| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535029 | A. BUILDING **01**<br>B. WING _____ | **02/16/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CROOK COUNTY MEDICAL SERVICES DISTRICT LTC** | **713 OAK STREET**<br>**SUNDANCE, WY 82729** |

| (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 |
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| E 000 | Initial Comments<br><br>An Emergency Preparedness Survey was conducted by Healthcare Licensing and Surveys on 02/16/2023. Based upon the findings, it was determined the facility was in compliance with all requirements of 42 CFR 483.73. | E 000 | | |
| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 02/09/2023.<br><br>Requirements for Long Term Care Facilities Section 42 CFR 483.90 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.<br><br>The facility was a fully sprinklered, single story building of Type II (111) construction built in 1985. The building was equipped with a supervised automatic wet sprinkler system, and an addressable fire alarm system. The facility had a capacity of 32 certified Medicare and Medicaid beds with a census of 23 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90. | K 000 | | |
| K 345 SS=D | Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>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. | K 345 | | 4/15/23 |

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

Electronically Signed | 03/10/2023

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| K 345 | Continued From page 1<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 72, National Fire Alarm Code. Failure to maintain fire detection systems as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous requirements for the fire alarm system. The findings were:<br><br>Observation on 02/16/2023 at 1:05 PM at the fire annunciator panel revealed that the Underwriter's Laboratory (UL) certification for the fire alarm was expired. Subsequent record review revealed that a current certification had been received, but not placed near the panel.<br><br>Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA Sections 19.3.4.1; 9.6.1.3<br>2010 NFPA 72 Section 26.3.4.3 | K 345 | Crook County Medical Services District maintenance personnel have since placed the correct Underwriter□s Laboratory (UL) certification at the fire alarm panel. The Crook County Medical Services District maintenance manager reached out to the contracted fire alarm testing company to have all documents delivered directly to the maintenance manager□s company email. The contracted fire alarm testing company then removed all other contacts to ensure all documents go to the correct recipient. By doing this, it will eliminate the possibility of future documents getting lost in another account. This will be monitored by the Crook County Maintenance Manager on all future documents. | |
| K 761<br>SS=F | Maintenance, Inspection & Testing - Doors<br>CFR(s): NFPA 101<br><br>Maintenance, Inspection & Testing - Doors<br>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 | | 4/15/23 |

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| K 761 | Continued From page 2<br>patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.<br>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.<br>Written records of inspection and testing are maintained and are available for review.<br>19.7.6, 8.3.3.1 (LSC)<br>5.2, 5.2.3 (2010 NFPA 80)<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review and staff interview, the facility failed to perform annual inspections of fire doors in accordance with the 2012 NFPA 101, Life Safety Code and 2010 NFPA 80. The failure to perform annual inspections of fire doors as required could result in injury or death due to an increased risk of fire spread. The deficiency affected the entire facility facility. The findings were:<br><br>Document review on 02/16/2023 at 3:00 PM indicated that the facility had been performing testing and inspection of fire doors, but no inventory list was available to indicate the doors included for testing and inspection. As such, the surveyor could not verify that all applicable fire-rated doors were being included.<br><br>Interview with the facility manager at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>Ref: 2012 NFPA 101, Section 19.7.6, 8.3.3.1<br>2010 NFPA 80, Sections 5.2, 5.2.3 | K 761 | Crook County Medical Services District maintenance personnel created an inventory checklist for all of the fire doors and a labeled floorplan. Each fire door on the checklist has a corresponding number labeled on a floorplan to know exactly where each door is located. The objective of this is to use one testing criteria form for all of the fire doors to confirm if each the fire doors have passed or failed and can then be recorded on the checklist. The checklist consists of four columns for each fire door: pass, fail, deficiency, and corrective action. Any door where a deficiency is found can then be recorded as fail, the deficiency, and the corrective action taken to resolve the issue. This will be the process moving forward for every annual fire door testing each year. This will be monitored by maintenance personnel with every annual fire door testing each year. | |

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| K 781 SS=E | Portable Space Heaters<br>CFR(s): NFPA 101<br><br>Portable Space Heaters<br>Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to provide portable space heaters in accordance with the 2012 NFPA 101, Life Safety Code. The failure to portable space heaters as required could result in injury or death due to an increased risk of fire. The deficiency affected one (1) of multiple rooms in the facility. The findings were:<br><br>Observation on 02/16/2023 at 1:46 PM in the dining room revealed a large portable space heater (artificial fireplace). The room served as a congregating area for residents, and the documentation provided was unable to determine the maximum temperature of the heating elements.<br><br>Interview with the facility manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>Ref: 2012 NFPA 101, Section 19.7.8 | K 781 | Crook County Medical Services District maintenance personnel have removed the heating elements from the artificial fireplace in the dining area. Maintenance personnel will continue to monitor for space heaters with heating elements that exceed 212 degrees Fahrenheit. | 4/15/23 |
| K 923 SS=D | Gas Equipment - Cylinder and Container Storag<br>CFR(s): NFPA 101 | K 923 | | 4/15/23 |

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| K 923 | Continued From page 4<br>Gas Equipment - Cylinder and Container Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.<br>Less than or equal to 300 cubic feet<br>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.<br>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."<br>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the | K 923 | Crook County Medical Services District | |

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| K 923 | Continued From page 5<br>facility failed to maintain gas cylinder storage in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to maintain gas cylinder storage as required could result in injury or death. The deficiency affected one (1) of numerous rooms in the facility. The findings were:<br><br>Observation on 02/16/2023 at 1:26 PM at the nurses station med room revealed an oxygen cylinder sitting unsecured on the floor.<br><br>Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>Ref: 2012 NFPA 99 11.6.2.3(11) | K 923 | maintenance personnel have since removed the oxygen cylinder and educated staff on the requirement. Crook County Medical Services District maintenance peronnel will monitor and document daily for any deficiencies. | |