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 _____	**09/13/2022**

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 09/13/2022. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E 000		
E 026 SS=F	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.	E 026		10/28/22

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

Electronically Signed | 09/27/2022

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E 026	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to include a policy addressing 1135 waivers in accordance with §483.73(b)(8). Failure to include a policy addressing 1135 waivers could result in the facility improperly utilizing or requesting 1135 waivers. The deficiency affected the emergency preparedness plan. The findings were: Document review on 09/13/2022 starting at 12:00 PM revealed that the Emergency Preparedness Plan (EPP) did not include a policy that addressed the role of the facility under a 1135 waiver. Interview with administrator at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency.	E 026	The facility will ensure compliance by developing and writing a policy that addresses the role of the facility under an 1135 waiver to include with the overall Emergency Preparedness Plan. The policy will be written by 09/30/22. The policy will be presented and approved by the emergency prepardness committee by 10/28/22. All residents have the potential to be affected by the failure to address the appropriate processes to obtain an 1135 waiver per the regulations. Annual audit of the emergency preparedness plan to include all necessary policies are included and up to date.	
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	E 031		10/28/22

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E 031	Continued From page 2 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. *[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 include all emergency officials contact information in accordance with §483.73(c)(2). Failure to include all emergency officials contact information could result in agencies being unaware of emergency conditions at the facility. The deficiency affected the emergency preparedness plan. The findings were:	E 031	The facility will ensure compliance by adding all emergency officials contact information to the emergency preparedness plan by 09/30/22. This will be taken back to the emergency preparedness committee for approval by 10/28/22. All residents have the potential to be affected by not having complete contact information as they could be required in	

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E 031	Continued From page 3 Document review on 09/13/2022 starting at 12:00 PM revealed that the Emergency Preparedness Plan (EPP) did not include contact information for the State Licensing and Certification Agency and the Office of the State Long-Term Care Ombudsman. Interview with administrator at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency.	E 031	the case of an emergency. Annual audit of the emergency preparedness plan to include ensuring all appropriate emergency numbers are included.	
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 09/13/2022. Requirements for Long Term Care Facilities Section 42 CFR 483.90(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, one story building of Type II (000) construction built in 1995. The building was equipped with a supervised, automatic wet sprinkler system and an addressable fire alarm system. The facility had a capacity of 100 certified Medicare and Medicaid beds with a census of 56 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90(a).	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101	K 324		10/28/22

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K 324	Continued From page 4 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * 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 properly protect cooking facilities could result in the spread of smoke and fire, which could result in injury or death. The deficiency could impact all staff within the kitchen. The findings were:	K 324	The facility will ensure compliance by placing permanent markings on the floor to indicate the approved location of all cooking appliances requiring fire-extinguishing protection should they be moved for cleaning or maintenance. Facilities management and the nutrition services director or designee will collaborate to paint permanent marking in the appropriate places by 10/28/22.	

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K 324	Continued From page 5 Observation on 09/13/2022 at 10:56 AM revealed a gas-fire cook-top under a commercial exhaust hood located in the facility's kitchen. Observation of the cook-top revealed that no means was provided to ensure it is returned to the approved location after being moved. Cooking appliances requiring fire-extinguishing protection shall be provided with a means of return to the approved location after being moved for cleaning or maintenance purposes. Interview with the facilities management at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.2.5.5, 9.2.3; 2011 NFPA 96 12.1.2.3	K 324	All residents and staff of the kitchen have the potential to be affected as this is a safety concern that could result in the spread of smoke and fire resulting in injury or death. Education by the nutrition services director or designee will be provided to all kitchen staff to make them aware of the importance of replacing equipment to the approved location by 10/28/22. The nutrition services director or designee will audit and keep records of those staff that attend the education.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 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 _____ c) Water system supply source	K 353		10/28/22

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K 353	Continued From page 6 _____ 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 REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire sprinkler system in accordance with the 2011 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to properly test and maintain the fire sprinkler system could result in the failure of the system, which could result in injury or death during an emergency. The deficiency could impact all residents, visitors, and staff in the facility. The findings were: Document review on 09/13/2022 at starting at 11:30 AM revealed that the water flow alarm devices associated with the fire sprinkler system were not tested as required. Document review revealed that the water flow alarm devices were tested 3 times in the last 12 months and not once every quarter as required. Interview with the facilities management at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2011 NFPA 25 5.3.3.1	K 353	The facility will be in compliance with NFPA25, Standard for the Inspection, Testing, and maintaining of Water-based Fire Protections Systems. In review of the documentation, the contracted company had conducted an annual and a quarterly at the same time, not providing adequate documentation of the quarterly test. Facility management staff will verify that tests completed included the annual and the quarterly. If so, will provide documentation of same. If not, a test will be scheduled no later than 10/28/22. This has the potential to affect all residents, visitors and staff in the facility as inappropriate maintenance of the sprinkler system could result in the failure of the system resulting in injury of death during an emergency. Facilities Director or his designee will provide documentation of the sprinkler tests to the Administrator, Medical Director, QAPI Steering Committee, and Quality Council. The QAPI Steering Committee will ensure overall compliance.	