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 _____	10/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	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 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 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 54 residents.	K 000	<u>K29</u> 1. The facility will ensure all hazardous locations that are self-closing smoke compartments will have self-closers devices on them. 2. The kitchen door leading to the dining and the dietary office door leading to the kitchen will have their self-closing devices put on. 3. DCC maintenance or designee will do monthly audits and bring to monthly QAPI until resolved.	10/16/15
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide doors to hazardous locations that were self-closing in 1 of 7 smoke compartments. The findings were:	K 029		

CERTIFIED MAIL
7014 2120 0000 2301 7657

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 10/24/15

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.

RECEIVED
OCT 29 2015
Healthcare Licensing and Surveys

POC Accepted via Phone Call with Administrator Kelli Rosse on 11/12/15 at 11:25 AM 34354

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K 029	Continued From page 1 Observation on 10/05/15 from 4:15 PM to 4:25 PM revealed the kitchen door leading to the dining room, and the dietary office door leading to the kitchen were not provided with self-closing devices. Further observation revealed both doors had been equipped with self-closing devices in the past, but at some point had been removed. At the time of the observations the Facility Maintenance Manager could not explain why the self-closing devices had been removed. Ref: 2000 NFPA 101 Sections 19.3.2.1 and 3.3.13.2	K 029		
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 observation and staff interview, the facility failed to ensure exit access is so arranged that exits are accessible at all times in 2 of 7 smoke compartments. The findings were: 1. Observation on 10/05/15 at 3:16 PM of the conference room door in the main foyer area revealed a small dead bolt lock on the left door leaf approximately 72" above the floor. When activated the lock prevented the door opening from the egress side. At the time of the observation the Facility Maintenance Manager acknowledged the dead bolt, and stated he would	K 038		

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K 038	Continued From page 2 have it removed. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.1 2. Observation on 10/05/15 at 3:59 PM of the solarium delayed egress exit on the B wing revealed that when 15 lbf was applied to the door for more than 3 seconds the releasing process did not initiate. At the time of the observation the Facility Maintenance Manager acknowledged the delayed egress hardware was not functioning. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.6.1 (c)	K 038	**K38** 1. The facility will ensure that exit access is arranged that exits are accessible at all times. 2. The dead bolt lock on the left door leaf of the conference has been removed. 3. The solarium delayed egress exit on the Bwing has been repaired. 4. DCC maintenance or designee will do monthly audit of all exit access's to ensure that they are accessible at all times. This will be done monthly and brought to QAPI until resolved.	10/16/15
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide periodic testing of emergency lighting equipment. The findings were: Observation on 10/05/15 at 3:49 PM revealed the South A Wing middle exit emergency light did not function. When the test button was activated the lights did not turn on. At the time of the observation the Facility Maintenance Manager acknowledged the emergency light fixture did not function. Ref:	K 046	**K46** 1. The facility will ensure to provide periodic testing of emergency lighting equipment. 2. The South A wing middle exit emergency light is now functioning. 3. DCC Maintenance or designee will do monthly audits of the all emergency lighting using a check off of where all emergency lights are placed in the building. These audits will be brought to QAPI on a monthly basis until resolved.	10/16/15

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K 046	Continued From page 3 2000 NFPA 101, Sections 19.2.9.1 and 7.9.3	K 046		