STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535045	A. BUILDING **01** B. WING _____	**08/11/2021**

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

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 08/11/2021. .	E 000		
E 042 SS=F	Integrated EP Program CFR(s): 483.73(f) §416.54(e), §418.113(e), §441.184(e), §460.84(e), §482.15(f), §483.73(f), §483.475(e), §484.102(e), §485.68(e), §485.625(f), §485.727(e), §485.920(e), §486.360(f), §491.12(e), §494.62(e). (e) [or (f)]Integrated healthcare systems. If a [facility] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must- [do all of the following:] (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program. (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered. (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and	E 042		9/17/21

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

Electronically Signed | 09/03/2021

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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E 042	Continued From page 1 is in compliance [with the program]. (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following: (i) A documented community-based risk assessment, utilizing an all-hazards approach. (ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach. (5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide a compliant unified and integrated emergency preparedness program. The findings were: Review of the Emergency Preparedness Plan on 08/11/21 at 2:00 PM revealed that the emergency preparedness plan is set up as a unified and integrated program between the nursing home and hospital however, individual facility-based risk assessments for each separately certified facility were not provided. Interview with the facility administrator acknowledged the deficiency, and revealed they were unaware that this requirement	E 042	The facility will ensure compliance by providing a unified and integrated emergency preparedness program. The facility will conduct an individual separate facility-based risk assessment for the Care Center by the completion date. Recommendation will be taken to the facility emergency preparedness committee by Sept 17th to ensure moving forward this requirement for the individual program specific to the Care Center is carved out of the overall facility committee emergency preparedness committee at the next committee meeting. All residents have the potential to be affected by the failure to ensure a unified	

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E 042	Continued From page 2 was missing from the plan. .	E 042	and integrated preparedness program in accordance with the regulations. Audit to be conducted to ensure annual review to ensure the individual risk assessment and elements specific to Care Center emergency preparedness are separated and annual audit results will be reported to QAPI steering committee, Care Center (CC) Medical Director and Care Center (CC) Administrator.	
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on August 11th, 2021. Requirements for Long Term Nursing Homes Section 42 CFR 483.700(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, two-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 77. .	K 000		
K 100 SS=D	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are	K 100		10/15/21

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K 100	Continued From page 3 deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire-resistive construction in accordance with the 2012 NFPA 101 Life Safety Code. Failure to maintain fire-resistive construction could result in injury or death in the event of an emergency. The deficiencies affected one (1) of three (3) 2-hour fire barriers. The findings were: Observation on 08/11/21 at 12:39 PM revealed that the 2-hour fire barrier separating the nursing home from the adjacent hospital had a new door installed that was not fire rated. The door was located in the wall that separated the cafeteria from the recently renovated emergency room department. The door, frame, and glass vision panel did not include labels indicating they were fire rated. Fire-resistive construction must be continuously maintained. Interview with the facility director at the time of the observation acknowledged the deficiency, and indicated that they were aware of the requirement. Interview with the Administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101 18.1.1.1.3, 4.6.12.1,	K 100	The facility will ensure compliance with fire restrictive construction by ensuring a 2 hour fire rated door is installed separating the Care Center from the hospital The 2 hour fire door was ordered on 8/26/21. Delivery time is 6-8 weeks due to long shipping times. The facility will replace the existing door in the cafeteria leading to the ER and separating from the Care Center with an appropriate 2 hour fire rated door. All residents have the potential to be affected by failure to ensure appropriate fire restrictive construction between the Care Center and hospital. Audits will be completed monthly by Plant Operations Maintenance tech or designee to ensure 2 hour fire rated doors separating care center from hospital. Results will be aggregated monthly and reported to QAPI steering committee, CC Med Director and CC Administrator.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		9/17/21

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K 920	Continued From page 4 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to use power strips in accordance with the 2012 NFPA 99 Health Care Facilities Code. Failure to use power strips properly could result in injury or death in the event of an emergency. The deficiencies affected one (1) of six (6) smoke compartments. The findings were: Observation on 08/11/21 at 11:41 AM revealed that in resident room 411A power strips were outside the patient care vicinity that were being	K 920	The facility will ensure compliance with the use of approved power cords for patient/resident care equipment. The power strip in room 411A has been removed and replaced with an approve power strip with the appropriate UL 1363 label on the strip. The staff will be educated regarding the approved power strips and uses for those in accordance with the guidelines in this regulation. All residents have the potential to be affected by failure to ensure the use of	

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K 920	Continued From page 5 used for non-patient care electrical equipment. The room did not have any patient care related electrical equipment in it. At the time of the survey it could not be confirmed if the power strips met any UL listing. Resident rooms without patient care related electrical equipment must have UL 1363 listed power strips for use with non-patient care related equipment. Interview with the facility director at the time of the observation acknowledged the deficiency, and indicated that they were aware of the requirement. Interview with the Administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 99 10.2.3.6, CMS S&C: 14-46-LSC	K 920	approve power cords. Audits will be conducted monthly to ensure no unapproved power strips. The information will be aggregated and reported quarterly at QAPI steering committing, CC Med Director, and CC Administrator	