DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535045	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL VALLEY CARE CENTER	777 AVENUE H POWELL, WY 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
K 000	INITIAL COMMENTS 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 2000 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, 1-story building of Type II (111) 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 81.	K 000	**K021** The facility shall provide protection of hazardous areas from adjacent corridors and non-hazardous rooms. A. The Engineering Technician will order and install the appropriate closure for the storage room door located in the Physical Therapy room. B. All residents, visitors, and staff members have the potential to be affected by failure to provide protection of hazardous areas from adjacent corridors and non-hazardous rooms. C. Education will be provided to all Engineering Technicians regarding the need to ensure doors in hazardous areas have appropriate closures. The Plant Operations Director or designee will perform monthly visual inspections of all doors located in hazardous areas to ensure the proper closures as required D. The Plant Operations Director will aggregate monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall	
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by:	K 021		

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

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.

Nicole Ostermiller Administrator 5/20/14

POC ACCEPTED ON 05/27/14 W/NICOLE OSTERMILLER. JW

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K 021	Continued From page 1 Based on observation and interview, the facility failed to provide protection of hazardous areas from adjacent corridors and non-hazardous rooms in 1 of 8 smoke compartments. The findings were: Observation of the Storage Room located in Physical Therapy on 04/02/14 at 3:05 PM showed the door to this hazardous area did not have a closer. Interview with the facility maintenance personnel at the time of the observation confirmed that the hazardous area was not provided with a door closer.	K 021	responsibility to ensure the facility is in compliance. Completion Date **K038** The facility shall identify a door that is neither an exit nor a way of exit but is likely to be mistaken for an exit. 1. A. The Engineering Technician will order and install a "No Exit" sign above the exterior door in the Physical Therapy room. B. All residents, staff, and visitors have the potential to be affected by failure to display appropriate signage above exterior doors that are not an exit C. Education will be provided to all Engineering Technicians regarding the need to ensure any exterior doors without a means to exit have "No Exit" signage. The Plant Operations Director or designee will perform monthly visual inspections to all exterior doors that are neither an exit or a way to exit has signage indicating "No Exit." D. The Plant Operations Director will aggregate random monthly data and report results to the Administrator, Care Center	05/12/2014
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: 1) Based on observation and interview, the facility failed to identify a door that is neither an exit nor a way of exit access that is likely to be mistaken for an exit in 1 of 8 smoke compartments. The findings were: Observation of an exterior door in the Physical Therapy Room on 04/02/14 at 3:06 PM revealed an exterior door with no panic hardware that could be mistaken for an exit. The door was not provided with signage indicating " NO EXIT ". Interview with the facility maintenance staff at the time of the observation confirmed that the door could easily be mistaken as an exit.	K 038		

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K 038	Continued From page 2 2) Based on observation and interview, the facility failed to provide doors in a means of egress equipped with an approved entrance and egress access control system in 1 of 8 smoke compartments. The findings were: Observation of the doors into the secure Alzheimer unit located near Rooms 307 and 309 on 04/02/14 at 2:11 PM revealed that the doors were not provided with a sensor on the egress side to detect an occupant approaching the doors and that the doors would not unlock in the direction of egress. Interview with the facility maintenance staff at the time of the observation confirmed that the occupant sensor was not provided.	K 038	Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. 2. A. The Plant Operations Director will obtain quotes and acquire services for installation of appropriate sensor for the egress side of the doors into the special care unit. Plans for this installation will be submitted to the state for approval and upon approval the sensor will be installed.	05/12/2014
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to cap all gas outlets where equipment has been disconnected and the outlet is not used again immediately per NFPA 54, Section 3.8.2. The findings were: Observation of gas piping behind the cook line in the Kitchen on 04/02/14 at 1:17 PM revealed that equipment had been removed and that the	K 067	B. All residents, staff, and visitors have the potential to be affected by failing to provide doors in a means of egress equipped with an approved entrance egress access control system. C. The Facilities Director or designee will perform monthly audits to ensure the doors provide a means of egress according to K038. D. The Facilities Director will aggregate monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date Waiver Requested.	

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K 067	Continued From page 3 remaining gas piping had been left open downstream of the shut-off valve. Interview with the facility maintenance staff at the time of the observation acknowledged that the piping had not been capped after removal of the equipment.	K 067	K067 The facility shall cap all gas outlets where equipment has been disconnected and the outlet is not used. A. The remaining gas piping has been capped by the Engineering Technician. B. All residents, staff, and visitors have the potential to be affected by failure to cap gas outlets after removal of equipment. C. Education will be provided to all Engineering Technicians regarding the need to cap any remaining gas pipes after removal of equipment. The Plant Operations Director or designee will perform monthly visual inspections to ensure any remaining gas piping has been capped. D. The Plant Operations Director will aggregate random monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide the minimum safety requirements for cooking equipment per NFPA 96. The findings were: Observation of the deep fat fryer in the Kitchen on 04/02/14 at 1:17 PM revealed that a minimum 16 inch space had not been provided to the adjacent griddle per NFPA 96, Section 12.1.2.4. Interview with the facility maintenance staff at the time of the observation acknowledged that the separation distance was not provided. Additional observation and interview revealed that the existing hood did not allow the equipment to be adjusted while maintaining the required positioning under the hood. The facility maintenance staff agreed to investigate the addition of a splash guard to protect the griddle from fryer oil.	K 069	Completion Date 05/12/2014	

K069

The facility shall ensure that minimum safety requirements for cooking equipment are met.

A. A splash guard will be installed to the griddle to provide protection from fryer oil.

B. All residents, staff, and visitors have the potential to be affected by failure to ensure safety requirements are met for cooking equipment.

C. The Facilities Director or designee will perform monthly inspections to ensure the splash guard is in place to prevent fryer oil from splashing on the griddle.

D. The Facilities Director will aggregate monthly data and report results to the Administrator, Care Center Medical Director and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance.

Completion Date 05/12/2014