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

PRINTED: 07/31/2013
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
	53A050	A. BUILDING 01 _____ B. WING _____	07/16/2013

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	K 000		
	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, New and 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 and 2010. The building was equipped with a supervised, automatic wet sprinkler system and an addressable fire alarm system. The facility had a capacity of 24 certified Medicaid beds with a census of 23.			
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	The facility will ensure all smoke resistant corridor doors are free from any impediment to the closing of these doors. This will be accomplished by: 1) The door to resident room #212 will not be impeded by any device or object. The elastic cord was removed. The temporary mattress will be held in place by a nylon strap. This will prohibit the door from being impeded. 2) The door to resident room #212 will not be impeded by any device or object. The elastic cord was removed. The temporary mattress will be held in place by a nylon strap. This will prohibit the door from being impeded.	08/15/13 08/15/13

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

RN BSN MHA — 8-9-13

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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Healthcare Licensing and Surveys

FOR ADMINISTRATOR, MIKE HAMMER, VP OF SUPPORT SERVICES, DN 8/29/13

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VK4P21 Facility ID: WY0039 If continuation sheet Page 1 of 9

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STAR VALLEY CARE CENTER	110 HOSPITAL LANE AFTON, WY 83110

8/21/13

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure corridor doors were smoke resistant in 1 of 2 smoke compartments. The findings were: Observation of the corridor system on 7/16/13 between 9 AM and 10 AM showed the corridor doors to resident room #212 and #210 were impeded from closing by elastic cords. Further observation showed the elastic cords were permanently used to hold temporary mattresses against the wall behind the corridor doors. On 7/16/13 at 9:35 AM maintenance technician #1 reported he was aware corridor doors were prohibited from being impeded by devices requiring more than one action to close the door. At 9:42 AM certified nurses ' aid #1 reported the elastic band was used because the mattresses were wider than the gap behind the doors and they pushed the door partially closed.	K 018	3) All other elastic cords being used to hold the temporary mattresses in place will be replaced with nylon straps. 4) The maintenance supervisor or designee will conduct monthly compliance rounds to assure all doors are free from any impediment to their closing. These compliance rounds will documented on the quality calendar and reported to the Quality Compliance Committee on a quarterly basis. The results will be included in the facility-wide continuous quality improvement program.	08/15/13 08/15/13
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		

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K 029	Continued From page 2	K 029	The facility will ensure all hazardous areas are separated from use areas. This ensures the integrity of their smoke resistant properties. This will be accomplished by:	
	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 1 of 2 smoke compartments. The findings were: Observation of the mechanical room on 7/16/13 at 9:20 AM showed four unsealed pipe penetrations in the ceiling. The largest gap measured ⅛ inch across. At the time of the observation, maintenance technician #1 reported hazardous areas were not routinely inspected to ensure they were smoke resistant.		1) The 4 unsealed pipe penetrations will be sealed with fire wool to ensure the compartments are smoke resistant.	07/17/13
			2) The maintenance supervisor or designee will schedule monthly compliance rounds to assure inspection of all hazardous areas to ensure there are no penetrations. These compliance rounds will documented on the quality calendar and reported to the Quality Compliance Committee on a quarterly basis. The results will be included in the facility-wide continuous quality improvement program.	
K 038 S5=E	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	K 038		08/15/13
	This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure doors within a required means of egress were unobstructed in 1 of 2 smoke compartments. The findings were: Observation of the west corridor on 7/16/13 at 2:46 PM showed the single cross corridor door near resident room #213 was equipped with a magnetic lock and key pad. Further observation showed the lock was not equipped with a delayed egress function. Interview with the director of nursing at the time of the observation confirmed			

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K 038	Continued From page 3 the lock was not installed for the clinical needs of the resident. At the time of the observation maintenance technician #1 reported the door was relocated 45 degrees from the previous location during the 2010 remodel to limit resident access to the medical office building and the new conference room. Reference NFPA 101, 2000 Edition; 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path.	K 038	The facility will ensure egress doors are unobstructed. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. This will be accomplished by: 1) The single cross corridor door in the west corridor by resident room #213 will remain unlocked and unobstructed at all times. The current magnetic lock will be removed. The egress door will be re-equipped with an alarm that maybe by-passed by use of a code pad. 2) The maintenance supervisor or designee will schedule monthly compliance rounds to assure inspection of the egress door to ensure it is unobstructed. These compliance rounds will documented on the quality calendar and reported to the Quality Compliance Committee on a quarterly basis. The results will be included in the facility-wide continuous quality improvement program.	08/31/13 08/31/13
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 staff interview, the facility failed to ensure emergency battery lights were operational in 1 of 2 smoke compartments. The findings were:	K 046		

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K 046	Continued From page 4 Observation of the electrical room on 7/16/13 at 9:14 AM showed the emergency battery light would not illuminate the bulbs when the test button was depressed. Further observation showed the electrical circuit supplying power to this light was turned off. At the time of the observation, maintenance technician #2 reported he tested this light by turning off the electrical circuit. He could not explain why the circuit was not turned back on after the monthly 30 second test was completed. The last monthly test was performed on 6/26/13. Reference NFPA 101, 2000 Edition, 19.2.9.1; 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 046	The facility will ensure emergency battery lights are operational for at least a 1 ½ hour duration. This will be accomplished by: 1) The test button on the battery light will be used for 30 second tests.	07/22/13
			2) For the 1 ½ hour test , while the power is turned off, the maintenance technician will set an alarm on his cell phone to remind him to reset the battery lighting.	07/22/13
			3) The maintenance supervisor will conduct a functional test on the emergency lighting system at 30-day intervals for not less than 30 seconds. Scheduling and completion of this functional test will be documented on the quality calendar and reported to the Quality Advisory Committee on a quarterly basis.	08/15/13
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	K 052	4) The maintenance supervisor or designee will conduct an annual test on the emergency lighting system for not less than 1 ½ hours. Scheduling and completion of this annual test will be documented on the quality calendar and reported to the Quality Advisory Committee on a quarterly basis. The results will be included in the facility-wide continuous quality improvement program.	08/15/13

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K 052	Continued From page 5	K 052		
	This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure fire alarm annunciator strobes where synchronized in 2 of 2 smoke compartments. The findings were: Observation of the east corridor on 7/16/13 at 2:06 PM showed three fire alarm annunciator strobes were installed in the corridor. Further observation showed the strobes were not synchronized. At the time of the observation, maintenance technician #2 reported he was unaware strobes were required to be synchronized when more than two were in the same field of view. He also reported the fire alarm system strobes were not synchronized. Further observation showed the west corridor was equipped with four strobes. Reference NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; 4-4.4.1.1 Strobe Spacing shall be: 4. More than two in the same field of view shall be synchronized.		The facility will ensure the fire alarm annunciator strobes are synchronized. The facility standard will be NFPA #72. This will be accomplished by: 1) The facility will use a qualified fire alarm contractor to replace the strobes and synchronization modules. 2) During monthly fire drills, the maintenance supervisor or designee will verify that the fire alarm strobes remain synchronized. The compliance round will be documented on the quality calendar and reported to the Quality Advisory Committee on a quarterly basis. The results will be included in the facility-wide continuous quality improvement program.	09/16/13 09/16/13
K 062 SS=E	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	K 062		

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K 062	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the facility had complete sprinkler coverage in 1 of 2 smoke compartments. The findings were: Observation of the kitchen sprinkler system on 7/16/13 at 9:55 AM showed two sprinkler heads were located more than 7 ½ feet from the kitchen hood metal shield. The sprinkler heads were located 10 feet from the shield. At the time of the observation, maintenance technician #1 could not explain why the contractor had installed the aforementioned heads with a 2 ½ foot unprotected area. Reference NFPA 101, 2000 Edition, 19.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 5-5.3.1 Maximum Distance Between Sprinklers. The maximum distance permitted between sprinklers shall be based on the centerline distance between sprinklers on the branch line or on adjacent branch lines. The maximum distance shall be measured along the slope of the ceiling. The maximum distance permitted between sprinklers shall comply with the value indicated in the section for each type or style of sprinkler. Table 5-6.2.2 (b) Protection Areas and Maximum Spacing (Standard Spray Upright/Standard Spray Pendent) for Ordinary Hazard Construction Type, ... All System Type, ... All Protection Area, ... 130 ft2 Spacing, ... 15 ft	K 062	The facility will ensure complete sprinkler coverage in all smoke compartments. This will be accomplished by: 1) The 2 sprinkler heads located in the kitchen will be moved to be no more than 7 ½ feet from the kitchen hood metal shield.	08/31/13
			2) With any further construction, the maintenance supervisor will ensure all smoke compartments are protected by complete sprinkler coverage.	08/31/13
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in	K 144		

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K 144	Continued From page 7 accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the results for 1 of 6 emergency generator tests was recorded. The findings were: Review of the emergency egress lights showed they were supplied with power from the emergency generator. Review of the generator testing records showed the transfer time from normal power to emergency power had not been collected in the past 10 months. The last time the transfer time was recorded was 8/3/12. On 7/16/13 at 1:50 PM maintenance technician #1 could not explain why the transfer times were not being collected. The generator was tested under full load on 7/16/13 at 3 PM and the transfer time was 8 seconds. Reference NFPA 101, 2000 Edition, 19.2.9.1; 7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted.	K 144	The facility will ensure emergency generator test results are recorded. This will be accomplished by: 1) The generator will be manually tested to ensure the transfer time is within 8 seconds. These results will be documented on the generator testing log. 2) The maintenance supervisor or designee will conduct an emergency generator test monthly and ensure the results are recorded on the generator testing log. Scheduling and completion of this emergency generator test will be documented on the quality calendar and reported to the Quality Advisory Committee on a quarterly basis. The results will be included in the facility-wide continuous quality improvement program.	07/16/13 08/15/13
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	K 147		

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K 147	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure electrical wires were not run through prohibited openings in 1 of 2 smoke compartments. The findings were: Observation of resident room #224 on 7/16/13 at 9:01 AM showed the oxygen concentrator was located outside of the restroom while the power cord was run into the restroom. The power cord had the potential of being pinched between the restroom door and door frame. At the time of the observation, maintenance technician #1 reported the oxygen concentrator was normally located in the restroom, but was removed when the exhaust fan stopped working making the room uncomfortably hot. He could not explain why the facility had not used another electrical receptacle so the cord did not have the potential of being damaged. Reference NFPA 101, 2000 Edition, 19.5.1, 9.1.2, NFPA 70, 1999 Edition; 400-8. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls ... (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147	The facility will ensure electrical wires are not run through prohibited openings. The facility will ensures oxygen concentrator power cords are protected and have no potential of being pinched in doors. This will be accomplished by: 1) The oxygen concentrator for resident room #224 has been re-located and positioned so the power cord cannot be pinched between a door and a door frame. 2) The DON will provide an inservice for the nursing staff and environmental services staff regarding safety of oxygen concentrator electrical cords. 3) The DON or designee will monitor monthly for on-going compliance to ensure proper positioning of all oxygen concentrators and the safety of their power cords. The results will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	07/16/13 08/31/13 08/31/13

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K 052	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure fire alarm annunciator strobes where synchronized in 2 of 2 smoke compartments. The findings were: Observation of the east corridor on 7/16/13 at 2:06 PM showed three fire alarm annunciator strobes were installed in the corridor. Further observation showed the strobes were not synchronized. At the time of the observation, maintenance technician #2 reported he was unaware strobes were required to be synchronized when more than two were in the same field of view. He also reported the fire alarm system strobes were not synchronized. Further observation showed the west corridor was equipped with four strobes. Reference NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; 4-4.4.1.1 Strobe Spacing shall be: 4. More than two in the same field of view shall be synchronized.	K 052	The facility will ensure the fire alarm annunciator strobes are synchronized. This will be accomplished by: 1) A new, up-to-date, fire alarm annunciator system will be installed. This new system will be capable of synchronizing the strobes.	08/31/13
			2) The maintenance supervisor or designee will conduct an annual compliance round to verify that the fire alarm strobes remain synchronized. The compliance round will be documented on the quality calendar and reported to the Quality Advisory Committee on a quarterly basis. The results will be included in the facility-wide continuous quality improvement program.	08/31/13
K 062 SS=E	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	K 062	REVIEWED 8/13/13 NOT ACCEPTED	

Star Valley Medical Center

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FAX

To: Jason Hansen — Health Care Licensing **From:** Amy Johnson 307 885 5833

Fax: 307 777 7127 **Pages:** 2

Phone: 307 777 7123 **Date:** 8-21-13

Re: Revised Plan of Correction for K052 **cc:**

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Jason this is the revised PoC for K052

Thanks

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WY Dept of Health
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