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 _____	**07/17/2024**

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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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 07/17/2024. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E 000		
E 025 SS=F	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(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:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The	E 025		8/12/24

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

Electronically Signed | 07/30/2024

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 025	Continued From page 1 development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to develop and implement emergency preparedness policies and procedures as required. Failure to develop and implement emergency preparedness policies and procedures as required could result in a delayed response during an emergency leading to injury or death. The findings were: Document review on 07/17/2024 starting at 10:00 AM revealed the facility was not able to provide documentation demonstrating that they had developed an arrangement with other LTC facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to patients. Interview with administrative staff at the time of observation confirmed the deficiency, and indicated that they were aware of the requirement. Interview with administrative personnel at the time of exit confirmed the deficiency.	E 025	E025 Arrangement with Other Facilities A. Immediate Action Taken: All transfer agreements were reviewed. It was found that we do have a current agreement in place with St. Johns/Sage Living for evacuations required as a result of a disaster/emergency. Two other homes were contacted, Sublette Center and South Lincoln Nursing Center, both agreeing to enter into transfer agreements with one another in case of evacuations in our respective areas. Those agreements are currently being reviewed by our legal team and will be sent out for signatures by August 12th, 2024. 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: All administrative staff were educated on the requirements on 7/30/2024. Education on where the agreements are housed was also	

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E 025	Continued From page 2	E 025	provided. Each agreement has a review date within the system and reminders are sent out if the agreement is expired or needs renewed soon. D. How Performance Will Be Monitored: The long-term care administrator, or designee, will audit this monthly until substantial compliance is achieved.	
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 07/17/2024. 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 Medicaid beds with a census of 18 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the	K 351		8/2/24

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K 351	Continued From page 3 Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency affected one sprinkler head in the facility, and has the potential to affect all staff in the kitchen. The findings were: Observation on 07/17/2024 at 9:04 AM in the food freezer revealed a fire sprinkler head with the escutcheon missing, exposing the annular space. Interview with the maintenance manager at the time of observation confirmed the deficiency, and indicated he was aware of the requirement. Interview with administrative personnel at the time of exit confirmed the deficiency. REF: 2010 NFPA 13, Sections: 6.2.7.1	K 351	K351 Sprinkler System-Installation A. Immediate Action Taken: Maintenance has ordered the necessary parts to ensure the annular on the fire sprinkler is not exposed. B. The Potential to Affect Other Residents: All residents, staff, and visitors have the potential to be affected. C. Systemic Changes: The escutcheon on the fire sprinkler in the walk-in freezer will be installed by 8/2/2024. Education was provided to the kitchen staff to ensure the monitoring of the fire sprinklers and that the sprinkler head should not have the escutcheon missing, exposing the annular space on 7/29/2024. D. How Performance Will Be Monitored: Maintenance will perform monthly audits on all fire sprinklers within the care center until substantial compliance is achieved.	

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K 372	Continued From page 4	K 372		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a smoke-proof membrane as required by NFPA 101, Life Safety Code. Failure to maintain a smoke-proof membrane as required could result in the propagation of smoke and fire through annular spaces. The deficiency affected two (2) of multiple spaces throughout the facility. The findings were: Observation on 07/17/2024 at 9:01 AM in the kitchen revealed a ceiling tile that was missing/moved to accommodate communications wiring. This deficiency was repeated in the beauty salon. Interview with the maintenance manager at the time of observation confirmed the deficiency, and indicated that he was aware of the requirement.	K 372	K372-Subdivision of Building Spaces-Smoke Barrier Construction A. Immediate Action Taken: The reported ceiling tiles noted have been placed into their proper positioning. B. The Potential to Affect Other Residents: All residents, staff, and visitors have the potential to be affected. C. Systemic Changes: Education was provided to the IT staff on 7/29/2024 and Maintenance staff on 7/30/2024 and will be provided on 8/13/2024 to all care center staff regarding the importance of environmental rounds to ensure all ceiling tiles remain in their correct position, and to notify maintenance if they are out of place. D. How Performance Will Be Monitored: Environmental rounds will be assigned to the care center department director, or	8/13/24

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K 372	Continued From page 5 Interview with administrative personnel at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101 Sec. 19.3.2.5.3, 19.3.7.3, 8.5	K 372	designee, to be completed throughout the facility, noting any variances in ceiling tiles, until substantial compliance is achieved.	
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to perform annual testing and maintenance of main and feeder circuit breakers in accordance with NFPA 99, Health Care Facilities Code. Failure to routinely test and maintain main and feeder circuit breakers could allow mechanical failures to go undetected, leading to power loss within the facility, which could result in injury or death. The deficiency could impact all residents, staff, and visitors in the facility. The findings were: Document review on 07/17/2024 starting at 10:00 AM revealed that the facility could not provide documentation demonstrating that overload trip conditions were used during the annual testing of main and feeder circuit breakers. Main and feeder circuit breakers shall be inspected annually, and a program for periodically exercising the components shall be established.	K 911	K911- Electrical Systems- Other A. Immediate Action Taken: The maintenance director contacted an outside company to get a quote to come out and test the care centers breakers. B. The Potential to Affect Other Residents: All residents, staff, and visitors have the potential to be affected. C. Systemic Changes: Education was provided on 7/30/2024 to all maintenance staff regarding the requirements for circuit breaker testing and potential solutions. D. How Performance Will Be Monitored: We will continue to test the breakers internally until we are able to contract with an outside company, or any other company performing the required testing. We may potentially need to investigate and submit a request for a variance until a sustainable long-term solution can be	8/12/24

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K 911	Continued From page 6 Main and feeder circuit breakers should be tested under simulated overload trip conditions. Interview with administrative personnel at the time of observation confirmed the deficiency, and indicated that they were aware of the requirement. Interview with administrative personnel at the time of exit confirmed the deficiency. Ref: 2012 NFPA 99 Sec. 6.4.4.1.2	K 911	established. A contract with an outside company, or request for variance, will be completed by August 12th, 2024.	