STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A050	A. BUILDING 01 B. WING _____	05/13/2010

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

(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 1996. The building was equipped with a supervised automatic wet sprinkler system and addressable fire alarm system.	K 000		
K 027 SS=E	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. 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 observation and staff interview the facility failed to ensure 1 of 4 smoke barrier doors had an attached self closure device (SCD). The findings were: Observation on 5/11/10 at 10:00 AM revealed the smoke barrier door between the dining room and the north exit hallway did not have a SCD attached. The facility maintenance manager	K 027	**K027** The facility will include door-closer checks on the routine smoke/fire door inspections as part of the Quality Assurance program. The door closer was installed. This process was monitored by the Facilities Director. **May 17, 2010**	

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

Jean Pinter RN CNO NHA | NHA | 03 June 2010

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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K 027	Continued From page 1 stated at this time that the contractor probably forgot to attach a SCD to the door during the most recent construction project.	K 027	**K062** The facility will provide a handle for the sprinkler head wrench. The wrench will be installed in the sprinkler head cabinet June 25, 2010. This process will be monitored by the Facilities Director. **June 25, 2010**	
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 suppression (sprinkler) system was properly maintained. The findings were: Observation on 5/11/10 at 3:48 PM revealed a sprinkler head cabinet with an adequate number of spare sprinkler heads at the facility sprinkler system riser. However, missing from the cabinet was a handle for the sprinkler head wrench. Interview with the facility maintenance manager at 3:38 PM confirmed the wrench needed a handle.	K 062		
K 144 SS=E	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.	K 144	**K144** The facility will ensure that proper documentation occurs on the generator load tests and that the activity will be included in the Quality Assurance Calendar.	

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K 144	Continued From page 2 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to maintain a log of emergency generator tests during the previous year. The findings were: Review of facility emergency generator testing records on 5/11/10 at 2:48 PM revealed the operations log of the facility emergency generator was only maintained through April 2009. Interview with the maintenance manager on 2:48 PM revealed load test of the facility emergency generator was routinely done at 5 AM once a month. However, documentation of the testing was unavailable.	K 144	Proper documentation will commence at the first routine scheduled generator load test in June, 2010. This activity will be monitored by the Facilities Director. **June 24, 2010**	
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by:	K 211	<u>K211</u> The facility will add ABHR checks to the Quality Assurance Calendar to ensure this requirement is met upon installation of all ABHR units. The ABHR units referenced above were moved to locations which meet current code on 5/17/2010. The Facilities Director monitored this process. **May 17, 2010**	

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K 211	Continued From page 3 Based on observation and staff interview, the facility failed to ensure alcohol based hand rub (ABHR) dispensers were not installed over ignition sources in 1 of 2 smoke compartments. The findings were: Observation on 5/11/10 at 11:18 AM revealed two ABHR dispensers were attached to the wall directly over two electrical outlets in the facility main dining room. Interview with the maintenance manager at 11:18 AM confirmed the observation.	K 211		