STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535045	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **08/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Powell Valley Care Center	**777 Avenue H , Powell, Wyoming, 82435**

(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
K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 08/26/2026. Requirements for Long Term Care Facilities Section 42 CFR 483.90 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 V (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 48 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K0000		09/22/2026
K0524 SS = F Bldg. 01	HVAC - Direct-Vent Gas Fireplaces CFR(s): NFPA 101 Direct-Vent Gas Fireplaces Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to properly protect direct-vent gas fireplaces as required in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly protect direct-vent gas fireplaces could result in the spread of carbon monoxide gas, resulting in injury or death. The deficiency affected the activities room and main entrance lobby and has the potential to affect all residents, staff, and visitors. Observation on 08/26/26 at 10:35AM revealed that the facility failed to meet the requirements for	K0524	Electronically monitored Carbon Monoxide detectors will be installed with the upgraded smoke detection system A quote for installation was provided by a 3rd party on 9/21/2026. PVHC Board approval is needed for a capital purchase of that size. PVHC Board meeting was held on 9/28/2026. This project was approved on 9/28/2026 The contractor being used will set the installation date based on availability. This will include at minimum 2 carbon monoxide detectors; one in main lobby and one in the recreation area.	10/31/2026

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 reverse for further 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.

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

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K0524 SS = F Bldg. 01	Continued from page 1 direct-vent gas fireplaces. Observation of the activities room and main entrance lobby revealed a natural gas fireplace. Observations of the spaces revealed that no carbon monoxide detectors were provided. Direct-vent gas fireplaces are acceptable in smoke compartments containing patient sleeping areas provided that the controls are locked or located in a restricted location, and that an electronically supervised carbon monoxide detector is provided in the room where the fire place is located. The carbon monoxide detector shall be provided in accordance with NFPA 720. Interview with facility maintenance personnel at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101, 19.5.2.3(2)	K0524		10/31/2026
K0324 SS = E Bldg. 01	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: * 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 STANDARD is NOT MET as evidenced by:	K0324	Kitchen Hood will receive owners inspection at least monthly starting October 2026. This will be completed by facilities department. Monthly inspection will occur by the last day of the month. Quality Assurance will be executed by either administrator or nutrition director by the 10th day of the month following for compliance. This will be done a total of 6 times concluding April 10, 2027. Documentation of the monthly inspection will be on the WYO safety fire tag located on the pull handle in the kitchen nearest the entrance of the pantry and sink. A photo of the monthly inspection tag will be captured and kept on a word document for quality assurance through April 2027.	10/31/2026

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K0324 SS = E Bldg. 01	Continued from page 2 Based on document review and staff interview, the facility failed to inspect the kitchen hood extinguishing system as required in accordance with the 2012 NFPA 101, Life Safety Code, and 2009 NFPA 17A, Standard for Wet Chemical Extinguishing Systems. Failure to properly inspect the kitchen hood extinguishing system could result in the spread of smoke and fire, resulting in injury or death. The deficiency affected the kitchen and could potentially affect all staff and visitors in the kitchen. Document review on 08/26/26 starting at 11:15 AM revealed that the facility failed to conduct the monthly owner's inspection of the kitchen hood extinguishing system as required. No documentation was available at the time of the survey to confirm the kitchen hood extinguishing system had been inspected as required. Kitchen hood extinguishing systems shall be inspected monthly to verify the extinguishing system is in its proper location, the manual actuators are unobstructed, the tamper indicators and seals are intact, the maintenance tag is in place, no obvious damage, the pressure gauges are in the operable range, the nozzle blowoff caps, are intact and undamaged, and the equipment has not been replaced, modified, or relocated. Interview with the facilities director 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 confirmed the deficiency. Ref: 2012 NFPA 101 19.3.2.5.1, 9.2.3; 2011 NFPA 96 10.2.6; 2009 NFPA 17A 7.2	K0324		10/31/2026

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E0000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 08/26/2026. Based on the findings of the survey team, it was determined that the facility was in compliance with all requirements in accordance with 42 CFR 483.73.	E0000		09/22/2026

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