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 _____	09/10/2018

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 Stories: 1 Construction: Type V (111) Constructed: 1968, 2011 remodel K0180: Fully Sprinkled Certified Beds: 60 Capacity: 60 Census: 53	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a	K 222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE NHA | (X6) DATE 9/24/18

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.

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K 222	Continued From page 1 complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to provide egress doors as required. Findings include:	K 222	**K222** 1. Douglas Care Center (DCC) will provide egress doors as required. Door leaves will be equipped to be operable from the egress side. 2. The hasp on the outside of the med recorded room in basement will be changed so that it is operable from the egress side. 3. The hasp on the mattress storage room in basement will be changed to that it is operable form the egress side. 4. All doors at DCC will be operable from the egress side. 5. Department heads will be educated to understand that egress doors are required to be equipped to be operable from the egress side. 6. Maintenance or designee will do monthly audits to ensure that egress doors are equipped to be operable from the egress side. The monthly audits will be taken to QAPI monthly for a minimum of three months and/or until resolved.	10/10/18

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K 222	Continued From page 2 On 9/10/18, the following doors were equipped with locks or latches not operable from the egress side. Door leaves are required to be operable from the egress side whenever the building is occupied. - Hasp on outside of med records, basement - Hasp on mattress storage room Ref: 2012 NFPA 101 Section 19.2.2.2.1, 7.2.1.5.1 The Maintenance Supervisor was present when the deficiency was identified. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected two of numerous doors in the building.	K 222		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to test the fire alarm system as required. Findings include:	K 345		

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K 345	Continued From page 3 On 9/10/18, there was no record that smoke detector sensitivity testing had been performed as required. Testing is required on alternate years unless previous testing shows that the detectors have remained within its listed and marked sensitivity range after the second required calibration test. The interval between testing may then be extended to 5 years. If the frequency is extended, records of nuisance alarms and subsequent trends on these alarms are required to be maintained. There were no records that indicated that the detectors met this requirement or the alternate year testing. Ref: 2012 NFPA 101 Section 19.3.4.1, 9.6.1.3; 2010 NFPA 72 Section 14.4.5.3.(1-3) The Maintenance Supervisor was present when the deficiency was identified. Failure to test the fire alarm system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous required tests of the fire alarm system.	K 345	**K345** 1. DCC will ensure the to test the fire alarm system as required. 2. DCC will have the smoke detector sensitivity testing done, every five years at a minim and maintain the records for the sensitivity test. The records will include two years of tests that indicate that the detectors have remained within range and a record of the nuisance alarms. 3. Maintenance will be educated on the importance of having the smoke detector sensitivity testing done every five years.	
K 711 SS=D	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2.	K 711	4. Maintenance or designee will do a monthly audit to ensure the sensitivity test is done and bring to QAPI until resolved.	10/10/18

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K 711	Continued From page 4 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a fire plan as required. Findings include: On 9/10/18, the fire plan did provide for evacuation of smoke compartment as required. Ref: 2012 NFPA 101 Section 19.7.1.1, 19.7.2.2 The Maintenance Supervisor was present when the deficiency was identified. Failure to provide a fire plan as required increases the risk of death or injury due to fire. The deficiency affected one of nine required provisions.	K 711	K711 1. Douglas Care Center (DCC) will provide a fire plan that includes the evacuation of smoke compartments. 2. The fire evacuation plan will be changed to include description of evacuations of smoke compartments. 3. Staff will be educated on the new evacuation plan. 4. An audit to ensure that the evacuation plan is changed and staff are educated will be done monthly and brought to QAPI until resolved.	10/10/18