2.67
NE exit, TV area	Ion	B3	2.14
SE corner, cafeteria	Photo	C2	2.47
NE corner, cafeteria	Ion	C3	2.59
NW corner, cafeteria	Photo	C4	3.04
SW corner, cafeteria	Ion	C5	2.32
Above main entry nurse station	Ion	C6	1.94
Between rooms 7, 8	Ion	D1	2.40
Outside beauty shop	Ion	D2	2.09
NW exit, TV area	Ion	D3	2.03
Basement	Ion	BSMT1	1.67
Basement	Ion	BSMT2	1.29
Basement	Ion	BSMT3	2.53

API Systems Integrators

Douglas Care Center
Sensitivity test
7-7-09

Location in bldg.	Device Type	Device Number	Sensitivity
Outside room 25	Ion	A1	3.65
Outside room 27	Ion	A2	2.08
Closest to main panel	Ion	A3	2.26
Main entry vestibule	Photo	A4	2.38
Outside utility room	Ion	A5	2.30
Outside room 3	Ion	A6	2.14
SW Exit outside room 5	Ion	A7	2.14
Between rooms 22,23	Photo	B1	2.90
Between rooms 20,21	Photo	B2	2.67
NE exit, TV area	Ion	B3	2.14
SE corner, cafeteria	Photo	C2	2.47
NE corner, cafeteria	Ion	C3	2.59
NW corner, cafeteria	Photo	C4	3.04
SW corner, cafeteria	Ion	C5	2.32
Above main entry nurse station	Ion	C6	1.94
Between rooms 7, 8	Ion	D1	2.40

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K 069	Continued From page 5 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure annual maintenance of the facility's kitchen fire suppression equipment was done. The findings were: Review of facility's maintenance records revealed the last semi-annual inspection of the kitchen fire suppression system was conducted on 02/11/08 by Billings Extinguishers System. Interview with the facility's maintenance manager on 6/23/09 at 9:10 AM confirmed the date of the last inspection was correct and that no other inspection had been done.	K 069	K-069 Casper Fire Extinguishing Co. will inspect the fire suppression equipment system in the kitchen in August, 2009 and again in January, 2010. Reports will be kept on file. Monitor by facilities QA committee.	~~8-21-09~~ 8/02/09
K 211 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by:	K 211	All alcohol based hand rub dispensers in rooms listed have been moved away from switches and electrical outlets. Maintenance and house keeping will ensure that any placement of future alcohol hand rub dispensers are not installed over ignition sources. Monitor by facilities QA committee.	7-15-09

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K 211	Continued From page 6 Based upon observation and staff interview the facility failed to ensure alcohol based hand rub dispensers were not installed over ignition sources in 16 of 25 resident rooms. The findings were: Observation on 6/23/09 between the hours of 8:11 AM and 10:48 AM revealed alcohol based hand rub dispensers were located directly over the wall-mounted light switches or electrical outlets in the following resident rooms: 4, 7, 9, 10, 11, 12, 14, 15, 17, 20, 21, 22, 23, 25, 26, 28. The facility's maintenance manager confirmed the above observations.	K 211		