STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING 01, 02 B. WING	08/27/2014

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 159 residents.	K 000	**K 017** **The facility will ensure that ceilings will be smoke resistant.** **This will be accomplished by:** 1. **Repair of ceiling 1-inch circular penetration in the Medical Supply room.** 2. **Maintenace Staff have been inserviced to the deficiency.** 3. **The Maintenance Director will review and if necessary revise qtrly audit reports to assure that ceilings and walls are smoke resistant. Results of the audits will be reported to the QA team for a minimum of 6 months at which point the team will determine appropriate reporting until ongoing compliance is established.**	10/7/14
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Jill Hult TITLE Administrator (X6) DATE 9-17-14

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 via Phone c Jill Hult (Administrator) on 9/25/14 c 4:10pm
JWyatt

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K 017	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure ceilings were smoke resistant in 1 of 9 smoke compartments. The findings were: Observation of the Medical Supply room, adjacent to Room #107 on 08/26/2014 at 12:14 PM revealed several 1-inch circular penetrations in the ceiling and wall. Interview of the facility maintenance director at the time of observation confirmed the unsealed penetrations. Reference, NFPA 101, 2000 Edition; 19.3.6.2.2	K 017	**K 018** **The facility will ensure a suitable means for keeping the doors closed accessing the egress corridors.** **This will be accomplished by:** 1. **Maintenance Staff have been inserviced to the above deficiency.** 2. **Doors to the Nursing Station storage closet, nurse managers office, resident room #57 will latch properly.** 3. **Maintenance will audit doors for proper latching on a monthly basis making immediate corrections for noted deficiencies.** 4. **Maintenance Director will report 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.**	10/7/14
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		

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K 018	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a suitable means for keeping the doors closed accessing the egress corridors in 1 of 9 smoke compartments. The findings were: Observation of Nurses Station Storage Closest on 08/26/14 at 1:41 PM, the Nurse Manager Office on 08/26/14 at 1:43 PM, and resident room #67 on 08/26/14 at 1:35 PM on Ellbogen Hall revealed the doors would not latch appropriately. Pulling on the door revealed the hardware was not keeping the doors closed. Interview of the facility maintenance director at the time of observation confirmed the door would not remain closed. Reference NFPA 101, 2000 Edition 19.3.6.3.2	K 018	**K027** **Smoke departments will be smoke resistive. This will be accomplished by:** **1. The South Station Linen Room door will be equipped with a closer.** **2. Central Soiled Utility room door will fully close.** **3. Maintenance Staff been inserviced to the deficiency.** **4. The Maintenance Director or designee will conduct monthly door inspections making immediate corrections to identified infractions.** **5. 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 027 SS=D	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	K 027		10/7/14

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

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K 027	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 9 smoke compartments were smoke resistive. The findings were: Observation of the South Linen Room on 08/26/14 at 10:45 AM showed the door was not provided with a closer. Interview of the facility maintenance director at the time of observation confirmed the door did not have a closer. Observation of the Central Soiled Utility Room on 08/26/14 at 2:07 PM showed the door would not fully close to provide resistance to the passage of smoke. Interview of the facility maintenance director at the time of observation confirmed the door would not remain closed.	K 027	**K 038** **The facility will ensure that exits are readily accessible at all times.** **This will be accomplished by:** 1. **Maintenance Staff have been inserviced to the deficiency.** 2. **West Station exit discharge door keypad will be activated.** 3. **The gate adjacent to room #208 will be removed.** 4. **The above mentioned gate will bear signage "PUSH TO EXIT".** 5. **The Maintenance Director will review and if necessary revise qtrly audit reports to assure that exits are readily accessible at all times. Results of the audits will be reported to the QA team for a minimum of 6 months at which point the team will determine appropriate reporting until ongoing compliance is established.**	
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, the facility failed to ensure access to an exit discharge was available in 2 of 9 smoke compartments. The findings were: Observation of the exit discharge door in the Secured Unit, adjacent to the Staff Lounge, on 08/26/14 at 3:55 PM showed the exit door only	K 038		10/7/14

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K 038	Continued From page 4 opened in the event the fire alarm was activated. A keypad is located at the door but had been disconnected. Staff members are not able to readily unlock the exit door at all times. At the time of the observation, the facility maintenance director confirmed the function of the door. Observation of the exit discharge in the protected stairwell, adjacent to room #208, on 08/26/14 at 2:30 PM revealed an accessed controlled gate equipped with a manual release button at the upper landing. Upon pushing the release button, it was discovered that the gate would not stay unlocked unless the release button was held as pressure was applied to the gate. Further observation revealed the gate was not provided with a sensor on the egress side to detect an occupant approaching, nor was any signage present stating "PUSH TO EXIT". At the time of the observation, the Facility Maintenance Director confirmed the function of the gate and additional findings. REFERENCES 19.2.2.2.4 (Exception No. 1): Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. 7.2.1.6.2 Access-Controlled Egress Doors.	K 038	**K 052** **The fire alarm system will be tested semi-annually for battery load voltage. This will be accomplished by:** **1. Maintenance staff will be inserviced to the deficiency.** **2. Maintenance director will draft agreement with vendor to assure semi-annual testing occurs.** **3. Maintenance director will present schedule to QA committee to ensure that all tests are properly conducted and documented.** **4. The QA committee will review Schedules monthly to assure compliance, making corrections/revisions as necessary.**	10/7/14
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is	K 052		

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K 052	Continued From page 5 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 067 SS=D	This STANDARD is not met as evidenced by: Based on review of fire alarm testing and maintenance records and staff interview; the facility failed to provide documentation identifying the required semi-annual battery load voltage testing in compliance with the requirements of NFPA 72. The findings were: Review on 08/26/14 from 10:30 AM to 11:45 AM of the fire alarm testing and maintenance records revealed the absence of one semi-annual battery load test in 2014 as required by NFPA 72-1999, Section 7-3.2 (6). At the time of the review, the Facility Maintenance Director acknowledged the lack of documentation for the battery load test. NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	**K 067** **HVAC systems will be tested every 4 years.** **This will be accomplished by:** 1. **Maintenance staff will be inserviced to the deficiency.** 2. **Maintenance director will arrange for vendor to test HVAC system every 4 years.** 3. **Maintenance director will present schedule to QA committee to ensure that HVAC tests are conducted in timely manner.** 4. **The QA committee will review the fire drill schedule each month for a minimum of 3 months, making corrections/revisions as necessary.**	10/7/14

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K 067	Continued From page 6 This STANDARD is not met as evidenced by: Based on document review & staff interview, the facility failed to ensure that HVAC systems are tested per the requirements of NFPA 90A. The findings were: Document review and staff interview on 08/26/14 between 10:30 AM and 11:45 AM revealed that no documentation was available to indicate that fire dampers are being tested on a 4-year basis in accordance with NFPA 90A, Section 3-4.7. Interview with the Facility Maintenance Director at the time of document review acknowledged the missing documentation.	K 067	**K 130** **Door hardware will be operable with only one action and without tight pinching to operate.** **This will be accomplished by:** 1. **Maintenance staff will be inserviced to the deficiency.** 2. **Door hardware for the Beauty Shop Salon door, Conference Room door & Sprinkler Room door on East station will be replaced according to code.** 3. **Maintenance director will present audits to Quarterly QA committee to ensure that all tests are properly conducted and documented.** 4. **The QA committee will review Schedules monthly to assure compliance, making corrections/revisions as necessary.**	10/7/14
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide door hardware that was operable with only one action and without tight pinching to operate. The findings were: Observation of the Beauty Salon door on 08/26/14 at 1:55 PM and the Conference Room on 08/26/14 at 2:45 PM revealed a thumb-turn lock on the door knob. The action of the knob did not release the lock in one release action and the thumb-turn lock required tight pinching to release. Interview with the Facility Maintenance Director at the time of the review acknowledged the door hardware.	K 130		

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K 130	Continued From page 7 REFERENCE NFPA 101 Life Safety Code, 2000 Edition 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. A.7.2.1.5.4 Examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This requirement is permitted to be satisfied by the use of conventional types of hardware, whereby the door is released by turning a lever, knob, or handle or by pushing against a panic bar, but not by unfamiliar methods of operation such as a blow to break glass. The operating devices should be capable of being operated with one hand and should not require tight grasping, tight pinching, or twisting of the wrist to operate. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide door hardware that were operable with only one action and without tight pinching to operate. The findings were: Observation of the Sprinkler Room on the East Unit on 08/26/14 at 11:10 AM revealed a thumb-turn lock on the door knob. The action of the knob did not release the lock in one release action and the thumb-turn lock required tight pinching to release. Interview with the Facility Maintenance Director at the time of the review acknowledged the door hardware.	K 130		

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K 130	Continued From page 8 REFERENCE NFPA 101 Life Safety Code, 2000 Edition 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. A.7.2.1.5.4 Examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This requirement is permitted to be satisfied by the use of conventional types of hardware, whereby the door is released by turning a lever, knob, or handle or by pushing against a panic bar, but not by unfamiliar methods of operation such as a blow to break glass. The operating devices should be capable of being operated with one hand and should not require tight grasping, tight pinching, or twisting of the wrist to operate.	K 130		