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 _____	**03/28/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	**130 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 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on March 28, 2018. 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 Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single story building of Type II (111) construction with plan approval in 1998 and 2010. 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 Medicare and Medicaid beds with a census of 16 residents.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain corridor doors in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 80, Standard for Fire Doors and Other Opening Protectives. The	K 211	The facility will maintain corridor doors in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 80, Standard for Fire Doors and Other Opening Protectives. This will be	5/11/18

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

Electronically Signed | 04/20/2018

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	53A050	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/28/2018**

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STAR VALLEY CARE CENTER	**130 HOSPITAL LANE** **AFTON, WY 83110**

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K 211	Continued From page 1 deficiency affected 2 of 2 smoke compartments. The findings were: Document review on 3/28/2018 at 9:25 AM revealed the facility could not verify that the required annual fire door assembly inspection had been completed. Failure to maintain fire door assemblies as required could result in injury or death during an emergency. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was unaware of the requirement. REF: 2012 NFPA 101 Section: 8.3.3.1 2010 NFPA 80 Section: 5.2.1	K 211	accomplished by: 1) A certified fire door inspector will be employed to perform annual fire door assembly inspections and provide records of completion to the facility after each annual inspection. 2) Education to be provided to maintenance staff on ensuring that documentation is up to date to verify that annual fire door assembly inspections had been completed. 3) The Maintenance Director or designee will complete audits monthly to verify that the records of inspection are complete and up to date. Results of these findings will be reported on the monthly quality calendars and reviewed by the quality advisory committee monthly.	
K 227 SS=D	Ramps and Other Exits CFR(s): NFPA 101 Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a ramp in accordance with	K 227	The facility will comply with the 2012 NFPA 101, Life Safety Code. This will be	5/11/18

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	53A050	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/28/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	**130 HOSPITAL LANE** **AFTON, WY 83110**

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K 227	Continued From page 2 the 2012 NFPA 101, Life Safety Code. The deficiency affected one (1) of four (4) exits. The findings were: Observation on 3/28/2018 at 9:14 AM at Entrance 8 revealed an exterior ramp with no handrails on either side. Per the definition of the Life Safety Code a ramp is classified as a walkway with a slope greater than 1:20. During observation a length of approximately 540 inches and a height of approximately 34 inches was measured. The height exceeded the allowed 27 inches and therefore was classified a ramp. Failure to provide ramps as required could result in falls causing injury or death. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated awareness of the requirement. REF: 2012 NFPA 101 Sections: 19.2.2.6; 3.3.219; 7.2.5.2.(2) (c)	K 227	accomplished by: 1) The exterior ramp outside of Entrance 8 mentioned in this observation will have handrails installed on both sides, extending the length of the defined ramp. 2) Education will be provided to the maintenance department on the 2012 NFPA 101, Life Safety Code pertaining to ramps. 3) The Maintenance Director will communicate the installation of the side rails for the ramp to the quality advisory committee for their information.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of	K 321		5/11/18

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	53A050	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/28/2018**

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STAR VALLEY CARE CENTER	**130 HOSPITAL LANE** **AFTON, WY 83110**

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K 321	Continued From page 3 hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. The deficiency affected one (1) of two (2) smoke compartments. The findings were: Observation on 3/28/2018 at 8:49 AM in the Electrical Room revealed an adjoining mechanical room with fuel-fired water heaters. Further observation revealed the adjoining door frame was rated, but the door could not be verified as rated. Additionally, the door was propped open. Failure to maintain hazardous areas as required can allow fire spread resulting in injury or death. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was aware of the requirement. REF: 2012 NFPA 101, Sections: 19.3.2; 8.7.1.3	K 321	The facility will maintain hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. This will be accomplished by: 1) The door in question will be replaced with a door that can be verified as a fire rated door. This new door will also have an automatic door closer installed. 2) The rest of the facility will be screened by the maintenance department to ensure that all fire rated doors have documentation verifying that they are indeed fire rated. 3) Education to be provided to the maintenance staff on ensuring that all fire doors have verification that they are fire rated.	

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	53A050	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/28/2018**

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K 321	Continued From page 4	K 321	4) The Maintenance Director or designee will report the results of the screening of the facility for fire doors to the quality advisory committee for review. These fire doors will also be checked annually and documented, then reported to the quality advisory committee for review.	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm and Signaling Code. The deficiency affected one (1) of one (1) fire detection systems. The findings were: Observation on 3/28/2018 at 9:05 AM at the fire alarm annunciator panel revealed that the Underwriter's Laboratory certification for the fire alarm had expired in March 2017. Failure to maintain fire alarm systems as required could cause system failure resulting in injury or death. Interview with the Facility Maintenance Manager at the time of observation acknowledged the deficiency, and indicated he was aware of the	K 345	The facility will maintain fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm and Signaling Code. This will be accomplished by: 1) Maintenance will obtain a current Underwriters Laboratory certification for the fire alarm systems. 2) The facility will perform an itemized testing of all the audible and visible fire alarm system devices which will include device type, address, location and test result.	5/11/18

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K 345	Continued From page 5 requirement. REF: 2012 NFPA 101, Section: 9.6.1.3 2010 NFPA 72, Section: 27.3.7.4.2 Based on document review and staff interview the facility failed to maintain fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm and Signaling Code. The deficiency affected two (2) of two (2) smoke compartments. The findings were: Document review on 3/28/2018 at 9:25 AM revealed the facility could not verify that the required annual testing of audible and visible devices of the fire alarm system had been performed during the previous 12 months. Device test results are required to be itemized with the following information: device type, address, location, and test result. Failure to maintain fire alarm systems as required could cause system failure resulting in injury or death. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was unaware of the requirement. REF: 2012 NFPA 101, Sections: 19.3.4.1; 9.6.1.5 2010 NFPA 72, Sections: 14.4.5; 14.6.2.4	K 345	3) Education will be provided to the maintenance department on ensuring that the certification for the fire alarm systems are kept up to date. 4) The Maintenance Director or designee will perform audits monthly to ensure that the certification for the fire alarm system is current. Results of these findings will be reported on the monthly quality calendars and reviewed by the quality advisory committee monthly.	

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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

Electronically Signed | 04/22/2018

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.