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

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	04/01/2010

2010 APR 29 PM 12:54

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 42 CFR 483.70(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 1971, 1973, 1981 K7 SURVEY UNDER: 2000 Existing K8 SNF Type of Structure: Type V (111) 1971 one story, protected wood frame; Type II (111)1971 one story, protected, noncombustible; Type II (111) 1973 one story building addition, protected noncombustible and a Type V (111) 1981 one story building addition, protected wood frame structure. The 1981 building addition has a partial basement. The facility has a partial automatic (wet) sprinkler system. All of the facility is sprinkler protected except for the 1971 protected wood frame laundry building and has nine smoke compartments. A Comparative Federal Monitoring Survey was conducted on 04/01/10, following a State Agency Annual Survey on 03/24/10 in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, Shepard of the Valley Care Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).	K 000		
K 014 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including	K 014	K 014 Interior finish for corridors and exit ways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns and ceilings has a flame spread rating of class A or class B. 19.3.3.1, 19.3.3.2	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4-23-10

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.

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K 014	Continued From page 1 exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide interior finishes for corridor walls with a flame spread rating of Class A or Class B. This condition affected three of nine smoke compartments, staff and approximately 38 residents. The facility has the capacity for 192 beds with a census of 175 the day of survey. Findings include: Observation on 04/01/10 at 10:15 a.m. revealed that the corridor walls in the 1971 protected noncombustible portion of the building consisted of carpeting and oak paneling on the lower third of the walls in three different smoke compartments. The facility was unable to provide documentation to identify the flame spread rating of the carpet or oak paneling. Interview on 04/01/10 at 10:15 a.m. with the Maintenance Supervisor revealed that the carpet and oak paneling had been in place for a number of years and the age or information on the flame spread rating was unknown. The census of 175 was verified by the Administrator on 04/01/10. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/01/10.	K 014	K 014 This will be accomplished by: 1. The carpeting on the lower third of the walls in the three smoke compartments will be treated with a flame retardant in accordance to manufacturers specifications Flamebuster for fabric enclosed are the manufacturers application specifications, the flammability test reports and the flame spread reports for the carpet. 2. The oak paneling on the lower third of the walls in the three smoke compartments will be treated with a fire retardant polyurethane varnish in accordance to manufacturers specifications. Burn Barrier no. 133 enclosed are the application specifications as well as the ASTM 84-01 test report. 3. Maintenance staff will be in-serviced to the deficiency. 4. The Facilities Director or designee will conduct monthly facility inspections and record reviews to ensure all interior finishes for corridors and exit ways have a flame spread rating of class A or class B 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.	5/5/2010 5/5/2010 4/2/2010 4/2/2010 4/2/2010

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K 014	Continued From page 2 Actual NFPA standard: Interior finish for corridors and exit ways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. NFPA 101, 19.3.3.1 and 19.3.3.2.	K 014	K 038 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1 19.2.1	
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: Based on observation and interview, the facility failed to provide single action hardware for opening the exit door at an emergency egress exit. This deficient practice affected one of nine smoke compartments, three staff and no residents. The facility has the capacity for 192 beds with a census of 175 the day of survey. Findings include: Observation on 04/01/10 at 10:00 a.m. revealed the exit door across from the West wing mechanical room of the facility had two locking devices consisting of a magnetic locking device and a double keyed dead bolt lock located approximately five feet from the floor on the door. The locking devices required two actions to release and open the door. Interview with the facility Maintenance Supervisor on 04/01/10 at 10:00 a.m. revealed that the facility was not aware of the double keyed dead bolt was on the	K 038	This will be accomplished by: 1. The double keyed dead bolt lock on the door across from the west wing mechanical room will be removed. 4/4/2010 2. Maintenance staff will be in serviced to the deficiency. 4/3/2010 3. The Facilities Director or designee will conduct monthly exit inspections to ensure accessibility. 4. 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. 4/4/2010 CMS-2568 dated March 24, 2010 K 038 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1 19.2.1 This was 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 was be placed on exit door in the Skatrud dining room. 4/12/2010 2. Maintenance staff was in-serviced to the deficiency 3/25/2010	

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K 038	Continued From page 3 door. The census of 175 was verified by the Administrator on 04/01/10. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/01/10. Actual NFPA Standard: NFPA 101, 7.2.1.5.4*. A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation.	K 038	3. The Facilities Director or designee will conduct monthly inspections on all delayed egress doors to ensure that the proper signage is provided. 4. 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 3/25/2010
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 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide documentation of a fire drill on the third shift for the first quarter for the 2010 calendar year. The deficient practice affected all smoke compartments, staff and residents. The	K 050	K 050 Fire drills are held at unexpected time under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of an established routine. Responsibility for planning and conducting drills is assigned to only 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 will be accomplished by: 1. The documentation for the fire drill conducted on 03/28/2010 at 5:00 am will be retrieved from the Environmental Service Director	4/3/2010

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K 050	Continued From page 4 facility has the capacity for 192 beds and at the time of the survey the census was 175. Findings include: On 04/01/10 at 1:00 p.m., during a review of the facility's fire drill report documentation provided by the facility for the previous calendar year, the documentation indicated that no fire drill was conducted on the third shift for the first quarter of 2010. During an interview with the Maintenance Supervisor on 04/01/10 at 1:00 p.m. the facility was unaware of the missing fire drill documentation and was unable to provide a documented fire drill for the third shift. The census of 175 was verified by the Administrator on 04/01/10. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/01/10. Actual NFPA Standard: NFPA 101, 19.7.1.2. Requires fire drills be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts to simulate the unusual conditions occurring in case of fire.	K 050	K 050 2. Maintenance staff will be in serviced to the deficiency. 4/3/2010 3. The Facilities Director or designee will conduct monthly record reviews to ensure fire drills are being done at least quarterly on every shift and to ensure there is proper documentation for said drills. 4/3/2010 4. The Facilities Director or designee will report the results of the record review to the Quality Assurance Team no less than quarterly for a period of not less than 6 months 4/3/2010	
K 052 SS=F	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	K 052 A fire alarm system required for life safety is installed, tested and maintained in accordance with NFPA 70 The National Electric Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72 19.6.1.4	

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K 052	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a properly maintained and installed fire alarm system. The deficient practice would affect all smoke compartments of the facility, staff and residents. The facility has the capacity for 192 beds with a census of 176 the day of survey. Findings include: On 04/01/10 at 12:45 p.m. during the testing of the fire alarm system by the Maintenance Supervisor, it was observed that the system consisted of one fire alarm control panel (FACP), with a fire alarm communication automatic dialer panel. The (FACP) panel was located at the nursing station on the East wing. The automatic dialer was located in a communication room. The communication room was not a continuously occupied location. The automatic dialer component, when placed in trouble with phone line failure, indicated a local line failure with a trouble signal. The main fire alarm control panel (FACP) at the nursing station and remote panels indicated that all systems were normal when the automatic dialer component of the system was in trouble. No trouble signal could be heard at the nursing station or any other continuously occupied location. The system was not functioning as a single system with all trouble signals located in an area where they were likely to be heard. Interview with the facility Maintenance Supervisor on 04/01/10 at 12:45	K 052	K 052 This will be accomplished by: 1. The fire alarm communication automatic dialer panel will be removed from the communication room and placed in the east nurses station beside the fire alarm control panel and wired so that any communication failures will sound an audible trouble signal. — 4/4/2010 2. Maintenance staff will be in serviced to the deficiency. — 4/2/2010 3. The Facilities Director or designee will conduct quarterly inspections on the fire alarm system in accordance with NFPA 70 and 72 to ensure proper function of the alarm system. — 4/4/2010 4. The Facilities Director or designee 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. — 4/4/2010	

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K 052	Continued From page 6 p.m. revealed that the facility monitoring company did receive a trouble signal from the facility for phone line interruption when the automatic communicator of the system was in trouble due to phone line interruption with the (FACP) and the remote panels were indicating all systems were normal. The census of 175 was verified by the Associate Administrator on 04/01/10. The finding was acknowledged by the Associate Administrator and verified by the Maintenance Supervisor at the exit interview on 04/01/10. Actual NFPA Standard: NFPA 72 section 3-8.1. Fire alarm system components shall be permitted to share control equipment or shall be able to operate as standalone subsystems, but, in any case, they shall be arranged to function as a single system. Actual NFPA Standard: NFPA 72 section 1-5.4.6. The trouble signal(s) shall be located in an area where it is likely to be heard. Actual NFPA Standard: NFPA 72 section 1-5.4.4. Fire alarms, supervisory signals, and trouble signals shall be distinctively and descriptively annunciated.	K 052	CMS-2567 dated March 24, 2010 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 was be accomplished by: 1. The fire alarm will be activated monthly in accordance with NFPA 70 and 72. — 3/25/2010 2. Maintenance staff was 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 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	
K 070 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by:	K 070	K 070 Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating element of such devices does not exceed 212 degrees F. (100 degrees) 19.7.8	

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K 070	Continued From page 7 Based on observation and interview, the facility failed to prohibit the use of space heaters in the facility. The deficient practice affected one of nine smoke compartments in the building, staff and 20 residents. The facility has the capacity for 192 beds and at the time of the survey the census was 175. Findings include: Observation on 04/01/10 at 12:05 p.m., revealed the MDS office had electrical space heater located on the floor by the desk. The heater was the type that could exceed 212 degrees. Interview with the facility Maintenance Supervisor on 04/01/10 at 12:05 p.m. indicated that he was not aware the portable space heater was in the building. The census of 175 was verified by the Administrator on 04/01/10. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/01/10. Actual NFPA Standard: NFPA 101 section 19.7.6. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212° F (100°C).	K 070	~~K 070~~ This will be accomplished by: 1. The electric space heater will be removed from the MDS office. — 4/1/2010 2. All staff will be in-serviced to the deficiency — 4/30/2010 3. The Facilities Director or designee will conduct monthly inspections of the facility to ensure no portable space heaters are be used. — 4/2/2010 4. 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. — 4/2/2010 CMS-2567 dated March 24, 2010 CMS-2567 dated April 1, 2010	
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 143	K 143 Transferring of oxygen is: (a) separate 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	

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K 143	Continued From page 8 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 interview, the facility failed to provide exhaust ventilation to the outside of the building and maintain a one hour fire resistive separation barrier in a location designated for the transferring and storage of liquid oxygen. The deficient practice affected one of nine smoke compartments, three staff, and no residents. The facility has the capacity for 192 beds and at the time of the survey the census was 175. The findings include: Observation during the tour of the facility on 04/01/10 at 11:15 a.m. revealed the liquid oxygen was being stored in an oxygen storage room that was attached to a sprinkler riser room. There was a vented opening between the liquid oxygen storage room and the sprinkler riser room. The liquid oxygen storage room was not venting to the outside of the building. The liquid oxygen storage	K 143	This will be accomplished by: 1. 4 liquid oxygen tanks will be removed from the oxygen storeroom. — 3/23/2010 2. The fan exhausting from the oxygen storage room into the sprinkler riser room will be removed and an exhaust fan will be installed venting directly through the exterior wall.. — 4/30/2010 3. Maintenance staff will be in serviced to the deficiency. — 3/25/2010 4. Facilities Director or designee will conduct monthly inspections to ensure proper ventilation and to ensure no more than the maximum number of liquid oxygen tanks are stored in the oxygen storage room. — 3/25/2010 5. 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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K 143	Continued From page 9 area was also being used for transferring of liquid oxygen. The enclosure walls of the storage and transferring room were not a one hour fire resistive as constructed with a vented opening between the storage room and the sprinkler riser room. Interview on 04/01/10 at 11:15 a.m. with the Maintenance Supervisor revealed that the facility was made aware of the requirements for storage and transferring of liquid oxygen since the last state survey on 03/24/09 and was working on the ventilation problem. The census of 175 was verified by the Administrator on 04/01/10. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview on 04/01/10. Actual NFPA Standard: NFPA 99, 8-6.2.5.1, Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: (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; and (b) The area is mechanically ventilated, is sprinkler protected, and has ceramic or concrete flooring; and (c) The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.	K 143		