STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A050	A. BUILDING **01** B. WING _____	**06/23/2022**

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
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 06/23/2022.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.	E 004		7/26/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/15/2022

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 004	Continued From page 1 * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to update the emergency preparedness plan on an annual basis as required. Failure to update the emergency preparedness plan could result in out-of-date procedures or policies in the event of an emergency. The findings were: Document review of the emergency preparedness plan on 06/23/2022 starting at 10:45 AM revealed that no documentation was available to demonstrate the date of the most recent review and update of the emergency plan was performed within the past twelve (12) months. Interview with the facility administrator and maintenance director at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	E 004	E004 Develop EP Plan, Review and Update Annually A. Immediate Action Taken: We began updating and reviewing our Emergency Preparedness plan on 7/15/2022. This will go to the Quality and Safety Committee on 7/19/2022 and the Board Meeting on 7/26/2022 for final review and approval. B. The Potential to Affect Other Residents: All residents, staff and visitors have the potential to be affected by an emergency and the facilities emergency plan. C. Systemic Changes: The Emergency Management position was reassigned to the EMS director for direct oversight due to his expertise in emergency management. The policy was set to be updated and reviewed annually in our policy system. The next review date for updates is set for 7/1/2023 and for the board review it is 7/25/2023. D. How Performance Will Be Monitored: The Emergency Manager or designee will continue to set the reminder date for	

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E 004	Continued From page 2	E 004	review to annual in our policy system. This will be reported to the Quality and Safety Oversite committee on an annual basis. Continuing education to staff will be provided as deemed necessary if any noncompliance is noted.	
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance.	E 031		7/26/22

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E 031	Continued From page 3 *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to develop and maintain emergency preparedness contact information in accordance with §483.73(c). Failure to develop and maintain the emergency preparedness contact information could result in the supervising agency not being notified in an emergency. The deficiency affected the contact list in the emergency preparedness plan. Document review on 06/23/2022 starting at 10:45 AM revealed that the contact list in the emergency preparedness plan was missing contact information for: The State Licensing and Certification Agency, and the Office of the State Long-Term Care Ombudsman. Interview with the facility administrator and maintenance director at the time of observation acknowledged the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency.	E 031	E031 Emergency Officials Contact Information A. Immediate Action Taken: An Emergency Preparedness Communication plan was added within the Emergency Management plan. The following numbers were added: 1. Federal, state, tribal, regional, and local emergency preparedness staff 2. The state Licensing and Certification Agency 3. The Office of the State Long-Term Care Ombudsman 4. The State Protection and Advocacy Agent The policy will go to the board meeting on 7/26/2022 for final review. B. The Potential to Affect Other Residents: All residents, staff and visitors have the potential to be affected by an emergency and the facilities emergency plan. C. Systemic Changes: The Emergency Management position was reassigned to the EMS director for direct oversight due to his expertise in emergency management. The emergency manager, or designee, will stay up to date on all current regulations surrounding emergency management and update the	

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E 031	Continued From page 4	E 031	policy as necessary to reflect any new or updated regulations. This includes updating any phone numbers of above listed agencies. D. How Performance Will Be Monitored: The Emergency Manager, or designee, will audit the policy for applicable regulations regarding Emergency management and updated numbers quarterly for the next year.	
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 06/23/2022. 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 19 residents	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:	K 324		8/1/22

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K 324	Continued From page 5 * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect cooking facilities in accordance with the 2012 NFPA 101, Life Safety Code. Failure to protect cooking facilities could result in injury or death in the event of a fire. The deficiency may affect staff working within the kitchen. The findings were: Observation on 06/23/22 at 9:00 AM revealed a wheeled gas cooktop under a commercial exhaust hood located in the facility's kitchen. Observation of the cooktop revealed that no means was provided to ensure it is returned to the approved location after being moved. Cooking	K 324	K324 Cooking Facilities A. Immediate Action Taken: Caster placement set ordered on 7/13/2022 that will ensure cooking equipment is returned to the proper location under the kitchen hood. The estimated time of arrival is 7-10 days (the week of 18th-25th). Once they arrive, they will be installed immediately. B. The Potential to Affect Other Residents: All residents, staff and visitors have the potential to be affected. C. Systemic Changes: Once the equipment arrives, it will be installed. Education will be provided to all kitchen staff at that time regarding the importance of returning all cooking appliances	

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K 324	Continued From page 6 appliances requiring fire-extinguishing protection shall be provided with a means of returning to the approved location after being moved for cleaning or maintenance purposes. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and indicated he was not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.3.2.5.5 and 9.2.3. 2011 NFPA 96, Section 12.1.2.3	K 324	requiring fire-extinguishing protection to the approved location after being moved for cleaning or maintenance. D. How Performance Will Be Monitored: The kitchen director, or designee, will audit the location of the wheeled gas cooktop weekly for 4 weeks once equipment is installed.	
K 345 SS=D	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 document review and staff interview, the facility failed to inspect and test the fire alarm system in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain the fire alarm system as required could impact all residents, staff, and visitors within the facility. The deficiency impacted	K 345	K345- Fire Alarm System- Testing and Maintenance A. Immediate Action Taken: Our fire alarm system batteries are checked by Fire Services of Idaho. They were contacted on 7/14/2022 to notify them of the requirement to move the testing to a semi-annual basis. On 7/14/2022 an	7/22/22

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K 345	Continued From page 7 one (1) of numerous testing requirements. The findings were: Document review on 06/23/2022 starting at 10:15 AM of the fire alarm testing reports revealed that the required semi-annual testing of batteries had been performed in April of 2022, but no information was available to indicate that a second test had been performed during the past twelve (12) months. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and indicated that he was aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: NFPA 72, Table 14.3.1(3)(d)	K 345	appointment was scheduled for 7/22/2022 to come complete the second battery check. B. The Potential to Affect Other Residents: All residents, staff and visitors have the potential to be affected. C. Systemic Changes: Fire Services of Idaho will complete testing semiannually. They are aware and have agreed to these requirements on 7/14/2022. D. How Performance Will Be Monitored: The maintenance director, or designee, will audit the fire alarm system battery checks are completed semiannually for the next year. The checks have been added to the maintenance binder to be completed. The results of the audit will be provided in the Quality and Safety Oversite Committee.	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 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	K 918		7/21/22

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K 918	Continued From page 8 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, readily identifiable, and separate from normal power circuits. 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 REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and inspect the emergency generator in accordance with the NFPA 101, Life Safety Code, and the 2010 NFPA 110, Standard for Emergency and Standby Power systems. Failure to test and inspect the emergency generator as required could result in system failure, which could impact all staff, residents, and visitors within the facility during an emergency. The deficiency affected one (1) of numerous testing requirements. The findings were: Document review on 06/23/2022 starting at 10:15 AM revealed no documentation was available to demonstrate that the monthly maintenance of batteries had been performed.	K 918	K918- Electrical Systems- Essential Electric System A. Immediate Action Taken: A conductance battery tester was ordered on 6/23/2022. Upon its arrival, monthly maintenance of the batteries will be performed. B. The Potential to Affect Other Residents: All residents, staff and visitors have the potential to be affected. C. Systemic Changes: The monthly battery maintenance for the emergency generator was added to the maintenance quality calendar and will be completed and documented monthly. Education will be provided to all maintenance staff on 7/21/2022 of this requirement. D. How Performance Will Be Monitored:	

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K 918	Continued From page 9 Interview with the maintenance director at the time of observation acknowledged the deficiency, and indicated he was not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: NFPA 110, Section 8.3.7.1	K 918	The maintenance director, or designee, will audit the battery maintenance was completed monthly x 4 months.	