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

PRINTED: 05/01/2014
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 - MAIN BUILDING 01 B. WING	04/16/2014

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, New and Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, 1-story building of Type II (111) construction built in 1996 (Existing Health Care) with an addition built in 2010 (New Health Care). 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 22.	K 000		
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 and staff interview, the facility failed to provide self-closing doors for protection of hazardous areas in 1 of 2 smoke compartments. The findings were:	K 029	The facility will provide self-closing doors for protection of hazardous areas. This will be accomplished by: a) The facility has provided an automatic door closer on the door separating the storage room from the kitchen. b) The maintenance supervisor or designee will conduct quarterly compliance rounds to inspect the self-closing doors to ensure all are functioning properly. These compliance rounds will be 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.	05/15/14 06/01/14

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

Amy Johnson RN BSN — WHA — 5-8-14

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.

PLAN OF CORRECTION (POC) ACCEPTED W/AMY JOHNSON (ADMIN) ON 06.09.14

JW yatt

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K 029	Continued From page 1 Observation of the Storage Room located within the Kitchen on 4/16/14 at 1:42 PM revealed that a closer was not provided on the door separating the storage room from the kitchen. Interview with the VP of Operations at the time of the observation verified that no closer was provided on the door.	K 029		
K 045 SS=D	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: Based on observation and staff interview, the facility failed to provide illumination of a means of egress to ensure failure of any single lighting fixture does not leave the area in darkness. The findings were: Observation of the Meeting Room constructed in 2010 on 4/16/14 at 11:10 AM revealed that all lighting was provided via switched circuits. Upon switching all switches to the "off" position, the room was left with no illumination. Interview with the VP of Operations at the time of the observation revealed that he had previously questioned the lack of egress lighting within the space, but could not explain why the space was not provided the required lighting.	K 045	The facility will ensure egress lighting within the Meeting Room. This will be accomplished by: a) The facility has installed fixtures with battery powered ballasts for emergency lighting of at least 1 ½ hour duration at two exit locations in the meeting room. b) The maintenance supervisor or designee will conduct semi-annual testing of emergency lighting to ensure no egresses are left in darkness. Scheduling and completion of this semi-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.	06/01/14 06/01/14
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1¼ hour duration is	K 046		

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K 046	Continued From page 2 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 provide emergency lighting of at least 1.5 hour duration. The findings were: Observation and interview of the Meeting Room constructed in 2010 on 4/16/14 at 11:10 AM revealed that emergency lighting was not provided throughout the space. Interview with the VP of Operations at the time of the observation could not establish that lighting was circuited to the emergency generator system as switches were not colored red to indicate emergency power and no fixtures were noted to include battery-powered ballasts.	K 046	The facility will ensure emergency battery lights are operational for at least a 1 ½ hour duration. This will be accomplished by: a) The facility has provided egress security lighting in two locations near exits in the meeting room.	06/01/14
K 050 SS=D	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 announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to demonstrate that fire drills are held at least quarterly on each shift. The findings	K 050	b) The maintenance supervisor or designee will conduct semi-annual testing of emergency lighting to ensure no egresses are left in darkness. Scheduling and completion of this semi-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.	06/01/14

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K 050	Continued From page 3 were: Review of documentation on 4/16/14 at 10:00 AM revealed that fire drills had not been conducted for the second shift between the months of October and December of 2013. Interview with the facility maintenance staff #1 assisting with document review confirmed that no records were available to demonstrate that fire drills were conducted during this period.	K 050	The facility will ensure the fire drills are held at least quarterly on each shift. This will be accomplished by: a) The maintenance supervisor or designee will conduct training sessions with maintenance employees who conduct fire drills. Emphasis will be placed on ensuring fire drills are conducted for all shifts in the Care Center.	05/15/14
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051	b) The maintenance supervisor or designee will conduct quarterly compliance reviews of the fire drills on both day and night shifts to ensure compliance and verify the recording of the drills are completed. 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.	06/01/14

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K 051	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that fire alarm circuits were installed per the requirements of the Life Safety Code and NFPA 70. The findings were: Observation of the Electrical Room on 4/16/14 at 11:33 AM revealed that the fire alarm circuits were not identified at the terminal locations. Interview with the VP of Operations at the time of the observation verified that the circuits were not identified.	K 051	The facility will ensure that fire alarm circuits are installed per requirements of the Life Safety Code and NFPA #70. This will be accomplished by: a) The facility has, in accordance with the Life Safety Code and NFPA70, identified in red the fire alarm electrical circuits in the electrical panel.	06/01/14
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 document review and staff interview, the facility failed to provide documentation identifying a maintenance policy of the fire alarm system or documentation to indicate that systems have been tested in accordance with NFPA 72. The findings were:	K 052	b) The maintenance supervisor or designee will conduct annual compliance reviews of the fire alarm circuits to ensure they are identified in red in the electrical panel. The compliance reviews will be documented on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	06/01/14

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K 052	Continued From page 5 Document review of the testing and maintenance documentation on 4/16/14 from 8:30 AM to 10:30 AM confirmed the lack of testing or maintenance policies for the following aspects of the fire alarm system: 1. Fire alarm - monthly activation (NFPA 72 Table 7-3.2, 23): Documentation was not available at the time of the survey to demonstrate that the fire alarm has been activated monthly. Activation could not be established for the months of August and November of 2013. 2. Smoke damper operation - annual test (NFPA 90A, 4-4.1): Documentation was not available at the time of the survey to demonstrate that smoke dampers have been tested and operated within the past 12 months. 3. Smoke detectors - in place, smoke entry - annual test (NFPA 72, Table 7-3.2, 15): Documentation was not available at the time of the survey to demonstrate that in-place smoke entry tests have been performed within the past 12 months. 4. Smoke detector sensitivity - bi-annual tests (NFPA 72, Table 7-3.2, 15): Documentation was not available at the time of the survey to demonstrate that sensitivity tests have been performed within the past 24 months. 5. Interview with maintenance staff #1 at the time of the document review verified the lack of testing or maintenance policies.	K 052	The facility will ensure documentation to indicate the fire alarm system has been tested in accordance with NFPA #72. This will be accomplished by: a) The facility has retrained maintenance staff in accordance with NFPA72 to document and keep records of (1) monthly fire alarm activations, (2) annual smoke damper operations tests, (3) smoke detectors - in place smoke entry annual test, and (4) the smoke detector sensitivity bi-annual tests. (5) Testing and maintenance policies and procedures have been updated to reflect the necessary protocols for fire alarm and smoke detector testing. b) The maintenance supervisor or designee will conduct quarterly compliance documentation reviews of (1) monthly fire alarm activations, (2) annual smoke damper operations tests, (3) smoke detectors - in place smoke entry annual test, and (4) the smoke detector sensitivity bi-annual tests to ensure compliance and verification that the recording of the testing is completed. The compliance reviews will be documented on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	06/01/14 06/01/14
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	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 that the facility had complete sprinkler coverage in 1 of 2 smoke compartments. The findings were: Observation of the dry storage area located within the kitchen revealed that one sprinkler head was installed and the distance to the furthest wall was greater than 7.5 feet. The single sprinkler head provided within the space was located 10 feet from the furthest wall. Interview with the VP of Operations confirmed that the room was not provided with adequate sprinkler head coverage to maintain the maximum 7.5 feet separation distance.	K 062	The facility will ensure complete sprinkler coverage in all smoke compartments. This will be accomplished by: a) The facility, in accordance with NFPA13 and NFPA25, will have a qualified fire sprinkler system contractor adjust the sprinkler system to provide sprinkler heads to maintain the maximum 7.5 feet separation distance in the dry storage area located within the kitchen.	06/01/14
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and and staff interview, the facility failed to ensure that mechanical equipment had been installed and maintained with respect to the manufacturer's installation instructions and listing. The findings were: Observation of the packaged rooftop air handling	K 067	b) With any further construction, the maintenance supervisor will ensure all smoke compartments are protected by complete sprinkler coverage.	06/01/14

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K 067	Continued From page 7 units installed on the roof of the 2010 addition on 4/16/14 at 1:33 PM revealed that the furnace flue assembly had been field modified by creating a penetration in the units' casing and affixing a field fabricated hood. Modifications to the interior of the unit and combustion chamber could not be established at the time of the observation. Interview with the VP of Operations at the time of the observation revealed that the facility had experienced difficulty with maintaining combustion during windy conditions. To alleviate the condition, the facility contracted with the installing contractor to modify the furnace flue assembly in an attempt to improve performance. It was established that neither the facility nor the contractor had coordinated with the manufacturer for approval of the modifications in accordance with the equipment's listing. Therefore, it could not be established at the time of the survey that the equipment has been maintained in a manner that has not violated the equipment's listing.	K 067	The facility will ensure all mechanical equipment is installed and maintained according to manufacturer's installation instructions. This will be accomplished by: a) The facility will work with a qualified contractor to remove the field modifications to the unit and bring the equipment back to original specification and listing. b) With any further construction, the maintenance supervisor will ensure all mechanical equipment is installed and maintained according to manufacturer's installation instructions.	06/01/14 06/01/14
K 147 SS=E	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 and staff interview, the facility failed to provide electrical wiring and equipment in accordance with the Life Safety Code and NFPA 70. The findings were: a. Observation of the fire alarm equipment in the Mechanical Room on 4/16/14 at 10:33 AM revealed that fire alarm and computer equipment utilized a power tap without a circuit breaker.	K 147		

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K 147	Continued From page 8 Additionally, the fire alarm systems utilized a 3-prong to 2-prong adapter before being connected to the power tap. Interview with the VP of Operations at the time of the observation revealed that the fire alarm contractor was utilizing the adaptor to eliminate the ground to the fire alarm system as the system was reporting an error due to ground fault. b. Observation of the following rooms on 4/16/14 from 10:01 AM until 11:01 AM revealed the use of power taps without circuit breakers: Commons Area (one powering the TV & DVD and one powering the aquarium), Multi-Purpose Room (one powering the copier and one at a desk), Activities Room, and the Clean Utility room. At the time of the observation, the Maintenance Director confirmed he was aware that the use of power taps without circuit breakers was noncompliant but acknowledged he was unaware of the before-mentioned power taps.	K 147	The facility will provide electrical wiring and equipment in accordance with the Life Safety Code and NFPA 70. This will be accomplished by: a) The facility has removed the power tap and the 3-prong to 2-prong adapter in the mechanical room and will work with the fire alarm contractor to find and repair the ground fault. A completion date extension request was submitted to [redacted] on May 8, 2013. HLS TW	07/31/14
			b) All other power tap devices (commons area; activities room; clean utility room) have been removed and replaced with circuit breaker-type power strips.	04/19/14
			c) All maintenance and facility staff will have education regarding only using circuit breaker-type power strips.	06/01/14
			d) The maintenance supervisor and DON will conduct quarterly compliance rounds to ensure only the use of circuit breaker-type power strips within the facility. 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.	06/01/14