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

PRINTED: 07/02/2013
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	06/18/2013

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 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, 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 West and Central buildings had a capacity of 126 certified Medicare and Medicaid beds. The facility is comprised of the West, Central and East buildings with a combined census of 156 residents.	K 000	**K 018** **The facility will ensure corridor doors are smoke resistant in all smoke departments.** **This will be accomplished by:** **1. Corridor door to resident room #40 will withstand 5 lbs of force applied to the latch side of the door with the door latched into the door frame.** **2. Corridor door to room #23 latch will insert bolt into the strike plate.** **3. Corridor door to room 17 will have latch that bolt inserts into the strike plate.** **4. Corridor door to room 14 will no longer be impeded from closing by the door frame and allow the door to latch in the door frame.** **5. Maintenace Staff been inserviced to the deficiency.** **6. The Maintenance Director will review and if necessary revise qtrly audit reports to assure that all doors are inspected for proper closer and smoke resistance. Results of the audits will be reported to the QA team monthly for a minimum of 6 months at which point the report results of drills will be reported to the QA team for a minimum of 90 days at which**	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		

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.

POC ACCEPTED W/ MEDICAL DIRECTOR, DON, ON 7/25/13.

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

7/22/13

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure corridor doors were smoke resistant in 2 of 7 smoke compartments. The findings were: Observation of the corridor system on 6/18/13 between 11:30 AM and 2:30 PM showed the following corridor doors were not smoke resistant: a. The corridor door to resident room #40 could not resist 5 lbs. of force applied to the latch side of the door with the door latched into the door frame. b. The corridor door to resident room #23 could not insert the latch bolt into the strike plate. c. The corridor door to resident room #17 could not insert the latch bolt into the strike plate. d. The corridor door to resident room #14 was impeded from closing by the door frame. The alignment of the door would not allow the door to latch in the door frame. On 6/18/13 at 2:24 PM the maintenance director could not explain why the aforementioned doors had not been noticed and repaired during the quarterly safety inspections.	K 018	**point the team will determine appropriate reporting until ongoing compliance is established.**	7/19/13
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass	K 025		

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K 026	Continued From page 2 panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 4 smoke barrier walls were smoker resistant. The findings were: 1 Observation of the north smoke barrier in the central building on 6/18/13 at 4:09 PM showed a ½ inch unsealed cable penetration. At the time of the observation the maintenance director reported the identified cables were part of a new nurse call system installed in December 2012. He could not explain why the penetration was not sealed after the project was completed. 2. Observation of the south smoke barrier in the west building on 6/18/13 at 4:20 PM showed a ½ inch unsealed cable penetration. At the time of the observation the maintenance director reported the identified cables were part of a new nurse call system installed in December 2012. He could not explain why the penetration was not sealed after the project was completed.	K 025	**K 025** **The facility will ensure that all smoke barrier walls are smoker resistant.** **This will be accomplished by:** 1. **Maintenance department personnel will be inserviced to the above deficient practice.** 2. **North smoke barrier in the central building cable penetration will be sealed.** 3. **South smoke barrier in west building unsealed cable penetration will be sealed.** 4. **Maintenance Director will review and if necessary revise quarterly audits to ensure that smoke barriers are included and addressed.** 5. **Maintenance Director will report audit results to monthly QA x 6 months at which point the QA committee will determine if substantial compliance has been achieved.**	7/19/13
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.	K 050		

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K 050	Continued From page 3 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 This STANDARD Is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure fire drills were held on a quarterly basis during 1 of 3 shifts. The findings were: Review of the fire drill testing records showed the first shift occurred between 6 AM and 2 PM. Further review showed a fire drill had not been conducted on the first shift during the first quarter of 2013. On 6/18/13 at 5:40 PM the maintenance director could not explain why a fire drill had not been held during the aforementioned shift.	K 050	**K 050** **Fire drills will be held at unexpected times under varying conditions, at least quarterly on each shift.** **This will be accomplished by:** **1. Maintenance staff will be inserviced to the deficiency.** **2. Maintenace director will map out the fire drills for the year ensuring that there is one per shift per quarter.** **3. Maintenance director will present schedule to monthly QA committee to ensure that all shifts are properly represented.** **4. TheQA committee will review the fire drill schedule each month for a minimum of 3 months, making corrections/revisions as necessary.**	7/19/13
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, record review and staff interview, the facility failed to ensure sprinkler were not covered with foreign material and failed to ensure quarterly sprinkler system tests were held during 4 of the past 4 quarters. The findings	K 062		

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K 062	Continued From page 4 were: 1 Observation of the closet in resident room #204 on 6/18/13 at 3:16 PM showed the sprinkler head was covered with fire rated caulking. At the time of the observation the maintenance director could not explain why the sprinkler head was not noticed and repaired during the annual sprinkler system inspection. 2. Review of the sprinkler system testing records showed the quarterly waterflow devices were last test on 3/10/12. On 6/18/13 at 5:40 PM the maintenance director reported he was unaware the waterflow device was required to be tested on a quarterly basis. 3. Review of the sprinkler system testing records showed the quarterly supervisory signal devices were last tested on 9/28/12 and 3/10/12. On 6/18/12 at 5:40 PM the maintenance director reported he assumed the sprinkler contractor was performing all needed tests. He confirmed that he was unaware the supervisor signal device was required to be tested on a quarterly basis. 4. Review of the dry pipe sprinkler system testing records showed the quarterly priming water, low air pressure alarm and quick opening devices were last tested on 9/28/12. On 6/18/12 at 5:40 PM the maintenance director reported he assumed the sprinkler contractor was performing all needed tests. He confirmed that he was unaware the dry pipe system devices were required to be tested on a quarterly basis. Reference NFPA 101, 2000 Edition, 19.3.5.1, 9.7.5, NFPA 25, 1998 Edition;	K 062	**K 062** **Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. This will be accomplished by:** **1. Maintenance department pesonnel will be inserviced to the above deficiency.** **2. Maintenance will replace sprinkler head or remove caulking from the affected sprinkler head in room #204.** **3. Maintenace director or designee will visually inspect all sprinkler heads in the facility a minimum of each quarter, taking immediate corrective action when infractions are identified.** **4. Maintenance Director will arrange for and manage the qtrly testing of the dry pipe system and maintain the records of such.** **5. Records of the sprinkler system quarterly testing and sprinkler head inspections will be reported to the monthly QA committee for a minimum of 6 months at which point the QA committee will determine if substantial compliance has occurred making recommendations accordingly.**	7/19/13

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K 062	Continued From page 5 9-2.7 Waterflow alarm. All waterflow alarms shall be tested quarterly in accordance with manufacturer ' s instructions. 9-4.4 Dry Pipe Valves/Quick-Opening Devices. 9-4.4.2.1* The priming water level shall be tested quarterly. 9.4.4.2.4 * Quick-Opening devices, if provided, shall be tested quarterly. 9.4.4.2.6 Low air pressure alarms, if provided, shall be tested quarterly in accordance with the manufacturer ' s instructions. Reference NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; Table 7-3.2 Testing Frequencies. 15. Initiating Devices j. Supervisory Signal Devices, ... quarterly k. Waterflow Devices, ... quarterly	K 062		
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 temporary electrical adapters did not replace permanent fixed electrical wiring in 1 of 7 smoke compartments. The findings were: Observation of resident room #21 on 6/18/13 at 2:16 PM showed the radio was plugged into a 6-way electrical power tap. Further observation showed the power tap was not designed with a surge protection component to protect electronic	K 147	**K 147** **Electrical wiring and equipment is in accordance with NFPA 70, National Code 9.1.2. Facility will ensure that temporary electrical adapters do not replace permanent fixed electrical wiring. This will be accomplished by:** **1. Mainenance and Housekeeping Staff been inserviced to the deficiency.** **2. Housekeeping will remove 6 way electrical power tap that was not designated with a surge protection element in room 21.** **3. The Housekeeping Director or designee will conduct monthly inspections making immediate corrections to identified infractions.** **4. The Housekeeping Director will report results of audits to the QA team for a minimum of 90 days at which point the team will determine appropriate reporting until ongoing compliance is established.**	7/19/13

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K 147	Continued From page 6 equipment. At the time of the observation the maintenance director could not explain why the power tap had not been noticed and removed during the monthly safety inspections. 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 similar openings (4) Where attached to building surfaces	K 147		

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	535042	A. BUILDING 02 - EAST BUILDING 02 B. WING	06/18/2013

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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 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, 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 East building had a capacity of 66 certified Medicare and Medicaid beds.	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		

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.

POC ACCEPTED W/ JASON DINILLACCI, DON, RN 7/22/13

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure corridor doors were smoke resistant in 1 of 2 smoke compartments. The findings were: Observation of resident room #110 on 6/18/13 at 1:36 PM showed the corridor door was impeded form closing by a metal decorative hanger that rested on top of the door. At the time of the observation the maintenance director could not explain why the hanger had not been noticed and removed during the monthly safety inspections.	K 018	**K 018** **The facility will ensure corridor doors are smoke resistant in all smoke departments.** **This will be accomplished by:** 1. **Maintenance Staff have been inserviced to the above deficiency.** 2. **Metal docorative hanger has been removed from door #110 allowing the door to properly latch.** 3. **Maintenance will audit doors for proper latching on a qtrly basis making immediate corrections for noted deficiencies.** 4. **Maintenance Director will report monthly to the QA committee results of audits a minimum of 6 months at which time the QA committee will determine if substantial compliance has been realized and making recommendations accordingly.**	7/19/13
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 temporary electrical adapters did not replace permanent fixed electrical wiring in 2 of 2 smoke compartments. The findings were: Observation of the electrical system on 6/18/13 between 1:30 PM and 2 PM showed the following locations had prohibited temporary electrical adapters in use: a. The clock in resident room #102 was plugged into an extension cord. b. The fan in resident room #107 was plugged into 2 surge protectors ' in-line. On 6/18/13 at 1:51 PM the maintenance director	K 147		

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K 147	Continued From page 2 could not explain why the aforementioned prohibited electrical adapters had not been noticed and removed during the monthly safety inspections. 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 similar openings (4) Where attached to building surfaces	K 147	**K 147** **Electrical wiring and equipment is in accordance with NFPA 70, National Code 9.1.2. Facility will ensure that temporary electrical adapters do not replace permanent fixed electrical wiring. This will be accomplished by:** **1. Mainenance and Housekeeping Staff been inserviced to the deficiency.** **2. Housekeeping will remove extension cord in room #102 and 2 surge protectors ' in – line in room #107.** **3. The Housekeeping Director or designee will conduct monthly inspections making immediate corrections to identified infractions.** **4. The Housekeeping Director will report results of audits to the QA team for a minimum of 3 months at which point the team will determine appropriate reporting until ongoing compliance is established.** 7/19/13	