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 _____	**07/31/2018**

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 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on July 31,2018. 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 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered single story building with a basement of Type V (111) construction built in 1987 and 2010. The building was equipped with a supervised 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 57 residents.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain corridor doors in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 80, Standard for Fire	K 211	K211 Means of Egress 1. The facility will maintain corridor doors in accordance with the 2012 NFPA 101,	8/31/18

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

Electronically Signed | 08/21/2018

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	535040	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/31/2018**

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K 211	Continued From page 1 Doors and Other Opening Protectives. Failure to maintain fire doors as required could result in injury or death during an emergency. The deficiency affected 100 percent of the facility, as well as the 87 residents and staff. The findings were: Document review on 7/31/2018 at 11:30 AM revealed the facility could not verify that the required annual fire door assembly inspection had been completed. Interview with the facility maintenance supervisor at the time of observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the assistant facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 8.3.3.1 2010 NFPA 80, Section: 5.2.1	K 211	Life Safety Code and the 2010 NFPA 80, Standard for Fire Doors and other openings protectives. 2. The facility will be able to verify that the required annual fire door assembly inspection will be completed for the entire building. 3. Administrator or designee will educate the Maintenance Director and Maintenance Assistant on the importance of the required annual fire door assembly inspection for the building. 4. An audit of the annual fire door assembly inspection will be done monthly and brought to QAPI until resolved.	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain electrical systems in accordance with the 2010 NFPA 110, Standard for Emergency and Standby Power Systems. Failure to maintain electrical systems as required could result in injury or death during an	K 291	K291 Emergency Lighting 1. The facility will maintain electrical systems in accordance with the 2010 NFPA 110, Standard for Emergency and Standby Power Systems.	8/31/18

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	535040	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/31/2018**

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

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K 291	Continued From page 2 emergency. The deficiency affected one of one generator battery systems, and well as the 87 residents and staff. The findings were: Document review on 7/31/2018 at 11:30 AM revealed that the facility could not verify that the required monthly specific gravity test of the lead acid batteries for the emergency generator had been completed. Interview with the facility maintenance supervisor at the time of observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the assistant facility administrator at the time of exit acknowledged the deficiency. REF: 2010 NFPA 110, Section: 8.3.7.1 2012 NFPA 101, Sections 19.2.9.1, 7.9.2.4, 4.6.12.1 .	K 291	2. The facility will do the required monthly specific gravity test on the lead acid batteries for the emergency generator. 3. NHA or designee will educated Maintenance Director and Maintenance Assistant the importance of the required monthly specific gravity test that needs to be done on the lead acid batteries for the emergency generator. 4. An audit of the monthly specific gravity test on the lead acid batteries for the emergency generator for three months or until resolved. The results of the audits will be brought to QAPI.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that	K 363		8/31/18

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	535040	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/31/2018**

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K 363	Continued From page 3 do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 80, Standard for Fire Doors and Other Opening Protectives. Failure to maintain corridor doors as required could allow fire and smoke spread resulting in injury or death. The deficiency affected less than 10 percent of the corridor doors, residents, and staff. The findings were: Observation on 7/31/2018 at 10:09 AM adjacent to the central storage room revealed a set of fire	K 363	K 363 1. The facility will maintain corridor doors in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 80, Standard for Fire Doors and Other Opening Protectives. 2. The fire doors adjacent to the central storage room will close completely when the fire alarm sounds and initiates the closure of the fire doors.	

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	535040	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/31/2018**

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K 363	Continued From page 4 doors that failed to close completely when tested. Interview with the facility maintenance supervisor at the time of observation acknowledged the doors failed to close, and indicated awareness of the requirement. Interview with the assistant facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 8.3.3.3 2010 NFPA 80, Section: 5.2.4.2(6)	K 363	3. All fire doors will close completely when the fire alarm sounds and initiates the closure of the fire doors. 4. The NHA will educate the Maintenance Director and the Maintenance Assistant on the importance of ensuring that all fire doors close completely when fire alarm sounds and initiates the closure of the fire doors. 5. An audit of the closure of fire doors closing during a fire alarm will be done for three months or until resolved. The audit will be brought to QAPI until resolved.	

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

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E 000	Initial Comments A Emergency Preparedness survey was conducted by Health Care Licensing and Surveys on July 31, 2018. Based upon the findings of the survey team, it was determined the facility was in compliance with all requirements.	E 000		

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

Electronically Signed | 08/27/2018

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.