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

PRINTED: 05/27/2015
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
	535045	A. BUILDING 01 - MAIN BUILDING B. WING	05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL VALLEY CARE CENTER	777 AVENUE H POWELL, WY 82435

(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, 1-story building of Type II (111) construction built in 1995. The building was equipped with a supervised, automatic wet sprinkler system and an addressable fire alarm system. The facility had a capacity of 100 certified Medicare and Medicaid beds with a census of 80.	K 000	K 029 The facility shall ensure that hazardous areas are protected from the corridor with self-closing doors in smoke compartments. A. Self-closing device will be repaired on door leading into the Activities Storage Room to ensure protection of the hazardous area from the corridor in the smoke compartment. B. All residents, staff, and visitors have the potential to be affected by failure to maintain protection of the hazardous areas within a smoke compartment. C. Education will be provided to the Maintenance Techs and Care Center staff to ensure all hazardous areas are protected from the corridor with self-closing doors in smoke compartments. The Plant Operations Manager or designee will perform monthly inspections to ensure the door with the self-closing device between the corridor and hazardous area is functioning properly.	
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 ensure hazardous areas were protected from the corridor with self-closing doors in 1 of 8 smoke compartments. The findings were:	K 029		

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

Jason Kidney Care Center Nursing Director — 6-12-15

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

POC Accepted via Phone Call with SE Administrator Nicole Ostermiller on 6/29/15 @ 2:52pm.

34354

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

PRINTED: 05/27/2015
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
	535045	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL VALLEY CARE CENTER	777 AVENUE H POWELL, WY 82435

(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 029	Continued From page 1 Observation on 05/18/15 at 11:25 AM revealed the Activities Storage Room was provided with a self-closing device, but when activated, would not close the door completely to latch into the door frame. At the time of the observation the Facility Maintenance Manager acknowledged the door would not latch into the frame; Ref: 2000 NFPA 101, Section 19.3.2.1	K 029	D. The Plant Operations Manager or designee will aggregate random monthly data and report results to the Administrator, Care Center Medical Director and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance.	
K 074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 074	Completion Date 06/30/2015 K 074 The facility shall demonstrate compliance with flame propagation performance in smoke departments. A. Room #401 combustible decorations on the doors and walls in the corridor will be sprayed with fire retardant spray and identifying tags placed indicating the flame spread information. A. Room #402 combustible decorations on the doors and walls in the corridor will be sprayed with fire retardant spray and identifying tags placed indicating the flame spread information.	

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

PRINTED: 05/27/2015
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
	535045	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL VALLEY CARE CENTER	777 AVENUE H POWELL, WY 82435

(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 074	Continued From page 2 facility failed to demonstrate compliance with flame propagation performance in 3 of 8 smoke compartments. The findings were: 1. Observation of rooms #401, #402, #403, and #404 on 05/18/15 at 10:32 AM revealed combustible decorations on the doors and walls in the corridor. None of the items were provided with identifying tags to indicating the flame spread information. At the time of the observation, the Facility Maintenance Manager acknowledged the decorations. 2. Observation of the Secured Unit Commons Area on 05/18/15 at 11:02 AM revealed curtains that were not provided with an identifying tag to indicating the flame spread information. At the time of the observation, the Facility Maintenance Manager acknowledged the curtains and the missing information. 3. Observation of Room #208 on 05/18/15 at 11:06 AM revealed combustible decorations on the door and wall adjacent to the room in the corridor. None of the items were provided with identifying tags to indicating the flame spread information. At the time of the observation, the Facility Maintenance Manager acknowledged the decorations. Ref: 2000 NFPA 101, Section 19.7.5.4	K 074	A. Room #403 combustible decorations on the doors and walls in the corridor will be sprayed with fire retardant spray and identifying tags placed indicating the flame spread information. A. Room #404 combustible decorations on the doors and walls in the corridor will be sprayed with fire retardant spray and identifying tags placed indicating the flame spread information. A. Secured Unit Commons Area curtains will be sprayed with fire retardant spray and identifying tags placed indicating the flame spread information. A. Room #208 combustible decorations on the door and wall adjacent to the room in the corridor will be sprayed with fire retardant spray and identifying tags placed indicating the flame spread information. B. All residents have the potential to be affected by the failure to demonstrate compliance with flame propagation performance in smoke compartments.	

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

PRINTED: 05/27/2015
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
	536045	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL VALLEY CARE CENTER	777 AVENUE H POWELL, WY 82435

(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 074	Continued From page 2 facility failed to demonstrate compliance with flame propagation performance in 3 of 8 smoke compartments. The findings were: 1. Observation of rooms #401, #402, #403, and #404 on 05/18/15 at 10:32 AM revealed combustible decorations on the doors and walls in the corridor. None of the items were provided with identifying tags to indicating the flame spread information. At the time of the observation, the Facility Maintenance Manager acknowledged the decorations. 2. Observation of the Secured Unit Commons Area on 05/18/15 at 11:02 AM revealed curtains that were not provided with an identifying tag to indicating the flame spread information. At the time of the observation, the Facility Maintenance Manager acknowledged the curtains and the missing information. 3. Observation of Room #208 on 05/18/15 at 11:06 AM revealed combustible decorations on the door and wall adjacent to the room in the corridor. None of the items were provided with identifying tags to indicating the flame spread information. At the time of the observation, the Facility Maintenance Manager acknowledged the decorations. Ref: 2000 NFPA 101, Section 19.7.5.4	K 074	K 074 Cont. C. Education will be provided to Nursing, Maintenance, and Housekeeping staff regarding the importance of demonstrating compliance with flame propagation performance in smoke compartments regarding combustible decorations and curtains. The Plant Operations Manager or designee will perform monthly inspections to ensure all combustible decorations and curtains have been sprayed with fire retardant spray and identifying tags placed indicating the flame spread information. D. The Plant Operations Manager or designee will aggregate random monthly data and report results to the Administrator, Care Center Medical Director and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 06/30/2015	