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AUG 0 2 2012

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
	53A050	A. BUILDING _____ 01 - MAIN BUILDING 01 B. WING _____	07/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	110 HOSPITAL LANE AFTON, WY 83110

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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 sprinkled single story building of Type II (111) construction built in 1996. The building was equipped with a supervised automatic wet sprinkler system and addressable fire alarm system. The facility had a capacity of 24 certified Medicaid beds with a census of 23.	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 observation and staff interview, the facility failed to ensure the smoke barrier wall was smoke resistant. The findings were: Observation of the smoke barrier wall on 7/10/12 at 9:32 AM showed a 2 inch unsealed conduit	K 025	A) Smoke barrier wall conduit was sealed upon discovery on July 10th, 2012. July 10, 2012 B) A quality improvement monitoring tool will be implemented by the Director of Maintenance to ensure ongoing compliance with smoke barrier wall and fire barrier wall standards. This monitor will be	

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

Administrator 8/1/12

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.

POC ACCEPTED W/ DON HERBERT, NHA, ON 8/14/12

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K 025	Continued From page 1 penetration in the ceiling cavity above the south double doors. At the time of the observation the maintenance director reported the conduit was installed in February 2012, he could not explain why the gap had not been filled after the project was completed.	K 025	completed quarterly and reported quarterly at the Quality Advisory Committee meeting. Appropriate follow-up actions will be initiated by the Quality Advisory Committee. August 21, 2012	
K 029 SS=E	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	K 029	A) Ceiling conduits will be sealed by August 1st, 2012 August 1st, 2012	
	This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure hazardous areas were separated from use areas in 2 of 2 smoke compartments. The findings were: 1. Observation of the electrical room on 7/10/12 at 8:36 AM showed there were four unsealed conduit penetrations in the ceiling. The largest gap measured ¾ inch across. At the time of the observation the maintenance director reported the conduit was installed in February 2012, he could not explain why the gap had not been filled after the project was completed.		B) A quality improvement monitoring tool will be implemented by the Director of Maintenance to ensure ongoing compliance with smoke barrier wall and fire barrier wall standards. This monitor will be completed quarterly and reported quarterly at the Quality Advisory Committee meeting. Appropriate follow-up actions will be initiated by the Quality Advisory Committee. August 21, 2012	

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K 029	Continued From page 2 2. Observation of the kitchen on 7/10/12 at 9:48 AM showed there were three unsealed conduit penetrations in the ceiling tile. The largest gap measured ½ inch across. At the time of the observation the maintenance director could not explain why the gaps had not been noticed and repaired during the monthly inspections.	K 029		
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 observation and staff interview, the facility failed to ensure the central station certificate was posted. The findings were: Observation of the main fire alarm panel on 7/10/12 at 8:25 AM showed the central station certificate was not posted near the panel. At the time of the observation the maintenance director reported he was unaware the certificate was required to be posted within 36 inches of the main panel. Reference NFPA 101, 2000 Edition, 19.3.4.1,	K 052	A) A central station certificate will be posted within 36 inches of the main panel by August 25th, 2012. August 25th, 2012 B) A quality improvement monitoring tool will be implemented by the Director of Maintenance to ensure ongoing compliance with fire alarm system standards. This monitor will be completed monthly as part of current fire alarm testing procedures August 21, 2012	

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K 052	Continued From page 3 9.6.1.4, NFPA 72, 1999 Edition; 5-2.2.3.1.1 Fire alarm systems providing services that complies with all the requirements of this code shall be certified by the organization that has listed the central station, and a document attesting to this certification shall be located on or within 36 in. of the fire alarm system control unit or, if no control unit exists, on or within 36 in. of a fire alarm system component.	K 052	and reported monthly at the Quality Advisory Committee meeting. Appropriate follow-up actions will be initiated by the Quality Advisory Committee.	
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 record review and staff interview, the facility failed to test sprinkler system devices during 1 of the past 4 quarters. The findings were: Review of the sprinkler testing records showed the waterflow and supervisory signal devices had not been tested during the third quarter of 2011. Seven month elapsed between the 4/27/11 and 11/28/11 tests. On 7/10/12 at 11:10 AM the maintenance director reported the tests were not performed because they were looking for a new contractor. He could not explain why the test had not been completed by another contractor or facility staff. Reference NFPA 101, 2000 Edition, 19.3.5.1, 9.7.5, NFPA 25, 1999 Edition; 9 2.7 Waterflow alarm. All waterflow alarms shall	K 062	A) In the event a contractor cannot perform needed sprinkler system testing, employed staff will ensure completion of testing on a quarterly basis. B) Facility will review and make necessary changes to sprinkler system policy and procedure by August 25th, 2012. August 25, 2012 C) A quality improvement monitoring tool was implemented by the Director of Maintenance in December 2011 to ensure ongoing compliance with automatic sprinkler system standards. This monitoring	

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K 062	Continued From page 4 be tested quarterly in accordance with manufacturer's instructions. Reference NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; Table 7-3.2 Testing Frequencies. 15. Initiating Devices j. Supervisory Signal Devices,.....quarterly k. Waterflow Devices,.....quarterly	K 062	tool is completed quarterly and reported quarterly at the Quality Advisory Committee meeting. Appropriate follow-up actions are initiated by the Quality Advisory Committee. August 21, 2012	