PRINTED: 06/26/2007
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER	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 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 with a baement of Type V (111) construction built in 1967. A waiver was GRANTED to this facility for K-056 and K-069 until February 21, 2008.	K 000		
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	K018 Doors 17 and 24 were ~~are~~ repaired. ~~All other doors will be checked for~~ proper latching, and repaired if necessary. The maintenance director will audit all doors no less than quarterly, and report the findings of this audit to the next Quality Assurance committee meeting.	✓ 7-18-07

PoC approved 7/20/07 with corrections indicated by phone with Pat Miller, NHA at 5:30PM – Jean McLain, RD.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patricia M Miller	NHA	7-13-07

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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JUL 16 2007
Wyoming Dept of Health
Licensing and Surveys

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation the facility failed to maintain 2 of 51 corridor doors. The findings were: Observation 6/13/07 between 2 PM and 2:30 PM revealed corridor doors for the following rooms were equipped with latch bolts that did not insert into the strike plates of their respective door frames: a. Resident room #17. b. Resident room #24.	K 018		
K 020 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.	K 020	K020 The hold back latch on the dumb waiter door was removed. ~~There are no other vertical openings.~~ All Vertical Openings will be monitored. The maintenance director will audit all vertical openings quarterly and ensure they meet the standard. The results of this audit will be reported to the next Quality Assurance committee meeting.	7-18-07
K 027 SS=D	This STANDARD is not met as evidenced by: Based on observation the facility failed to prohibit devices that were designed to hold doors open on 1 of 1 fire rated vertical openings. The finding was: Observation on 6/13/07 at 12:52 PM revealed the dumb waiter door in the laundry was equipped with a hold back latch. The latch did not release with the activation of the fire alarm system. NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core.	K 027		

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K 027	Continued From page 2 Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations the facility failed to provide self-closing devices for 1 of 3 smoke barrier doors. The finding was: Observation on 6/13/07 at 3:25 PM revealed the smoke barrier door in the attic was not equipped with a self-closing device.	K 027	K027 The smoke barreier door in the attic has been Equipped with a self closing device. All other doors were inspected to see if they were appropriate for this device, and where this was found the case, self closers were installed. Quarterly, the Maintenance director will audit the doors of the facility to ensure this standard is met. The results of this audit will be reported to the next Quality Assurance committee meeting.	7-18-07
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 This STANDARD is not met as evidenced by: Based on observation the facility failed to separate 2 of 9 hazardous areas from other	K 029	The maintenance room and the store room doors were Equipted with self- closing devices. All other doors were inspected to see if they were appropriate for this device, and where this was found the case, self closers were installed. Quarterly, the Maintenance director will audit the doors of the facility to ensure this standard is met. The results of this audit will be reported to the next Quality Assurance committee meeting.	7-18-07

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K 029	Continued From page 3 spaces by smoke-resistant assemblies. The findings were: 1. Observation on 6/13/07 at 12:39 PM revealed the self-closing device attached the maintenance shop corridor door had the arm removed. 2. Observation on 6/13/07 at 1 PM revealed the file storeroom in the basement was equipped with a corridor door that lacked a self-closing device.	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation the facility failed to maintain 1 of 6 delayed egress locks as required. The finding was: Observation on 6/13/07 at 1:45 PM revealed the delayed egress lock on the northwest exit door did not emit an audible alarm with the activation of the release process.	K 038	K038 The This alarm was repaired on the NW exit door. All other egress doors were audited for this standard, and repairs were made as necessary. Quarterly, the Maintenance director will audit the doors of the facility to ensure this standard is met. The results of this audit will be reported to the next Quality Assurance committee meeting.	7-18-07
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by:	K 045		

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K 045	Continued From page 4 Based on observation, the facility failed to ensure fully functional light fixtures for 2 of 8 exits, that The findings were: Observation on 6/13/07 between 9 PM and 9:30 PM revealed the following locations had one of two lighting fixtures which were not illuminated: a. The center north exit. b. The northwest exit.	K 045	Bulbs were replaced in the emergency Exit lights at the center north exit and The northwest exit. All other exit doors were audited for this standard, and repairs were made as necessary. Quarterly, the Maintenance director will audit the doors of the facility to ensure this standard is met. The results of this audit will be reported to the next monthly Quality Assurance committee meeting.	7-18-07
K 046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to test 2 of 2 emergency battery lights. The findings were: 1. Review of test records revealed no records related to annual testing of the emergency battery lights. 2. Review of the emergency battery light testing records revealed the monthly 30 second emergency battery light tests had not been performed prior to April 2007. 3. Interview with the Maintenance Director on 6/13/07 at 12:30 PM revealed he had not performed the 90 minute test and had no other documentation to review. The maintenance director further reported he was unaware of the testing requirement.	K 046	K 048 All battery lights were tested for this standard. ~~Any lights found deficit were replaced or repaired.~~ The Maintenance director will test the lights monthly for 30 seconds of operation and annually for 90 minutes of operation. The results of these tests will be reported ~~to the next monthly~~ Quality Assurance committee on a quarterly basis.	7-18-07
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of	K 048		

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K 048	Continued From page 5 an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to provide emergency procedures which addressed the facilities needs. The findings were: 1. Review of the facility's emergency procedures revealed the tornado, power outage, and severe weather policies were "generic" and did not reference the facility's specific needs. The evacuation policy did not reference the means of transportation or the location to which residents would be transferred in the event of inclement weather requiring evacuation. The evacuation policy stated resident would be relocated to the fairgrounds. The evacuation policy did not indicate how the residents' nutritional and medical needs would be met. 2. Interview with the director of nursing (DON) on 6/13/07 at 4:20 PM revealed he thought the residents were supposed to be evacuated to the "little white church" across the street instead of the fairgrounds. The DON further reported he was unaware the disaster manual did not address the facility, specifically.	K 048 K048	The emergency procedures book will be updated To be facility specific and will include policies for Toronado,power outage,severe weather and the Evacuation policy → Staff will be inserviced regarding this policy. Annually the Administrator will review the disaster manual, and inspect to see it is still facility specific. Results will be monitored by the ~~Any changes in this plan will be reported to the next monthly~~ Quality Assurance committee ~~meeting.~~ ~~[illegible]~~ need to educate staff	7-18-07
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded	K 050		

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K 050	Continued From page 6 announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to conduct a fire drill on 7 of 8 quarterly shifts in the past year. In addition, staff were unfamiliar with actions required under varied fire conditions. The findings were: 1. Record review revealed the only fire drill conducted in the past year was done on 12/8/06. 2. Interview with the maintenance director on 6/13/07 at 12:30 PM verified the facility records only showed one drill being conducted in the past year. The maintenance director stated that he had not been involved in an in-service related to fire drills since he was hired in May 2007. 3. Observation on 6/13/07 between 3:50 PM and 4:02 PM revealed the Certified Nurse Aide (CNA)who was supposed to find the "fire" did not respond to the activated nurses' call light for a full 5 minutes. When the CNA found the "fire" she left the door open after she exited the room. The CNA came back to the room 4 minutes later and closed the door and went to the nurses' station were she announced through the intercom system "Fire, room number fourteen," two times instead of "Dr. Pyro" as stated in the facility's policy. Following the announcement the charge nurse came to the "fire" location and activated the nearest fire pull station, ten minutes after the nurses' call light was first activated. Throughout the drill, four carts were left in the corridor of the smoke compartment where the "fire" was located. The all clear was announced at 4:02 PM.	K 050	K050 The fire drill policy was rewritten to be a comprehensive training tool. Fire drill will be done in accordance with the standard. The maintenance director will audit fire drills and present these audits to the Administator immediately if there are concerns and routinely to the next monthly Quality Assuance committee meeting. Staff will be educated regarding the policy. Staff who deviate from policy will be counseled immediately. Unserved Administrator or designee will critique each drill. 1-18-07 education of Staff	

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K 052 SS=F	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 test 11 of 11 fire alarm system components. The findings were: 1. Review of the facility's testing records revealed the annunciator panel, annunciator batteries, duct detectors, heat detectors, fire alarm boxes, and alarm notification appliances had not been tested in the past 12 months. According to the records, the fire alarm system was last tested on 2/8/06. 2. Review of the fire alarm system testing records revealed the smoke detector sensitivity test had not been conducted in the past 2 years. 3. Observation on 6/13/07 at 1:15 PM revealed the posted central station certification placard for the facility's fire alarm system had expired on March 31, 2007. 4. Review of the fire alarm system testing records revealed the supervisory signal device had not	K 052		

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K 052	Continued From page 8 been tested during the third or fourth quarters of 2006. 5. Review of the facility's testing records revealed the supervising station fire alarm system receiver had not been tested for the months of August, September, October and November 2006 and January, March, April and May 2007. 6. Interview with the maintenance director on 6/13/07 at 12:30 PM revealed he did not know whether or not any testing was performed prior to May 2007, when he was hired. The maintenance director confirmed he had not tested the fire alarm system.	K 052	K052 The fire panel, notification appliances, and smoke detectors were checked by qualified professionals. The maintenance director will ensure The tests are done annually. The results of The audits will be reviewed by Q.A	
K 062 SS=F	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 observations on 1 of 1 day, record review and staff interview, the facility failed to provide a continuous ceiling membrane, failed to provide unobstructed sprinkler heads and failed to test 2 of 4 sprinkler system components. The findings were: 1. Observation on 6/13/07 at 12:55 PM revealed the laundry ceiling was not a continuous membrane: a hole was cut into the ceiling near the dryers. 2. Observation on 6/13/07 between 12:30 PM and 3 PM revealed the following areas had items	K 062	The laundry room ceiling membrane Was repaired. The obstructions to sprinkler heads were Removed in the activity closet, the closet Near room 14, and the nursing supply Closet. The entire ceiling was audited and all the sprinkler heads were inspected for obstruction. Repairs or resolution was done were necessary. The maintenance director will audit sprinkler heads weekly x 8 for obstruction and resolve immediately. The maintenance director will audit these issues quarterly, repair immediately, and report the findings of these audits to the next monthly Quality Assurance committee on a quarterly basis.	

last night
dates ?
Report to be sent to LSC surveyor.
7-18-07
and monitored
case
1-18-07
?
case
audit tool ? participate / report to QA comm.
Did not
The Main Drain Test and water flow device test will be completed for this quarter + quarterly thereafter.

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K 062	Continued From page 9 stored within 18 inches of the sprinkler head deflector: a. The activity director's closet. b. The closet near resident room #14. c. The nurses' supply closet. 3. Review of the facility's testing records revealed the main drain and waterflow device had not been tested during the third and fourth quarters of 2006. 4. Interview with the maintenance director on 6/13/07 at 12:30 PM revealed he was unaware of any testing being performed prior to May 2007 when he was hired. The maintenance director further reported he was unaware of the facility's quality assurance program.	K 062		
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide safe oxygen storage locations as required. The findings were:	K 076	K076 The oxygen will be relocated to the original Closet that did meet the requirements. Alloxygen will be stored in that closet And removed from any areas that do Not meet the code, including all cylinders stored outside. Maintenance will monitor on his daily Rounds for compliance,and results will Be reviewed by the Q.A. committee. 7-18-07 * Need specifically to know how staffs were addressed.	

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K 076	Continued From page 10 1. Observation on 6/13/07 at 1:36 PM revealed the facility was storing 48 "E" sized oxygen cylinders outside the facility under the east exit canopy. The storage location was not provided with a lockable gate. Furthermore, the oxygen was stored within 25 feet of windows. The storage location was not posted with required precautionary signage. 2. Observation on 6/13/07 at 1:51 PM revealed the facility had moved the indoor oxygen storage location to a closet near the tub room. The new oxygen room did not have 1-hour rated construction as required for new locations; the two doors were not 1-hour rated. The new oxygen storeroom also lacked a dedicated mechanical ventilation system.	K 076		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review the facility failed to test the corridor emergency lighting system. The findings were: 1. Review of the facility's testing records revealed the continuously illuminated corridor egress lights were being supplied with power from the	K 144		

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OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER	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 144	Continued From page 11 emergency generator electrical panel. The emergency generator testing records revealed in the past year the generator had only been transferred on February 26, 2007. 2. Interview with the maintenance director on 6/13/07 at 12:30 PM revealed he did not know how to run the generator "under load." Furthermore, the maintenance director stated that he did not know how to use the automatic transfer switch to transfer the essential electrical system from normal power to emergency power.	K 144	K144 The electrician assessed the transfer switch and Determined that the circuit breaker 2 in panel 1 Can be turned off which will cause the generator To operate under load. The maintenance super. Was inserviced on the Procedure and importance of generator testing. Records will be maintained.and admin will audit Monthly .QA will review quartly.	7/18/07
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 observation the facility failed to ensure flexible wiring did not replace temporary fixed wiring; failed to provide an emergency battery light at the automatic transfer switch (ATS); and failed to maintain adequate work space in front of electrical equipment. The findings were: 1. Observation on 6/13/07 between 12:30 PM and 1:30 PM revealed the following locations had temporary electrical wiring in place of permanent fixed wiring: a. The dietary office had a surge protector plugged into a 6-way adapter. b. The front lobby had a surge protector plugged into a 6-way adapter. 2. Interview with the Maintenance Director on 6/13/07 at 4:25 PM revealed he did not routinely conduct room audits to ensure the electrical wiring was safe for the residents.	K 147	K147 The incorrect surge protectors were Removed from the dietary office And the front lobby.all remaining Rooms were audited and incorrect Surge protectors removed. The maintenance director will make weekly rounds of the rooms to review for appropriate devices. All staff was inserviced on appropriate electrical devices, and how to intervene if they locate one. The results of The audits will be reviewed by Q.A quarterly.	7/18/07

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DOUGLAS CARE CENTER	1108 BIRCH STREET DOUGLAS, WY 82633

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K 147	Continued From page 12 3. Observation on 5/15/07 at 10:29 AM revealed the automatic transfer switch (ATS) was not equipped with an emergency battery light.	K 147	K147 Facility will have an emergency light installed at The ATS location. Due to the extent of the work temporary The facility will request a waiver in order to have The plans approved by the appropriate state department And the work completed. Admin will monitor the Progress of the process and review at QA committee.	7-18-07
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility lacked a policy and procedure to address the potential for the loss of water to the automatic sprinkler system. The findings were: 1. Review of the maintenance department's emergency policies revealed the facility did not have a fire watch policy in the event of an impairment of the automatic sprinkler system. 2. Interview with the maintenance director on 6/13/07 at 4:25 PM revealed there was no fire watch policy to review. The director of nursing (DON) was also unaware of any type of policy related to a fire watch.	K154	K154 A fire watch policy has been implemented and staff Have been inserviced. The maintenance supervisor Will inform the admin. Of any need to implement The fire watch policy. QA will review the policy ~~implementation as needed.~~ on 7/10/06. Admin reviews all policies annually and updates as needed!	7-18-07