STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 B. WING _____	09/17/2019

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 September 17, 2019. 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 55 residents. .	K 000		
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 observation and staff interview, the facility failed to maintain emergency lighting in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain emergency lighting as required could result in injury or death during an emergency. The deficiency affected two (2) of seven (7) smoke compartments. The findings were:	K 291	K291 Emergency Lighting A.) The facility will ensure to maintain emergency lighting in accordance with 2012 NFPA 101 Life Safety Code. B.) All residents are at risk for injury or death in the presence of an emergency. Emergency lights will be tested regularly to assure proper operation. Lights that	11/4/19

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Electronically Signed		10/03/2019

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K 291	Continued From page 1 Observation on 9/17/2019 at 10:13 AM in the hallway adjacent to the Alzheimer Coordinator office revealed an emergency light that when tested failed to operate. Further observation revealed a second emergency light at the bottom of the basement stairs which failed to operate when tested. Interview with the facility maintenance supervisor at the time of observation acknowledged the lights failed to operate when tested, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.9.1; 7.9.2 .	K 291	failed will be replaced as needed. C.) NHA will educate maintenance personnel on the importance that emergency lighting is functioning properly. D.) An audit of all emergency lighting will be done on a monthly basis and brought to QAPI for the next three months.	
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit signage in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain exit signage as required could result in injury or death during an	K 293	K293 Exit Signage A.) The facility will ensure to maintain exit signage in accordance with the 2012 NFPA 101 Life Safety Code. B.) All residents are at risk for injury or	11/4/19

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K 293	Continued From page 2 emergency. The deficiency affected one (1) of seven (7) smoke compartments. The findings were: Observation on 9/17/2019 at 9:25 AM in the kitchen revealed an exit sign with a left directional arrow. Further observation revealed that following the path indicated led you to an enclosed courtyard instead of the exit. Further investigation revealed that you must turn right at the exit sign to reach the exit. Interview with the facility maintenance supervisor at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.10.1; 7.10.2 .	K 293	death in the presence of an emergency. The light in the kitchen that was deemed deficient due to the arrow pointing in the wrong direction will be replaced in the proper direction which will lead all stakeholders to the proper exit destination. C.) NHA will educate maintenance personnel on the importance of maintaining exit signage and the importance of keeing all signs pointed in their appropriate directions. D.) An audit of all exit signage will be done on a monthly basis and brought to QAPI for the next three months.	
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4).	K 753		11/4/19

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K 753	Continued From page 3 o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain combustible decoration in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain combustible decorations as required could allow fire spread resulting in injury or death. The deficiency affected one (1) of seven (7) smoke compartments. The findings were: Observation on 9/17/2019 at 9:54 AM in room 112 revealed combustible decorations covering more than 50 percent of a resident's sleeping room wall. Interview with the facility maintenance supervisor at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.7.5.6(d)	K 753	K753 Combustible Decorations A.) The facility will ensure to maintain combustible decoration(s) in accordance with 2012 NFPA 101 Life Safety Code. B.) The resident in room 112 is at risk for fire spread which could result in injury or death. The facility will discuss with this resident that although he does have resident rights, he does have more than 50% of his sleeping room wall covered in combustible decorations. The facility will also discuss with the resident that this puts him at risk for injury or possible death; therefore, it is deemed necessary to re-evaluate belongings and move them accordingly. C.) NHA will educate all staff members on the importance of properly maintaining combustible decoration(s) and the importance of only allowing no more than 50% of a sleeping wall to be covered in combustible decorations. D.) An audit of combustible decorations will be done on a monthly basis and brought to QAPI for the next three months.	

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on September 17, 2019. .	E 000		
E 020 SS=F	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance.	E 020		11/4/19

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E 020	Continued From page 1 * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide a policy and procedure for evacuation in accordance with the 2016 CFR 483.73, Condition for Coverage for Long Term Care (LTC) Facilities. Failure to provide an evacuation plan as required could result in injury or death during an emergency. The deficiency affected 100 percent of the facility. The findings were: Document review on 9/17/2019 at 1:15 PM revealed that the facility failed to establish and maintain policies and procedures for evacuation. The facility identified an evacuation location, but did not include staff responsibilities, transportation requirements, or the care and treatment needs of the evacuees. Interview with the facility administrator at the time of observation, as well as during the exit, acknowledged the deficiency indicated she was unaware of the requirement.	E 020	E020 Policies for Evacuation and Primary/Alternative Communication The facility will provide a policy and procedure for evacuation in accordance with the 2016 CFR 483.73, Condition for Coverage for LTC Facilities. 1. The facility will develop an evacuation policy and procedure that includes staff responsibilities, transportation requirements and the care and treatment needs of the evacuees. 2. All residents could be affected by this so facility will develop an evacuation policy and procedure that includes staff responsibilities, transportation requirements and the care and treatment needs of the evacuees. 3. The NHA or designee will educate the safety committee that the facilities evacuation policy and procedures include staff responsibilities, transportation requirements and the care and treatment	

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E 020	Continued From page 2 REF: 2016 CFR 483.73(b)(3)	E 020	needs of the evacuees. 4. A review of the policy will be brought to QAPI to review until resolved.	
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of	E 036		11/4/19

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E 036	Continued From page 3 this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide a training and testing program in accordance with the 2016 CFR 483.73(d), Condition for Long Term Care (LTC) Facilities. Failure to provide a training and testing program as required could result in injury or death during an emergency. The deficiency affected 100 percent of the facility. The findings were: Document review on 9/17/2019 at 1:30 PM revealed the facility could not verify that training and testing of their emergency plan had been conducted. Facility staff stated they had conducted training but could not produce any documentation. Interview with the facility administrator at the time of observation, and at exit, acknowledged the missing documentation and indicated awareness of the requirement. REF: 2016 CFR 483.73(d)	E 036	E036 EP Training and Testing The facility will provide training and testing program in accordance with the 2016 CFR 483.73(d), Condition for LTC Facilities. 1. The employees of the facility will be trained on the emergency plan. 2. The NHA or designee will educate the safety committee on the requirement of training and testing. 3. An audit of the trainings will be done monthly and brought to QAPI on a monthly basis for three months or until resolved.	