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

PRINTED: 04/02/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY CARE CENTER	60 MAGNOLIA CASPER, WY 82604

(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 this 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 (NFPA). The facility was a fully sprinkled single story building, the west wing is of Type V (000) and the central wing is of Type V (111) with a basement, they were built in 1958 and 1987 respectively. The west wing was equipped with a supervised automatic wet sprinkler system and the central wing was equipped with a dry sprinkler system. The building had an addressable fire alarm system. The facility had a capacity of 192 certified Medicare and Medicaid beds, 126 beds were in these two wings.	K 000		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure smoke barrier doors were smoke resistant in 2 of 9 smoke compartments.	K 027	K 027 Door openings in smoke barriers have at least a 20-minute fire protection or are at least 1 ¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14 Doors are self closing or automatic closing in accordance with 19.2.2.2.6 Swinging doors are not required to swing with egress and positive latching is not required.19.3.7.5, 19.3.7.6, 19.3.7.7 RECEIVED Wyoming Dept of Health APR 29 2010 Office of Healthcare Licensing and Surveys	

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

Jay Elliott III — CEO / Administrator — 4-28-10

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.

FAX Copy to w/ Jim Elliot, NHA, on 4/29/10.

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K 027	Continued From page 1 The findings were: 1. Observation on 3/23/10 at 9:10 AM showed the cross corridor smoke barrier doors near resident room #215 were equipped with automatic closing devices. Further review showed one of the devices was not able to fully latch the door into the frame, with three attempts. At the time of observation the maintenance director reported all corridor doors were inspected quarterly. 2. Observation on 3/23/10 at 3:33 PM showed the attic smoke barrier door near resident room #211 was not smoke resistant. When the door was fully closed there was a 1/4 inch gap between the door and its frame. The maintenance director confirmed the door was not smoke resistant at the time of observation.	K 027	K 027 This will be accomplished by: 1. The cross-corridor smoke barrier doors near resident room 215 will be adjusted so that the doors are able to fully latch. 2. The attic smoke barrier door near resident room 211 will be adjusted so that the gap between the door and its frame will be less than 1/8 of an inch 3. Maintenance staff will be in-serviced to the deficiency. 4. The Facilities Director or designee will conduct smoke barrier inspections quarterly to ensure proper function. 5. The Facilities Director or designee will report inspection results to the Quality Assurance team no less than quarterly for a period of not less than 6 months.	3/23/2010 3/25/2010 3/25/2010 3/25/2010 3/25/2010
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure hazardous areas were separated from use areas in 2 of 9 smoke	K 029	K 029 One hour fire rated construction (with ¾ hour fire rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1. and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are to be self closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	

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K 029	Continued From page 2 compartments. The findings were: 1. Observation on 3/23/10 at 11:50 AM showed the medical records storeroom door was held open by a piece of rope. At the time of observation the maintenance director reported that he was aware that doors to hazardous areas were supposed to close automatically. He further reported that the medical records staff had been trained regarding this issue. 2. Observation on 3/23/10 at 1:41 PM showed the corridor door to the soiled utility room near resident room #28 was equipped with an automatic closing device. The closing device was not able to fully latch the door into the frame, with three attempts.	K 029	K029 This will be accomplished by: 1. The rope will be removed from the medical records storage room. 2. The automatic door closing device on the corridor door leading to the soiled utility room near resident room number 28 will be adjusted so that the door fully latches into the frame. 3. All staff will be in serviced to the deficiency. 4. The Facilities Director or designee will conduct quarterly inspections on all doors leading to hazardous areas to ensure that they are not impeded from properly closing. 5. The Facilities Director or designee will report inspection results to the Quality Assurance team no less than quarterly for a period of not less than 6 months.	3/23/2010 3/23/2010 3/30/2010 3/23/2010 3/23/2010
K 038 SS=E	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: Based on observation and staff interview the facility failed to ensure delayed egress locks were posted with operating instructions in 1 of 9 smoke compartments. The findings were: Observation on 3/23/10 at 10:42 AM showed the exit door in the Skartrud dining room was equipped with a delayed egress lock. The door did not have a signage that provided instructions for exiting the building. At the time of observation the maintenance director reported he was aware	K 038	K 038 Exit access is arranged so that all exits are readily accessible at all times in accordance with section 7.1, 19.2.1 This will be accomplished by: 1. A sign stating "Push Until Alarm Sounds Door Can Be Opened In 30 Seconds" with 1 inch letters on a contrasting background will be placed on exit door in the Skatrud dining room.	4/13/2010

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K 038	Continued From page 3 of the sign requirement, did not know why the door did not have a sign.	K 038	K 038 2. The Facilities Director or designee will conduct monthly inspections on all delayed egress doors to ensure that the proper signage is provided.	3/25/2010
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	3. The Facilities manager or designee will report inspection results to the Quality Assurance team no less than quarterly for a period of not less than 6 months.	3/25/2010
	This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure 1 of 7 fire alarm system components were completely tested. The findings were: Review of the fire alarm system testing records documented that the system was not activated during the month of May 2009. On 3/22/10 at 5:30 PM a member of the maintenance staff reported that he was aware of the requirement and thought the fire drills covered the monthly activation. He further confirmed the system had not been activated last May after calling the central monitoring service.		K 052 A fire alarm system required by life safety is installed, tested and maintained in accordance with NFPA 70 National Electric Code and NFPA 72. The system has an approved maintenance and testing complying with applicable requirements of NFPA 70 and 72 9.6.1.4 This will be accomplished by: 1. The fire alarm will be activated monthly in accordance with NFPA 70 and 72.	3/25/2010
			2. Maintenance staff will be in-serviced to the deficiency.	3/25/2010
			3. The Facilities Director or designee will conduct monthly record reviews to ensure that all maintenance and testing is done and has been properly documented.	3/25/2010
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to	K 056	4. The facilities Director will report the results of the record review to the Quality Assurance team no less than quarterly for a period not less than 6 months.	3/25/2010

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K 056	Continued From page 4 provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 2 of 9 smoke compartments had complete sprinkler coverage. The findings were: 1. Observation on 3/23/10 at 10:04 AM showed the sprinkler in the alcove near the minimum data set coordinators' office was 13 feet from the side wall. At the time of observation the maintenance director reported he was aware of the spacing requirement. He further reported that a sprinkler contractor conducted the annual inspection, and this area had not been noted on the last report. 2. Observation on 3/23/10 at 10:12 AM showed the sprinkler in the closet of resident room #204 was located less than 1 inch from the wall. At the time of observation the maintenance director reported this sprinkler had just been replaced by the sprinkler contractor during a system upgrade. He could not explain why the contractor installed a sprinkler within 4-inches of the wall. 3. Observation on 3/23/10 at 10:57 AM showed	K 056	K 056 If there is an automatic sprinkler system, it is installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems, to provide complete coverage for all potions of the building. The system is properly maintained in accordance with NFPA 25 Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electronically connected to the building fire alarm system. 19.3.5 This will be accomplished by: 1. A request for waiver will be submitted to eh OHLS. — 4/27/2010 2. Plan of approval will be sought and obtained for the installation of additional sprinkler heads for area outside of MDS office and room 35 with no more than 7 1/2 feet from the side wall and cross corridors. — 6/27/2010 3. Facility will request a plan approval from OHLS engineering department. — 7/15/2010 4. Installation of aforementioned additional sprinkler heads will be completed. — 7/27/2010 5. Final inspection of work performed will be completed. — 8/27/2010	

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K 056	Continued From page 6 the sprinkler in the corridor near resident room #35 was located 11 feet from two cross corridor doors. Further review showed the double doors closed when the fire alarm system was activated. When the doors were in the closed position a three and a half foot space did not have sprinkler coverage.	K 056	6. The sprinkler head in the closet in room 24 will be moved so that it is more than 4 inches away from the wall. 7. Maintenance staff will be in-serviced to the deficiency. 8. The Facilities Director or designee will conduct quarterly inspections on the fire sprinkler system to ensure there is proper sprinkler coverage. 9. Facilities Director or designee will report inspection results to the Quality Assurance Team no less than quarterly for a period of not less than 6 months.	4/15/2010 3/25/2010 3/25/2010 3/25/2010
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure sprinklers were unobstructed in 2 of 9 smoke compartments. The findings were: Observation on 3/23/10 between 9 AM and 3 PM showed the sprinklers in the shower room near resident room #222, the central shower room, and the infant daycare room were all obstructed by ceiling-mounted lights. The sprinklers were installed within 12 inches of the lights and the bottom of the lights were below the level of the sprinkler deflector. At 2:42 PM the maintenance director reported all of the above mentioned sprinklers were recently replaced by an outside contractor. At 3 PM the sprinkler contractor stated he did not know why the sprinklers were installed in obstructed locations.	K 062	K 062 Requires automatic sprinkler system are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This will be accomplished by: 1 The sprinkler head in the shower room near resident 222, the central shower room and in the infant day care room will be lower so the deflector will be at least ½ inch below the bottom of the light fixtures. 2 Maintenance staff will be in serviced to the deficiency.	3/25/2010 3/25/2010
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:	K 143		

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K 143	Continued From page 6 (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 1 liquid oxygen storeroom did not store more liquid oxygen than it was rated for. In addition, the facility failed to ensure the room had proper ventilation or that the room had 1-hour fire-rated separation. The findings were: 1. Observation on 3/23/10 at 11:39 AM showed the liquid oxygen storeroom contained 20 liquid oxygen tanks. Further review showed the room was designed to hold a maximum of 16 tanks. At the time of observation the maintenance director was not aware of the maximum number of tanks permitted. 2. Observation on 3/23/10 at 11:42 AM showed	K 143	3 Facility Director or designee will conduct quarterly inspections to ensure that the sprinkler heads are not obstructed. 4 Facilities Director will report the results of the inspection to the Quality Assurance team no less than quarterly for a period of not less than 6 months. K 143 Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined or treated by a separation of a fire barrier of 1 hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the compressed gas association. 8.6.2.5.2 This will be accomplished by: 1. A request for waiver will be submitted to OHLS. 2. Plan of approval for the installation of a fan exhausting from the oxygen storage room venting into the outside air will be sought.	3/25/2010 3/25/2010 4/27/2010 6/27/2010

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K 143	Continued From page 7 the room was equipped with a ceiling mounted vent. A piece of paper was put in front of the vent and the paper was not pulled toward the vent. A ceiling tile was removed to see if the fan was running. The fan was inserted into the wall that separated the liquid oxygen room and the sprinkler riser room. Observation of the sprinkler riser room showed the fan pushed air while the door was open, but stopped moving air when the room was sealed after the door was closed. At the time of observation the maintenance director reported he was not aware that the fan was required to vent outside to provide adequate air movement. He confirmed the fan was also not equipped with a 1-hour fire damper as required for this type of installation.	K 143	3. Facility will request a plan approval from OHLS engineering department. 4. Installation of aforementioned exhaust fan will be completed according to approved plans. 5. Final inspection of above work performed will be performed. 6. Oxygen room will not house more than 16 oxygen tanks at any given time. 7. Maintenance Staff will be inserviced to the deficiency. 8. The Facilities Director or designee will conduct monthly inspections on oxygen room to ensure proper ventilation and compliance with the number of oxygen tanks stored. 9. Facilities Director or designee will report inspection results to the Quality Assurance Team no less than quarterly for a period of not less than 6 months.	7/15/2010 7/27/2010 8/27/2010 4/15/2010 3/25/2010 3/23/2010 3/25/2010
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure temporary wiring did not replace permanent fixed wiring, failed to replace damaged electrical equipment and failed to ensure electrical receptacles located within 6 feet of a water source had ground fault circuit interrupter (GFCI) protection in 5 of 9 smoke compartments. The findings were: 1. Observation on 3/23/10 at 8:39 AM showed the refrigerator and microwave oven in the restorative office were plugged into a surge protector. The surge protector had a maximum rating of 15 amps. The refrigerator and microwave were both rated at 12 amps, which is combined rating of 24	K 147	K 147 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2 This will be accomplished by: 1. The microwave in the restorative office will be moved and plugged into a separate receptacle. 2. The oxygen concentrator in resident room 218 will be replaced with a new one	3/25/2010 3/25/2010

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K 147	Continued From page 8 amps. At the time of observation the maintenance director reported the electrical systems in offices were only inspected semi-annually. 2. Observation on 3/23/10 at 8:43 AM showed the power cord to the oxygen concentrator in resident room #218 was cut near the plug. As a result,the inner insulation of the cord was visible. At the time of observation the maintenance director reported the electrical systems in resident rooms were only inspected quarterly. 3. Observation on 3/23/10 at 8:51 AM showed the electrical receptacle near bed "A" in resident room #222 had a grounding blade broken off inside the top receptacle. Observation showed the grounding blade came from the power cord for the bed. At the time of observation the maintenance director reported the nursing staff should have noticed the damaged cord and submitted a work order to the maintenance department for repairs. 4. Observation on 3/23/10 at 9:49 AM showed the computer in the MDS (minimum data set) office was plugged into two surge protectors, in-line. At the time of observation the maintenance director reported he was aware that the plugging one surge protector into another was prohibited by the Life Safety Code. 5. Observation on 3/23/10 between 9:30 AM and 11 AM showed the electrical receptacles near the fish tank in the central lobby, the central clean utility room, in the central dining room near the ice machine, the bathroom in resident room #39 and in the west pantry were located within 6 feet of a water source and did not have GFCI protection. At 10:17 AM the maintenance director reported	K 147	3. The receptacle in resident room 222 will be replaced with a hospital grade receptacle as well as the plug on the bed being replaced with a hospital grade plug. 3/25/2010 4. The two surge protectors in the MDS office will be separated and plugged into separate receptacles. 3/25/2010 5. The receptacles near the fish tank in the central lobby, the central clean utility room, the central dining room, the bathroom in resident room 39 and the west pantry will be replaced with GFCI protected receptacles. 3/25/2010 6. Maintenance staff will be in serviced to the deficiency. 3/25/2010 7. The Facilities Director or designee will conduct monthly inspections to ensure that the electrical wiring and equipment is in accordance with NFPA 70 3/25/2010 8. The Facilities Director or designee will report inspection results to the Quality Assurance team no less than quarterly for a period of not less than 6 months. 3/25/2010	

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY CARE CENTER	60 MAGNOLIA CASPER, WY 82604

(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 147	Continued From page 9 he was aware of the spacing requirement, but was unsure why the above cited receptacles had not been noticed and replaced.	K 147		

SHEPHERD OF THE VALLEY CARE CENTER

60 MAGNOLIA
CASPER, WY 82604
PHONE: 307-234-9381
FAX: 307-472-3510

NO. OF PAGES
INCLUDING COVER SHEET: 11

PURPOSE:

_____ DIRECT PATIENT CARE
_____ PHYSICIAN REQUEST
_____ GENERAL
_____ EMERGENCY

PRIORITY:

_____ STAT
_____ ASAP
_____ ROUTINE
_____ VERBAL

DATE: 4/28/10 TIME: 5:48PM INITIALS: SE

TO: Susan Jensen

FROM: S Elliott

FAX# 777-7127 PHONE# _____

COMMENTS: attempt # 5,143 - let me know if we got it this time - thanks Jill