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

PRINTED: 03/15/2012
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
	535045	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL VALLEY CARE CENTER	777 AVENUE H POWELL, WY 82435

(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 42 CFR 483.70(a) Long Term Care Facilities Stories: 1 Construction type: Type II(111) Constructed: 1997 K0180: Fully Sprinkled The facility is certified for 100 beds with a census of 91 residents at the start of the survey day.	K 000	K011 The facility shall provide approved self-closing fire doors in accordance with 19.1.1.4.1, 19.1.1.4.2 NFPA 101. A. The Engineering Technician has ordered a 90 minute door to replace the door that led to the Cafeteria. The Engineering Technician will install this door as soon as it arrives. B. All patients, residents, visitors, and staff members have the potential to be affected by failure to provide proper self-closing doors. C. The Plant Operations Director or designee will perform monthly visual inspections of all self-closing fire doors to ensure there are approved fire barrier doors as required. D. The Plant Operations Director will aggregate monthly data and report results to the Administrator, Resident Services Administrator, Care Center Medical Director, Quality Council, and the Safety Committee quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance.	
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 observation and interview, the facility failed to provide approved doors in fire barriers as required. Findings include: On 3/6/2012 a door in a 2 hour fire resistance rated barrier separating the facility from the hospital and as identified on drawing provided by the facility did not have a label identifying the door as having the required 90 minute rating. The door led to the cafeteria. The Director of Plant Operations acknowledged the finding when the deficiency was identified.	K 011	Completion Date	05/1/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheri Bernander | TITLE: x Adm. | (X6) DATE: x 3/23/12

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. WY Dept of Health

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Healthcare Licensing and Surveys

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K 011	Continued From page 1 Failure to provide opening protective ' s as required increases the risk of death or injury due to fire. The deficiency affected 1 of 4 doors in the barrier. Ref: 2000 NFPA 101 Section 19.1.2.1(2), 8.2.3.2.3.1	K 011	K038 The facility shall maintain exists that are readily accessible at all times in accordance with Section7.1 and 19.2.1, Ref: 2000 NFPA 101 Section 19.2.2.1, 7.2.1.5.1 and 19.2.2.2.4. A. 19.2.2.2.4 Exception No. 1 indicates that " door-locking arrangements without delayed egress shall be permitted ... when the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times". The exit side of the doors requires specialized locks to decrease the traffic through the specialized unit, which is disruptive and causes undue anxiety and agitation of the residents in the Alzheimer's Unit. Based upon Section 19.2.2.2.5, The existence of a button to open the doors will remain intact to allow immediate exit however the Engineering Technician will place a sign in the immediate area that states "push button to exit" providing the staff with a reliable means of egress at	
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 and interview, the facility failed to maintain the means of egress so that they are available at all times. Findings include: On 3/6/2012 two sets of doors with exit signs above them entering the Alzheimer ' s unit were found to be secured with magnetic lock requiring the use of a keypad to use the exits. Doors in the Alzheimer ' s unit are permitted to be locked due to clinical need, however doors that provide exits from the areas that do not have a clinical need are not permitted to be locked where keys, tools, or special knowledge or effort is required for operation on the egress side. The Director of Plant Operations acknowledged the finding when the deficiency was identified.	K 038		

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K 038	Continued From page 2 Failure to maintain the means of egress as required increases the risk of death or injury due to fire. The deficiency affected 2 of 6 smoke compartments. Ref: 2000 NFPA 101 Section 19.2.2.1, 7.2.1.5.1, 19.2.2.2.4	K 038	**K038 Continued** all times. In addition, the Engineering Technician will release the locking mechanism in the bars on the doors allowing for only one such locking device on the doors. B. All residents, staff, and visitors have the potential to be affected by failure to maintain the means of egress so that they are available at all times. C. The Plant Operations Director or designee will perform monthly visual and physical inspections to ensure the doors provide an exit from the area that is available to staff at all times. D. The Plant Operations Director will aggregate random monthly data and report the results to the Administrator, Resident Services Administrator, Care Center Medical Director, Quality Council, and Safety Committee quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	05/1/2012
K 046 SS=D	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 observation and interview, the facility failed to provide emergency lighting as required Findings include: On 3/6/2012 the Director of Plant Operations acknowledged that the emergency generator provided power for emergency lighting. He also confirmed that the generator did not to have a remote manual stop station or a remote common audible alarm located outside of the EPS service room at a worksite readily observable by personnel as required. Failure to provide emergency lighting as required increase the risk of death or injury due to fire. The deficiency affected 1 component of the means of egress. Ref: 2000 NFPA 101 Section 19.2.9.1, 7.9.2.3;	K 046		

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K 046	Continued From page 3 1999 NFPA 110 3-5.5.6, 3-5.6.1	K 046	K046	
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 records review and interview, the facility failed to maintain the fire alarm system as required. Findings include: On 3/6/2012 the facility provided records that indicated that the required semiannual load voltage test for the fire alarm system had only been conducted once in the last year on 7/13/2011. The Director of Plant Operations acknowledged the finding when the deficiency was identified. Failure to test the fire alarm system as required increases the risk of death or injury due to fire. The deficiency affected 1 of 2 required load voltage tests in the last year.	K 052	The facility shall ensure that emergency lighting is provided as required. A. A remote manual stop station will be placed outside EPS room at a readily observable worksite. A remote common audible alarm will be placed at the North Nurses station. B. All residents, staff, and visitors have the potential to be affected by failure to provide emergency lighting as required. C. The Plant Operations Director or designee will perform monthly visual inspections to ensure the remote common audible alarm is functioning in order to provide emergency lighting as required. D. The Plant Operations Director will aggregate random monthly data and report results to the Administrator, Resident Services Administrator, Care Center Medical Director, Quality Council, and Safety Committee quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	05/1/2012

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K 052	Continued From page 4 Ref: 2000 NFPA 101 Section 19.3.4.1, 9.6.1.4; 1999 NFPA 72 table 7-3.2 item 6.d.3.	K 052	**K052** The facility shall ensure that the fire alarm system is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. . A. A semi-annual voltage test will be conducted. The Engineering Technician will add this requirement to the semi-annual inspection list. B. All residents, staff, and visitors have the potential to be affected by failure to test and maintain the fire alarm system by conducting semi-annual voltage testing. C. The Plant Operations Director or designee will perform semi-annual inspections to ensure the load voltage test is completed as required. D. The Plant Operations Director will report the data semi-annually to the Administrator, Resident Services Administrator, Care Center Medical Director, Quality Council, and Safety Committee. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	05/1/2012