STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ WING _____	04/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY HEALTHCARE 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 with a basement of Type V (111) construction with plan approval in 1958 and 1987. The building was equipped with a supervised automatic wet sprinkler system with a dry branch and an addressable fire alarm system. The building had a capacity of 126 certified Medicare and Medicaid beds.	K 000		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure walls and ceilings were smoke resistant in 3 of 5 smoke compartments. The findings were: Observation on 4/24/12 between 10:30 AM and 3 PM showed an unsealed ceiling penetration in the laundry and the closet of resident room #37. In addition, there was an unsealed wall penetration behind the door in resident room #120. The largest gap measured 1 inch by 4 inches. At 10:54 AM the maintenance director could not	K 012	K012 Wall penetrations will meet smoke resistance. This will ll be accomplished by: 1. The unsealed celing penetration in the laundry and closet of room 37 and behind the door in room 120 has been sealed. 2. Maintenance Staff been inserviced to the deficiency.	6/12/12

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

Jill Hulet Administrator June 8, 2012

POC ACCEPTED W/ JILL HULET, NHA, ON 5/29/12. 2:10PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/25/2012

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

5/21/12

(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 012	Continued From page 1 explain why the aforementioned penetrations had not been noticed and repaired during the quarterly inspections.	K 012	3. The Mainteance Director or designee will conduct monthly inspections making immediate corrections to identified infractions. 4. The Maintenance Director will report results of audits will be reported to the QA team for a minimum of 90 days at which point the team will determine appropriate reporting until ongoing compliance is established.	
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 form use areas in 1 of 5 smoke compartments. The findings were: Observation on 4/24/12 between 11 AM and 11:30 AM showed the corridor door to the laundry and south linen closet were both provided with self-closing devices. Further observation showed the closing devices were not able to fully latch the	K 029	K029 One hour fire rated construction or an approved automatic fire extinquishing 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 separtaed from other spaces by smoke resiting particians and doors. Doors are	6/12/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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 _____	04/25/2012

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

5/21/12

(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 029	Continued From page 2 doors into the door frames, with three attempts each. On 4/24/12 at 11:09 AM the maintenance director could not explain why the aforementioned doors had not been noticed and repaired during the quarterly inspections.	K 029	self-closing and non-rated or filed-applied protective plates that do not exceed 48 inces from the bottom of the door are permitted. This will be accomplished by: 1. The hazardous location doores by the laundry room and South linen closet will be repaired/adjusted allowing them to properly latch. 2. Maintenace Staff been inserviced to the deficiency. 3. The Mainteance Director or disignee will conduct monthly room inspections making immediate corrections to identified infractions. 4. The Maintenance Director will report results of audits will be reported to the QA team for a minimum of 90 days at which point the team will determine appropriate reporting until ongoing compliance is established.	
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 exit access doors were accessible at all times in 1 of 5 smoke compartments. The findings were: Observation on 4/24/12 between 11 AM and 12	K 038	K 038 The facility will ensure exit access doors are accessible at all times. This will be accomplished by:	6/12/12

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	535042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/25/2012

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

5/21/12

(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 038	Continued From page 3 PM showed the west boiler room exit door and southwest vestibule exit access door required excess force to open. On 4/24/12 at 11:07 AM the maintenance director reported he was aware the boiler room door required more than the allowed 15 pounds of pressure to open, but he had not recognized this door as an exit. He could not explain why the southwest vestibule door had not been noticed and modified during the quarterly inspections. Reference, NFPA 101, 2000 Edition, 19.2.2.2.1; 7.2.1.4.5 The forces required to fully open any door manually in a means of egress shall not exceed 15 lbf (67 N) to release the latch, 30 lbf (133 N) to set the door in motion, and 15 lbf (67 N) to open the door to the minimum required width. Opening forces for interior side-hinged or pivoted-swinging doors without closers shall not exceed 5 lbf (22 N). These forces shall be applied at the latch stile.	K 038	1. The door to the West boiler room and SW exit DBL doors will be adjusted/repaird to prevent the use of excessie force to open them. 2. Maintenace Staff been inserviced to the deficiency. 3. The Mainteance Director or designee will conduct monthly room inspections making immediate corrections to identified infractions. 4. The Maintenance Director will report results of audits will be reported to the QA team for a minimum of 90 days at which point the team will determine appropriate reporting until ongoing compliance is established.	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure the central generator was equipped with a remote stop button and failed to ensure 1 of 2 emergency battery light tests was performed. The findings were: 1. Review of the emergency battery light tests showed the last 90 minute annual test was	K 046	K 046 All Emergency generators will be equipped with remote ennunciator panels or the ability to identify generator failure allowing for emergency lighting of at least 1 and 1/2 hour in duration. This will be accomplished by:	6/12/12

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	535042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/25/2012

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

5/21/12

(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 046	Continued From page 4 performed on 3/11/11, more than one year ago. On 4/25/12 at 9:35 AM the maintenance director could not explain why the test had not been performed. Reference, NFPA 101, 2000 Edition, 19.2.9.1, 7.9.2.3, NFPA 110, 1999 Edition; 3-5.5.6 All Level 1 and Level 2 installations shall have a remote manual stop station of a type similar to the break-glass station located outside the room housing the prime mover, where so installed, or located elsewhere on the premises where the prime mover is located outside the building. Reference, NFPA 101, 2000 Edition, 19.2.9.1; 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 046	1. Emergency battery light tests lasting a minimum of 90 minutes will be performed annually for all generators. 2. Maintenance Staff will be inserviced to the above deficiency. 3. The Maintenance Director or designee will qtrly review mandatory inspections making immediate corrections to identified infractions. 4. The Maintenance Director will report results of audits will be reported to the QA team for a minimum of 90 days at whichpoint the team will determine appropriate reporting until ongoing compliance is established.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050		6/12/12

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	535042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/26/2012

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

5/24/12

(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 050	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure a fire drill was held during each quarter on 2 of 3 shifts and failed to ensure staff were familiar with emergency actions. The findings were: 1. Observation of a fire drill on 4/24/12 at 4:47 PM showed a hoyer lift and a wheeled cart were left in the corridor of fire origin throughout the drill. At 4:50 PM the maintenance director confirmed the facility policy and practice is to remove all obstructions from corridor throughout the building whenever the fire alarm is activated. He could not explain why the items were not removed. 2. Review of the fire drill records showed the first shift occurred between 7 AM and 3 PM, the second shift from 3 PM to 11 PM and the third shift from 11 PM to 7 AM. Further review showed a drill had not been conducted on the second shift during the second quarter of 2011. In addition, drills had not been conducted on the third shift during the second, third, and fourth quarters of 2011. On 4/25/12 at 9:35 AM the maintenance director could not explain why the drills had not been performed. He also reported the facility did not use a tracking system to ensure drills were performed on each shift on a quarterly basis.	K 050	K 050 Fire drills will be held during each quarter on 2 of 3 shifts ensuring staff are familiar with emergency actions. This will be accomplished by: 1. Corridors will be free of clutter during fire drills. 2. Fire drills will be conducted monthly on each shift x 3 months and then quarterly if substantial compliance has been achieved. 3. Staff been inserviced to the deficiency. 4. The Maintenance Director and Staff Development Coordinator or designee will conduct monthly fire drills making immediate corrections to identified infractions. 5. The Maintenance Director or SDC will report results of drills will be reported to the QA team for a minimum of 90 days at which point the team will determine appropriate reporting until ongoing compliance is established.	
K 062 SS=E	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,	K 062		6/12/12

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	535042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/25/2012

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

5/22/12

(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 062	Continued From page 6 9.7.5 This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure escutcheon rings were sealed and sprinkler heads were not obstructed or corroded. In addition, ensure sprinkler heads had proper spacing in 3 of 5 smoke compartments and that the facility failed to ensure 1 of 7 sprinkler system tests was performed. The findings were: 1. Observation of the sprinkler system in the Alzheimer's corridor on 4/24/12 at 1:38 PM showed two sprinkler escutcheon rings were not sealed. The largest gap measured ½ inch across. At the time of the observation the maintenance director could not explain why the gaps had not been noticed during the last annual inspection conducted on 9/1/11. 2. Observation of the sprinkler system on 4/24/12 at 1:38 PM showed a sprinkler head in the medical records storeroom was obstructed by cardboard boxes. The boxes were located 10 inches below and 6 inches on either side of the head. At the time of the observation the maintenance director reported staff has been instructed to not place boxes within 18 inches below and 3 feet on either side of sprinkler heads. 3. Observation of the sprinkler system on 4/24/12 at 2:04 PM showed 1 of 6 sprinkler heads near the kitchen hood was corroded. At the time of the observation the maintenance director could not explain why the corroded head had not been	K 062	K 062 Required automatic sprinkler systems are continuously maintained in reliable operating condition. This will be accomplished by: 1. Maintenance will replace or repair sprinkler heads in Secure Unit, Medical records storeroom, near kitchen hood. 2. The sprinkler heads that are occluded in the kitchen by a beam will be relocated. 3. The sprinkler system testing will have pressure gauge re-calibration no less than every 5 years. 4. Maintenance Staff been in serviced to the deficiency. 5. The Maintenance Director or designee will conduct quarterly sprinkler head inspections making immediate corrections to identified infractions. 6. The Maintenance Director or SDC will report results of drills will be reported to the QA team for a minimum of 90 days at which point the team will determine appropriate reporting until ongoing compliance is established.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 062	Continued From page 7 noticed during the last annual inspection conducted on 9/1/11. 4 Observation of the sprinkler system on 4/24/12 at 2:10 PM showed a branch line in the kitchen staging area was located 9 feet 7 inches from a ceiling beam. The 18 inch beam obstructed the next branch line from providing sprinkler coverage to this area. At the time of the observation the maintenance director could not explain why the corroded head had not been noticed during the last annual inspection conducted on 9/1/11. 5. Review of the sprinkler system testing records showed the facility did not have record of the last five year pressure gauge re-calibration. On 4/25/12 at 9:35 AM the maintenance director confirmed he did not have record of the pressure gauge test. Reference, NFPA 101, 2000 Edition, 19.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 3-2.7.2 Escutcheon plates used with a recessed or flush type sprinkler shall be part of a listed sprinkler assembly. 5-5.3.1 Maximum Distance Between Sprinklers. The maximum distance permitted between sprinklers shall be based on the centerline distance between sprinklers on the branch line or on adjacent branch lines. The maximum distance shall be measured along the slope of the ceiling. The maximum distance permitted between sprinklers shall comply with the value indicated in the section for each type or style of sprinkler. 5-5.3.2 Maximum Distance From Walls. The distance from sprinklers to walls shall not exceed one-half of the allowable maximum distance	K 062		

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	535042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/25/2012

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K 062	Continued From page 8 between sprinklers. The distance from the wall to the sprinkler shall be measured perpendicular to the wall. 5-5.6 Clearance to storage. The clearance between the deflector and the top of storage shall be 18 in. or greater. Table 5-6.2.2 (b) Protection Areas and Maximum Spacing (Standard Spray Upright/Standard Spray Pendent) for Ordinary Hazard Construction Type ... ...All System Type ... ...All Protection Area ... ...130 ft2 Spacing ... ...15 ft Reference, NFPA 101, 2000 Edition, 19.3.5.1, 9.7.5, NFPA 25 1998 Edition; 2-2.1.1* Sprinklers shall be visually inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged or loaded, or in the improper orientation. 6-3.6 Pressure gauges shall be tested every 5 years with a calibrated gauge in accordance with the manufacturer ' s instructions. Gauges not accurate to within 3 percent of the scale of the gauge be tested shall be recalibrated or replaced.	K 062		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		6/12/12

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SHEPHERD OF THE VALLEY HEALTHCARE CENTER	60 MAGNOLIA CASPER, WY 82604

5/24/12

(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 144	Continued From page 9 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 1 of 4 emergency generator tests was performed. The findings were: Review of the central emergency generator testing log showed the corridor lights were supplied with emergency power from a diesel generator. Further review showed the generator ran at 14% of the name plate during the monthly load test. The facility did not have records of the last load bank test. On 4/25/12 at 9:35 AM the maintenance director was unaware the annual test was required if the monthly load test ran at less than 30% of the name plate. Reference, NFPA 101, 2000 Edition, 19.2.9.1, 7.9.2.3, NFPA 110, 1999 Edition; 6.4.2.3* Diesel-powered EPS installations that do not meet the requirements of 6.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.	K 144	K 144 Generators are inspected weekly and exercised under a load for 30 minutes per month in acordance with NFPA 99. This will be accomplished by: 1. The East and Central Generators will conduct annual load tests if the monthly load test runs at less than 30% of the name plate. 2. Maintenance will maintain records of all generator inspections. 3. Maintenance Staff been in serviced to the deficiency. 4. The Maintenance Director will submit testing documentation to the QA team on an on-going basis until compliance is satisfactorily attained and maintained.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		6/12/12

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K 147	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring and failed to ensure damaged wiring was replaced in 3 of 5 smoke compartments. The findings were: 1. Observation of the electrical system on 4/24/12 between 11:30 AM and 2:30 PM showed the following: a. The refrigerator in the general store was plugged into an extension cord. b. The computer in the medical records office was plugged into a surge protector which was plugged into a 6-way electrical adapter. c. The radio in resident room #7 was plugged into a 3-way electrical adapter. At 11:46 AM the maintenance director reported he did not routinely inspected offices. At the time of the observation, he could not explain why the adapter in the resident room had not been noticed and removed during the quarterly inspections. 2. Observation of resident room #41 on 4/24/12 at 1:31 PM showed the electrical cord for bed "A" was damaged at the plug with exposed inner wires. At the time of the observation the maintenance director could not explain why the cord had not been noticed and removed during the quarterly inspections. Reference, NFPA 101, 2000 Edition, 19.5.1, 9.1.2, NFPA 70, 1999 Edition; 90-7 Examination of Equipment for Safety. ...It is the intent of this Code that factory-installed internal wiring or the construction of equipment need not be inspected at the time of installation of	K 147	K 147 Electrical wiring and equipment is in accordance with NFPA 70, National Code 0.1.2. This will be accomplished by: 1. Maintenance will remove extension cords in the gift store, Medical Records, and room 7. 2. The bed cord in room 41 will be repaired or replaced by Maintenance. 3. Maintenance will re-route time clock power cords. 4. Maintenance and Housekeeping Staff been in serviced to the deficiency. 5. The Maintenance Director, Housekeeping Director or designee will conduct monthly inspections making immediate corrections to identified infractions. 6. The Maintenance Director or SDC will report results of drills will be reported to the QA team for a minimum of 90 days at which point the team will determine appropriate reporting until ongoing compliance is established.	6.12.12

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SHEPHERD OF THE VALLEY HEALTHCARE CENTER	60 MAGNOLIA CASPER, WY 82604

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K 147	Continued From page 11 the equipment, except to detect alterations of damage ... 400-8. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls ... (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147		

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
	535042	A. BUILDING 02 - EAST BUILDING 02 B. WING _____	04/25/2012

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

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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 of Type II (111) construction with plan approval in 1979. The building was equipped with a supervised automatic wet sprinkler system and with an addressable fire alarm system. The building had a capacity of 66 certified Medicare and Medicaid beds.	K 000		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure walls were smoke resistant in 1 of 4 smoke compartments. The findings were: Observation of the basement storeroom on 4/24/12 at 3:59 PM showed there was a 1 inch unsealed conduit penetration. At time of the observation the maintenance director could not explain why the penetration had not been noticed and filled during the quarterly inspections.	K 012	K 012 Wall penetrations will meet smoke resistance. This will ll be accomplished by: 1. The basement storeroom unsealed conduit penetration has been sealed. 2. Maintenace Staff been inserviced to the deficiency. 3. The Maintenance Director or designee will conduct monthly inspections making immediate corrections to identified	6/12/12

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.

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5/21/12

(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 012	Continued From page 1	K 012	infractions. 4. The Maintenance Director will report results of audits will be reported to the QA team for a minimum of 90 days at whloh point the team will determine appropriate reporting until ongoing compliance is established.	
K 062 SS=D	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 escutcheon rings sealed the sprinkler penetration in 1 of 4 smoke compartments. The findings were: Observation of resident room #204 on 4/24/12 at 3:43 PM showed three sprinkler heads had gaps around the escutcheon rings. The largest gap measured ½ inch across. At the time of the observation the maintenance director could not explain why the gaps had not been noticed and repaired during the annual inspection on 9/1/11. Reference, NFPA 101, 2000 Edition, 19.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 3-2.7.2 Escutcheon plates used with a recessed or flush type sprinkler shall be part of a listed sprinkler assembly.	K 062	K 062 Required automoatic sprinkler systems are continuously maintained in reliable operating condition. This will be accomplished by: 1. Maintenance will replace or repair sprinkler heads in room 204. 2. Mainenance Staff been inserviced to the deficiency. 3. The Maintenance Director or designee will conduct monthly sprinkler head inspections making immediate corrections to identified infractions. 4. The Maintenance Director or SDC will report results of drills will be reported to the QA team for a minimum of 90 days at which point the team will determine appropriate reporting until ongoing	6/12/12

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5/24/12

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K 062	Continued From page 2	K 062	compliance is established.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		6/12/12

This STANDARD is not met as evidenced by:
Based on record review and staff interview, the facility failed to ensure 1 of 4 emergency generator tests was performed. The findings were:

Review of the east emergency generator testing log showed the corridor lights were supplied with emergency power from a diesel generator. Further review showed the generator ran at 6% of the name plate during the monthly load test. The facility did not have records of the last load bank test. On 4/25/12 at 9:35 AM the maintenance director was unaware the annual test was required if the monthly load test ran at less than 30% of the name plate.

Reference, NFPA 101, 2000 Edition, 19.2.9.1, 7.9.2.3, NFPA 110, 1999 Edition;
6.4.2.3* Diesel-powered EPS installations that do not meet the requirements of 6.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads

K144

Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.
This will be accomplished by:

1. The East and Central Generators will conduct annual load tests if the monthly load test runs at less than 30% of the name plate.
2. Maintenance will maintain records of all generator inspections.

3. Mainenance Staff been inserviced to the deficiency.
4. The Mainteance Director will submit testing documentation to the QA team on an on-going basis until compliance is satisfactorily attained and maintained.

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5/21/12

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K 144	Continued From page 3 at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.	K 144		
K 147 SS=D	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 flexible wiring did not run through ceiling tile in 1 of 2 smoke compartments. The findings were: Observation of the time clock on 4/24/12 at 4:31 PM showed it was plugged into an uninterrupted power supply (UPS) electrical adapter. Further observation showed the power cord for the UPS was run through the ceiling tile and plugged into an electrical outlet. At the time of the observation the maintenance director reported he was unaware power cords were prohibited from running through ceiling tiles, walls or similar barriers unless listed for such use. Reference, NFPA 101, 2000 Edition, 19.5.1, 9.1.2, NFPA 70, 1999 Edition; 400-8. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls ... (3) Where run through doorways, windows, or	K 147	K 147 Electrical wiring and equipment is in accordance with NFPA 70, National Code 0.1.2. This will be accomplished by: 1. Maintenance will re-route time clock power cords to assure that they do not run through ceiling tiles, walls or similar barriers. 2. Mainenance staff been inserviced to the deficiency. 3. The Mainteance Director, Housekeeping Director or designee will conduct monthly inspections making immediate corrections to identified infractions. 4. The Maintenance Director or SDC will report results of drills will be reported to the QA team for a minimum of 90 days at which point the team will determine appropriate reporting until ongoing compliance is established.	6/12/12

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K 147	Continued From page 4 similar openings (4) Where attached to building surfaces	K 147		