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

PRINTED: 03/12/2015
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	03/03/2015

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, one 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 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress free of all obstructions or impediments to full instant use. The findings were: Observation of Resident Corridors throughout the facility on 03/03/15 from 9:25 AM to 10:30 AM revealed wheel chairs and patient lifts being stored in the corridor. At the time of the	K 072	The facility will maintain means of egress free of all obstructions or impediments. Wheelchairs and patient lifts will not be stored in the corridors. This will be accomplished by: a) The DON or designee will conduct training sessions with nursing staff regarding were to store wheelchairs and patient lifts. Emphasis will be placed on ensuring the corridors remain free of obstructions and impediments. b) The DON or designee will perform audits daily for 2 weeks, 3x/week for 2 weeks, then weekly to ensure compliance and verify the wheelchairs and patient lifts are not stored in the corridors. 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. c) The maintenance supervisor or designee will perform audits monthly to ensure compliance and verify the wheelchairs and patient lifts are not stored in the corridors. 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.	04/12/15 04/12/15 04/12/15

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

Amy L Johnson RN BSN NHA 3-18-15

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 documentetare made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: S91621 Facility ID: WY0039 If continuation sheet Page 1 of 3

MAR 18 2015
Healthcare Licensing and Surveys

POC Accepted VIA Phone Call with Administrator Amy L. Johnson on 3/19/15 at 1:28pm. 34354

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K 072	Continued From page 1 observation, the Facility Maintenance Manager acknowledge the items were stored in the corridors on a regular basis. Ref: 2000 NFPA 101, Sections 19.2.1 and 7.1.10.1	K 072		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that medical gas storage and administration areas are protected in accordance with NFPA 99 in 1 of 2 smoke compartments. The findings were: Observation of the Oxygen Storage Room on 03/03/15 at 9:25 AM revealed plastic drawers and plastic wrapping being stored in the room. At the time of the observation, the Facility Maintenance Manager acknowledged the combustible material being stored within the space.	K 076	The facility will ensure that medical gas storage and administration areas are protected in accordance with NFPA 99. This will be accomplished by: a) The plastic drawers and plastic wrapping will be removed from the Oxygen Storage Room. b) The maintenance supervisor or designee will conduct training with the maintenance staff, respiratory staff and nursing staff regarding no combustible material being stored in the Oxygen Storage Room. c) The maintenance supervisor or designee will perform audits monthly to ensure no combustible materials are being stored in the Oxygen Storage Room. 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.	03/18/15 04/12/15 04/12/15

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K 076	Continued From page 2 Ref: 1999 NFPA 99, Section 4-3.1.1.2 (7)	K 076		