

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

PRINTED: 05/10/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535017	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 04/16/2018
NAME OF PROVIDER OR SUPPLIER SUBLETTE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 333 N BRIDGER AVE PINEDALE, WY 82941		
(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 revisit survey was conducted on 04/16/2018 for previous deficiencies cited on 02/13/2018. Requirements for Long Term Care Facilities Section 42 CFR 483.70(a) except as otherwise provided in this section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single story building of Type V (111) construction built in 1978 and 1983. The building was equipped with a supervised, automatic wet sprinkler system with a zoned fire alarm system. The facility had a capacity of 50 Medicare and Medicaid beds with a census of 35 residents.	{K 000}			
{K 916} SS=D	Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide electrical systems in	{K 916}	K916: Electrical Systems-Essential Electric System		5/3/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/03/2018

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535017	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 04/16/2018
NAME OF PROVIDER OR SUPPLIER SUBLETTE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 333 N BRIDGER AVE PINEDALE, WY 82941		
(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 916}	Continued From page 1 accordance with the 2012 NFPA 99, Health Care Facilities Code. This deficiency affected 1 of 1 annunciator panels for the essential electrical system. The findings were: Interview with the facility administrator via phone call on 04/13/2018 at 4:00 PM to request follow-up documentation revealed that the generator annunciator panel had not been corrected. Per the initial survey on 02/13/2018 the facility had been cited for a non-conforming annunciator panel in accordance with the 2012 Edition of NFPA 99. The facility's date of correction for the cited deficiency was 03/25/2018. During the call the facility administrator advised that the annunciator panel was scheduled to be replaced on 04/17/2018. Subsequent document review of the follow-up information provided by the facility on 04/16/2018 was unable to verify that the annunciator panel had been corrected in accordance with the 2012 Edition of NFPA 99. Failure to provide an essential electrical system as required could result in injury or death during an emergency. REF: 2012 NFPA 99, Section: 6.4.1.1.17.4 (4)	{K 916}	In response to deficiency K916, in which the facility was noted as having failed to provide electrical systems in accordance with the 2012 NFPA 99, Health Care code with respect to a non-functioning generator annunciator: Said annunciator will be repaired and operational. By completion, all generator components will be inspected and operational. Maintenance staff will monitor the annunciator daily with generator testing. This will be reported in the quarterly QAPI meeting.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/28/2018
NAME OF PROVIDER OR SUPPLIER STAR VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Licensing and Surveys on March 28, 2018. Based upon the findings of the survey team, it was determined the facility was in compliance with all Emergency Preparedness requirements.	E 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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