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	03/25/2008

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 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 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 2000 edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. 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 fire alarm system.	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to ensure 1 of 1 fire barrier wall was a 2-hour rated wall. The findings were: Observation on 3/25/08 at 9:40 AM revealed the fire barrier wall separating the nursing home from the hospital had two unsealed penetrations above the double doors. Interview with the maintenance director at the time of observation revealed the wall had only been checked after contractors installed new equipment.	K 011	K011 The facility will maintain NFPA 101 Section 19.1.1.4.1 and 19.1.1.4.2 standards for 2 hour fire barrier. The 2 unsealed penetrations will be sealed, WITH FIRE RATED CAULKING. Maintenance will monitor this standard through annual inspections, and inspections when any facility maintenance work or outside contract work has been done. POC ACCEPTED & MODIFIED W/ DORIS BROWN, NHA, DO 4/30/08	4/30/08
K 025	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Doris Brown — TITLE: CEO/Administrator — (X6) DATE: 4/28/08

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.

RECEIVED
APR 28 2008
Wyoming Dept of Health
Licensing and Surveys

CENTERS FOR MEDICARE & MEDIC) SERVICES

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 _____	03/25/2008

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

4/29/08

(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 025 SS=D	Continued From page 1 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure 1 of 1 smoke barrier wall was a 1/2-hour rated wall. The findings were: Observation on 3/25/08 at 9:57 AM revealed the smoke barrier wall above the medical records file shelves had an unsealed 1-inch penetration. Interview with the maintenance director at the time of observation revealed a contractor had been working in the area three weeks previously. He further reported the smoke barrier wall was only inspected after contractors installed new equipment.	K 025	K025 The facility will meet this NFPA 101 sections 19.3.7.3., 19.3.7.5, 8.3, 19.1.6.3, and 19.1.6.4 standards with annual inspections and inspections when any facility maintenance work or outside contract work has been done. The 1 inch penetration will be sealed, WITH FIRE RATED CAULKING.	4/30/08
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 047		

CENTERS FOR MEDICARE & MEDIC) SERVICES

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	03/25/2008

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

4/30/08

(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 047	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure exit signs were illuminated as required. The findings were: 1. Observation on 3/25/08 between 9:45 AM and 11 AM revealed the following exit signs each had one of two bulbs burned out: a. The exit sign near the hospital's fire barrier. b. The exit sign near the nurses' station. 2. Interview with the maintenance director on 3/25/08 at 9:45 AM revealed all exit signs were inspected weekly. He further reported that the aforementioned exit signs had at least one bulb that would burn out each time the generator ran.	K 047	K047 The facility will meet NFPA 101 section 7.10, 19.2.10.1 standards with inspections done monthly by maintenance and facility walk through inspections. All facility employees will report outages to Maintenance personnel in a timely basis. This will be incorporated into the employee inservice training to encourage reporting. Any lights not working will be replaced. L.E.D. replacement lights have been ordered. An indicator will be developed for monitoring and reported quarterly at the quality improvement meetings.	4/30/08
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure 1 of 9 fire alarm system components were tested. The findings were:	K 052	K052 The facility will meet NFPA 70 and 72 section 9.6.1.4 standards with semiannual testing of annunciator panel batteries to be done by Maintenance.	4/25/08

CENTERS FOR MEDICARE & MEDIC) SERVICES

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	03/25/2008

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 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 052	Continued From page 3 1. Review of the fire alarm system testing records revealed the semi-annual inspection for the annunciator panel batteries was last performed more than six months, prior to the date of survey, on 5/11/07. 2. Interview with the maintenance director on 3/25/08 at 10:50 AM revealed he was unaware of the testing requirement.	K 052		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the fire sprinkler system was maintained as required in 2 of 2 smoke compartments. The findings were: 1. Observation on 3/26/08 at 8:50 AM revealed the closet in the tub room had items stored within 18 inches of the sprinkler deflector. Interview with the maintenance director at the time of observation revealed all closets were inspected quarterly to ensure items were not stored too close to the sprinkler heads. 2. Observation on 3/25/08 at 9:12 AM revealed 2 of 2 sprinkler heads in the dish room were corroded. Interview with the maintenance director at the time of observation revealed all sprinkler heads were inspected semi-annually.	K 062	K062 The facility will maintain NFPA 101 sections 19.7.6, 4.6.12, NFPA 13, NFPA 25 9.7.5 standards will be monitored through monthly maintenance and walk through inspections of closets for 18 inch clearance and corroded sprinkler heads. Violations will be corrected in a timely fashion. Staff will be encouraged to report violations to Maintenance personnel. An indicator will be developed and reported on at the quarterly quality improvement meetings.	4/30/08
K 141	NFPA 101 LIFE SAFETY CODE STANDARD	K 141		

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING 01 - MA.. BUILDING 01 B. WING	03/25/2008

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 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 141 SS=F	Continued From page 4 Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on record review, observation and staff interview the facility failed to ensure oxygen use policies were met in 1 of 2 smoke compartments. The findings were: 1. Review of the Oxygen Safety policy revealed "A no smoking-oxygen in use sign..." shall be placed on the corridor door of the resident's room when oxygen is administered. However, observation on 3/25/08 between 11 AM and 11:30 AM revealed the following resident rooms had oxygen in use, and the corridor was not posted with a no-smoking sign: a. Resident room #207. b. Resident room #212. 2. Interview with the maintenance director on 3/25/08 at 11:21 AM revealed the no-smoking signs were checked weekly by the nursing staff.	K 141	K141 The facility will meet NFPA 101 19.3.2.4, NFPA 99 8.6.4.2. The facility is a no smoking facility with no smoking oxygen in use signs on all major entrances. The facility has rewritten the oxygen policy to reflect the no smoking facility policy. Revised policy attached.	4/28/08