

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

PRINTED: 09/13/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535040		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2022	
NAME OF PROVIDER OR SUPPLIER DOUGLAS CARE CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 08/12/2022. Based on the findings of the survey, it was determined that the facility was in compliance with all requirements in accordance with 42 CFR 483.73.			E 000			
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 08/12/2022. Requirements for Long Term Care Facilities Section 42 CFR 483.90(a) except as otherwise provided in this 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 automatic 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 54 residents. The following findings demonstrate noncompliance with 42 CFR 483.90(a).			K 000			
K 222 SS=E	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:			K 222			9/15/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/01/2022

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.

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

PRINTED: 09/13/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535040	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2022
NAME OF PROVIDER OR SUPPLIER DOUGLAS CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 222	Continued From page 1 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 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	K 222			

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

PRINTED: 09/13/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535040	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2022
NAME OF PROVIDER OR SUPPLIER DOUGLAS CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 222	Continued From page 2 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 staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could result in injury or death during an emergency. The deficiency affected three (3) exit doors equipped with delayed egress throughout the facility. The findings were: Observation on 08/12/2022 at 9:37 AM at the exit in dining, revealed the delayed egress locking system failed to operate as designed. When tested, the required force to activate an irreversible process to release the door was in excess of 35 lbf. Further observation at 10:01 AM at the exit across from soiled linens and next to rehab found to activate an irreversible process to release the door was in excess of 35 lbf. Further observation at 10:16 AM at the east exit door found that when tested the required force to activate an irreversible process to release the door was in excess of 35 lbf. Interview with the facility administrator at the time	K 222	K222 Egressed Doors 1. Maintenance staff have been educated that all egressed doors will release with 15lbf or less. 2. Pressure gauges to test doors were purchased to be used for monthly audits. 3. Monthly audits will be brought to QAPI for 90 days or until resolved. 4. Arrowhead scheduled to be here October 4, 2022 to train maintenance staff how to adjust egressed doors properly.		

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

PRINTED: 09/13/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535040	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2022
NAME OF PROVIDER OR SUPPLIER DOUGLAS CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 222	Continued From page 3 of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.4(2); 7.2.1.6.1.1(3)(a)	K 222			
K 345 SS=F	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 document review and staff interview, the facility failed to test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency affected the fire alarm system. The findings were: Document review on 08/12/2022 at 11:47 AM revealed that the fire alarm system batteries were inspected once in the last twelve (12) months. The fire alarm system batteries are required to be inspected every six (6) months. The facility provided records of a Fire alarm semi-annual inspection which contained an inspection for the	K 345	K345 Fire Alarm System – Testing and Monitoring 1. Maintenance staff have been educated that fire alarm system batteries need to be inspected every six months. 2. Batteries of the fire alarm system were inspected 6/16/22 by Johnson Controls. Next inspection of batteries for fire alarm system is scheduled for December 14, 2022. 3. Johnson Controls will be inspecting Fire Alarm System on September 26 and 27 2022. 4. Audits will be brought to QAPI for 90 days or until resolved.		9/15/22

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

PRINTED: 09/13/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535040	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2022
NAME OF PROVIDER OR SUPPLIER DOUGLAS CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 345	Continued From page 4 batteries, and a Fire Alarm annual inspection which was missing a battery inspection. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K 345			
K 353 SS=F	REF: 2010 NFPA 72 Table 14.3.1(3)(d) Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire sprinkler system in accordance with the 2011	K 353	K353 Sprinkler System – Maintenance and testing 1. Maintenance staff have been		9/15/22

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

PRINTED: 09/13/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535040	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2022
NAME OF PROVIDER OR SUPPLIER DOUGLAS CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 5 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Failure to test and maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency affected the fire sprinkler system. The findings were: Document review on 08/12/2022 at 11:50 PM revealed that the dry system tests priming water level and low air alarm were tested for two (2) of the last four (4) quarters. The water priming level and low air alarm are required to be tested quarterly. The facility provided records of the quarterly tests for the first (1st) and second (2nd) quarters of 2022 but was missing the third (3rd) and fourth (4th) quarters of 2021. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K 353	educated that the fire sprinkler system needs to be tested quarterly. 2. Quarterly audits will be brought to monthly QAPI until resolved.		
K 521 SS=F	REF: 2011 NFPA 25 13.4.4.2.1, 13.4.4.2.6 HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		10/11/22	

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

PRINTED: 09/13/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535040	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2022
NAME OF PROVIDER OR SUPPLIER DOUGLAS CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 521	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide record of fire damper testing conducted in accordance with the 2012 NFPA 101, Life Safety Code, the 2012 NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, and the 2010 NFPA 80, Standard for Fire Doors and Other Opening Protectives. The failure to perform fire damper testing as required could result in the spread of smoke and fire during an emergency. The deficiency affected facility-wide reliability of the fire dampers. The findings were: Document review on 08/12/2022 at 12:00 PM revealed that no record of testing of the fire dampers from the past four (4) years was available. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101 Sections 19.5.2.1, 9.2 2012 NFPA 90A Section 5.4.8.1 2010 NFPA 80 Section 19.4.1.1	K 521	K521 – HVAC 1. Maintenance staff has been educated that fire damper system needs to be inspected annually. 2. Inspection has been scheduled and will be completed by 10/11/22. 3. Audits will be done monthly and brought to QAPI for 90 days or until resolved		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to	K 761			10/11/22

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

PRINTED: 09/13/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535040	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2022
NAME OF PROVIDER OR SUPPLIER DOUGLAS CARE CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 761	Continued From page 7 patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect rolling fire-rated doors in accordance with the 2010 NFPA 80, Standard for Fire Doors and Other Opening Protectives. Failure to properly inspect rolling fire-rated doors could increase the risk of fire or smoke spread during an emergency, which could lead to injury or death. The deficiency affected all rolling fire-rated doors in the building. The findings were: Document review on 08/12/2022 at 12:01 PM revealed that the rolling fire-rated doors had been inspected during the 12 month period prior to the survey, but by a non-qualified person. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 8.3.3.1 2010 NFPA 80, Section 5.2.14.3	K 761	K761 – Maintenance Inspection and Testing Doors 1. Maintenance staff has been educated that rolling fire doors need to be inspected annually by a qualified person. 2. Maintenance staff will be taking a class to get certified to do these inspections within the next 2 months. 3. Arrowhead is scheduled to be at facility to inspect rolling fire doors. Will be completed by October 11, 2022 4. Monthly Audits will be done and brought to QAPI until maintenance staff gets certified to do the inspections.		