

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

PRINTED: 02/23/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535029	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/17/2016
NAME OF PROVIDER OR SUPPLIER CROOK COUNTY MEDICAL SERVICES DISTRICT LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 713 OAK STREET SUNDANCE, WY 82729	
(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 sprinklered, single story building of Type II (111) construction built in 1985. The building was equipped with a supervised, automatic wet sprinkler system with an addressable fire alarm system. The facility had a capacity of 32 certified Medicare and Medicaid beds with a census of 32 residents.	K 000		
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 arrange exit access so that exits are readily accessible at all times in 1 of 2 smoke compartments. The findings were: Observation on 02/17/16 from 10:07 AM to 10:20 AM revealed door locks requiring tight pinching, and more than one releasing operation to make the door operable in the following locations. Director of social services office, director of nursing office, and the janitor closet. At the time of the observations the Facility Maintenance Manager acknowledged the door locks required more than one operation. Ref: 2000 NFPA 101, Sections 19.2.2.1 and	K 038		

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.

MAR 09 2016

FORM CMS-2567(02-99) Previous Versions Obsolete

Healthcare Licensing
and Surveys

Event ID: MQ2C21

Facility ID: WY0009

If continuation sheet Page 1 of 2

POC Accepted via Phone Call with
The Administrator Nathan Hough on
3/14/16 @ 10:37AM JMR 34357

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K 038	Continued From page 1 7.2.1.5.4	K 038	<u>K038</u> <u>The facility will ensure exit accesses are readily accessible at all times in smoke compartments.</u> 1. The offices of the director of SS, LTC Manager and janitor door knobs will be replaced. 2. The Maintenance Manager or designee will conduct an audit of the entire facility, using an audit tool, to ensure that door knobs are compliant with Regulation 7.1. 19.2.1. Any door knobs that are not in compliance will be replaced. 3. Results of the audit will be brought to the QAPI committee. Further actions or follow up will be determined by the QAPI committee.	3/25/16	