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

PRINTED: 09/12/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/06/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES	BOX 517 SUNDANCE, WY 82729

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 Surveyor #: 18185 The regulatory reference is 42 CFR 483.70 (a) except where a different regulation may be specifically referenced. K3: Building: Type II (111) single story building with a complete automatic supervised wet sprinkler system and fire alarm system. K6: Date of Plan Approval: 1985 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=32;SNF/NF=32 K9: The facility meets the Life Safety Code standards based on an acceptance of a plan of corrections "NFPA" National Fire Protection Association	K 000		Ø
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	Acceptance of this POC with Larry Potter, NHA on 10/10/05 @ 4:45 PM via teleconference. [signature]	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] Larry Potter
TITLE: CEO
(X6) DATE: 9-29-05

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 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations and staff interview on 9/6/05, the facility failed to protect 2 of 32 corridor door openings in accordance with NFPA 101 Section 19.3.6.3. The findings were: 1.Observation at 3:07 PM revealed a gap between the corridor door of resident room #206 and the door frame. The gap was greater than the allowed 1/8th of an inch. 2. Observation at 3:35 PM revealed the corridor door to resident room #217 had 4 circular holes in the door preventing the door from being smoke resistant. 3. Maintenance staff also observed the findings.	K 018	K 018 This facility will maintain the standard of 1/8" gap or less on corridor doors. Monitoring will be by maintenance. Gap between corridor door and the door frame of resident room #206 will be within the standard by 10/15/05. This facility will maintain NFPA 101 Life Safety standards concerning doors resist to passage of smoke. Maintenance staff will monitor. Hole has been filled in room #217. MAINTENANCE DIRECTOR WILL POSITION QUALIFIED DOOR INSPECTIONS TO MAINTAIN COMPLIANCE.	10/15/05 9/16/05
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	K 029		

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K 029	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations and staff interview on 9/06/05, the facility failed to provide 1 of 5 hazardous areas with proper separation in accordance with NFPA 101 Section 19.3.2.1. The findings were: 1. Observation at 3:12 PM, the self-closing device on the door to the water heater room did not fully latch the door into the door frame with each self-closing operation. Maintenance staff verified the door required excessive force to latch.	K 029	K 029 This facility will meet the NFPA 101 Life Safety code standard for self closing doors. Door to door frame fit will be repaired as to allow for self closing operation of door to water heater room. Monitoring of self closing doors will be done by maintenance staff.	10/1/05
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051		

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K 051	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review, observations, and staff interview on 9/06/05, the facility failed to test the installed fire alarm system in accordance with NFPA 72 Table 7-3.2 (23). The findings were: 1. At 2:11 PM, review of the maintenance records revealed the Supervising Station Fire Alarm System Receiver at the sheriff's department had not been tested on a monthly basis for the months of January and April of 2005. Maintenance staff reported the receiver was being tested with fire drills, but the months with silent drills the fire alarm system had not been activated.	K 051	K 051 This facility will perform and record monthly fire drills required by NFPA 72 Table 7-3.2 (23). Monitoring to be done and recorded by maintenance staff. This will be evidenced by monthly compliance monitoring.	10/1/05
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations and staff interview on 9/06/05, the facility failed to provide an electrical system installed in accordance with NFPA 70 Section 110-27 and 400-8 respectively. The findings were: 1. Observation at 3:41 PM revealed the electrical	K 147		

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K 147	Continued From page 4 receptacle cover near the TV was damaged and was missing half of it's face plate. 2. Observation at 3:24 PM revealed the electrical room had two 3-way adapters that substituted for fixed wiring. 3. Maintenance staff also observed the findings.	K 147	K 147 This facility will maintain electrical receptacles and covers in accordance with NFPA 70 section 110-27 and 400-8. Maintenance and housekeeping staff will monitor. Receptacle cover near the TV was replaced. This will be evidenced by monthly compliance. This facility will monitor electrical adapters and met NFPA 70 section 110-27 and 400-8. Maintenance staff will monitor. Adapters in electrical room have been removed. This will be evidenced by monthly compliance rounds.	9/7/05 9/16/05