PRINTED: 07/05/2017
FORM APPROVED
OMB NO. 0938-0391

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

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	06/27/2017

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 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 06/27/17. 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 2012 Edition of the Life Safety Code, Existing Healthcare, of the National Fire Protection Association. The facility was a fully sprinklered, one story building of Type II (111) construction built in 1995. The building was equipped with a supervised automatic wet sprinkler system with an addressable fire alarm system. The facility had a capacity of 100 certified Medicare and Medicaid beds with a census of 88.	K 000		
K 131 SS=D	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: * They are not intended to serve four or more inpatients. * They are separated from areas of health care occupancies by construction having a minimum 2-hour fire resistance rating in accordance with Chapter 8. * The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR	K 131 K 131	The facility must provide 2 hour fire barriers in accordance with the 2012 NFPA 101 Life Safety Code A. 1. The latch on the 2- hour fire door barrier separating the Long Term Care and hospital was immediately fixed upon inspection with Life Safety Surveyor. Education will be provided to all Plant Ops staff regarding the need to inspect doors monthly and make corrections immediately in the event door does not latch. 2. The penetration in the 2-hr fire barrier along the north wall of the Long Term Care Cafeteria above the exit door has been fire caulked. All fire barrier doors will be inspected at interval of 10 feet and all penetrations will be fire caulked.	

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

Michelle Stevens BSN, RN NHA — 7/18/17

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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FORM CMS-2567(02-99) Previous Versions Obsolete — Event ID: TQ2U21 — Facility ID: WY0024 — If continuation sheet Page 1 of 8

Spoke with Nursing Director Jason Gedney on 07/19/17 to approve P.O.C. Martha Thavanarn

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K 131	Continued From page 1 485.623 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to provide a 2-hour fire barrier in accordance with the 2012 NFPA 101 Life Safety Code. The findings were: 1. Observation on 06/27/17 at 2:00 PM revealed that the cross-corridor door in the 2-hour fire barrier separating the Long Term Care and the Hospital did not completely close and latch when released from the magnetic hold open devices. Failure of the doors to properly close and latch could result in injury or death by allowing the propagation of smoke or fire through the doors. Interview with the facility personnel at the time of the observation revealed they were aware of the requirement but were unaware that the doors were not functioning properly by not self-closing. Reference: 2012 NFPA 101 19.1.3.5, 8.2.1.3, 2012 NFPA 221 4.8.4.1 2. Observation on 06/27/17 at 3:19 PM revealed a 1" diameter penetration in the 2-hr fire barrier along the north wall of the Long Term Care Cafeteria above the exit door. Failure to properly protect penetrations could result in injury or death by allowing the propagation or smoke or fire through the penetration. Interview with the facility personnel at the time of the observation revealed that they were unaware of the penetration in the fire barrier. Reference: 2012 NFPA 101 19.1.3.5, 8.2.1.3, 2012 NFPA 221 4.9.2.1	K 131	B. All residents have the potential to be affected by failure to ensure 2-hour fire door barriers latch correctly and there are no penetrations in fire barrier doors. C. The Plant Operations Director or designee will perform monthly inspections to ensure doors latch and there are no penetration and making any corrections immediately upon discovery and maintain documentation of the same D. The Plant Operations Director or designee will aggregate the random monthly data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	08/6/2017
K 291 SS=D	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration	K 291	K 291 The facility must provide emergency lighting in accordance with the 2012 NFPA 101 Life Safety Code A. A 90 minute test on battery operated emergency lighting has been completed and documentation was completed. Staff will be educated regarding this requirement and the schedule for completion annually.	

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K 291	Continued From page 2 is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on documentation review and interview the facility failed to provide emergency lighting in accordance with the 2012 NFPA 101 Life Safety Code. The findings were: Review of documentation on 06/27/17 at 4:05 PM revealed no evidence that the facility was performing annual 90 minute tests on all battery operated emergency lighting. Failure to perform tests of the battery operated emergency lighting could result in injury or death if the lighting does not perform as required in the event of an emergency. Interview with facility personnel at the time of the observation revealed that they were unaware of the required 90 minute annual test. Reference: 2012 NFPA 101 19.2.9.1, 7.9.3.1	K 291	B. All residents have the potential to be affected by failure to test the battery operated emergency lighting. C. The Plant Operations Director or designee will maintain the schedule and documentation showing compliance with this annual requirement. D. The Plant Operations Director or designee will aggregate the data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 08/6/2017	
K 341 SS=D	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	K 341	K 341 The facility must ensure a smoke detector is installed in transfer switch rooms occupied by fire alarm control units in accordance with 2012 NFPA 101 Life Safety Code. A. A new smoke detector will be installed in the transfer switch room. 2. The penetration in the 2-hr fire barrier along the north wall of the Long Term Care Cafeteria above the exit door has been fire caulked. All fire barrier doors will be inspected at interval of 10 feet and all penetrations will be fire caulked.	

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K 341	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to provide a fire alarm system in accordance with the 2012 NFPA 101 Life Safety Code. The findings were: Observation on 06/27/17 at 3:35 PM revealed that no smoke detector was installed in the transfer switch room occupied by a fire alarm control unit. Failure to provide a smoke detector in a non-continuously occupied room containing a fire alarm control unit could result in injury or death if a fire were to damage the control unit and thus be able to propagate without signaling the fire alarm. Interview with facility personnel at the time of the observation revealed that they were unaware of the requirement that a smoke detector must be installed at each fire alarm control unit located in a non-continuously occupied location. Reference: 2012 NFPA 101 19.2.9.1, 7.9.3.1	K 341	B. All residents, families, and visitors have the potential to be affected by failure to install a smoke detector in the transfer switch room. C. The Plant Operations Director or designee will perform monthly inspections to ensure smoke detector is in place and maintain documentation of the same D. The Plant Operations Director or designee will aggregate the random monthly data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	08/6/2017
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test	K 353	K 353 The facility must maintain and test the fire sprinkler system in accordance with 2012 NFPA 101 Life Safety Code. A. Pressure gauges will be replaced on the fire sprinkler riser branches and documentation of completion will be maintained. Plant operations will ensure a schedule is maintained for the next replacement due date. Plant Operations staff will be educated regarding this requirement.	

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K 353	Continued From page 4 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on documentation review and interview the facility failed to maintain and test the fire sprinkler system in accordance with 2012 NFPA 101 Life Safety Code. The findings were: Review of documentation on 06/27/17 3:45 PM revealed that no evidence was available to indicate that pressure gauges installed on the fire sprinkler riser branches were replaced or recalibrated within the last 5 years. Failure to replace or recalibrate pressure gauges could result in injury or death if failure of the fire sprinkler system is not realized due to gauges reading incorrectly. Interview with facility personnel at the time of the observation revealed that they thought the gauges had recently been replaced but could not confirm. Reference: 2012 NFPA 101 9.7.5, 2011 NFPA 25 5.3.2.1	K 353	B. All residents, families, and visitors have the potential to be affected by failure to test the fire sprinkler system and replace the pressure gauges as required. C. The Plant Operations Director or designee will perform monthly inspections to ensure pressure gauges are tested and replaced as required D. The Plant Operations Director or designee will aggregate the random monthly data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	08/6/2017
K 363 SS=D	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke	K 363	K 363 The facility must maintain corridor doors in accordance with the 2012 NFPA 101 Life Safety Code. A. Wheelchairs were moved upon receiving notification of the finding to prevent blocking of the corridor door. Nursing staff will has been educated regarding the need to ensure the corridor door is unobstructed.	

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K 363	Continued From page 5 compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to maintain corridor doors in accordance with the 2012 NFPA 101 Life Safety Code. The findings were: Observation on 06/27/17 at 2:45 PM revealed that Tubroom in the Dementia Care Unit was being used for storage of wheelchairs and the door was being obstructed from closing. Failure to maintain corridor doors in accordance with the Life Safety Code could result in injury or death as it may result in propagation of fire to the corridor.	K 363	B. All residents, families, and visitors have the potential to be affected by failure to test ensure corridor doors are not obstructed from closing C. The Nursing Director or designee will perform monthly inspections to ensure corridor doors are not being obstructed and if found provide immediate correction action and education. D. The Nursing Director or designee will aggregate the random monthly data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	08/6/2017

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K 363	Continued From page 6 Interview with facility personnel at the time of the observation revealed that they were aware that the door was not suppose to be held open or obstructed from closing but were unaware that was occurring in the Tubroom.	K 363		
K 918 SS=D	Reference: 2012 NFPA 101 19.3.6.3.10 NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable.	K 918	K 918 The facility must ensure to test the emergency generator as required in the 2012 NFPA 99 Health Care Facilities. A. A contract with a vendor will be obtained to complete the annual generator load bank testing as required and will be scheduled annually thereafter. Plant Operations staff will be educated regarding this requirement. B. All residents, families, and visitors have the potential to be affected by failure to test the emergency generator as required. C. The Plant Operations Director or designee will perform monthly inspections to load bank testing is being completed as required. D. The Plant Operations Director or designee will aggregate the random monthly data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	08/6/2017

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K 918	Continued From page 7 Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on documentation review and interview the facility failed to test the emergency generator as required in the 2012 NFPA 99 Health Care Facilities. The findings were: Review of documentation on 06/27/17 at 3:55 PM revealed that the facility performed monthly tests of the emergency electrical generator for 30 minutes or more at a time as required by 2012 NFPA 110 8.4.2 however, the voltage and amperage recorded during those tests revealed that the emergency generator was not consistently reaching 30% of name plate power usage. The voltage and amperage recorded on 03/16/17 calculated to be 21.2 kW of power which is 14.3% of the 150 kW on the emergency generator name plate. Documentation also revealed that annual load bank tests were not being performed as a substitute for the monthly tests. Failure to properly test the generator could result in injury or death if the emergency generator does not perform properly during an emergency. Interview with facility personnel at the time of the observation revealed that they were told by a contractor that the facility electrical load was greater than 30% of the generator name plate and that they believed they were meeting the requirement.	K 918		