PRINTED: 10/20/2014
FORM APPROVED
OMB NO. 0938-0391

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 01 - MAIN BUILDING 01 B. WING _____	10/07/2014

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 Stories: 1 Construction: Type V(111) and Type II(111) Constructed: 1960s original, additions 1979, 1986, 1987, 1990 K0180: Fully Sprinkled Certified Beds: 192 Capacity: 192 Census: 151	K 000	**K 011** **Common walls with nonconforming building will have a fire barrier of at least a two-hour fire resistance rating constructed of materials as required for the addition. This will be accomplished by:** **1. Facility will request a time-limited waiver for architecture analysis of current wall fire resistance rating and installation of 90 minute fire resistance door assembly.** **2. The common wall between facility and chapel will have a 2 hour fire resistance rating as well as 90 minute fire resistance door assembly by 12/1/14.** **3. Maintenance Staff been inserviced to the deficiency.** **4. The Maintenance Director or designee will conduct annual and upon construction changes, inspections making immediate corrections to identified infractions.** **5. The Maintenance Director will report results of audit to the QA team until the team determines appropriate and ongoing compliance is established.**	
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to separate a non-conforming addition with a fire barrier having a fire resistance rating of not less than 2 hours. Findings include: On 10/7/14, the chapel and the nursing home were not separated by a 2 hour fire resistant barrier as required. Doors in 2 hour fire resistance rated barriers are required to be rated fire resistant to a minimum of 90 minutes. The door to the chapel was not a rated door. In addition, the provider could not provide	K 011		10/31/14

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

Administrator 10-27-14

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.

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K 011	Continued From page 1 documentation that the barrier wall was of 2 hour fire resistance rated construction. The chapel was not protected with automatic fire sprinklers. As such, the chapel was a non-conforming addition. Maintenance Staff #1 was present when the deficiency was identified. Failure to separate non-conforming additions as required increases the risk of death or injury due to fire. The deficiency affected one of four additions to the building. Ref: 2000 NFPA 101 Section 19.1.2.1(2), 8.2.3.2.3.1	K 011	**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. Kitchen door dead bolt has been replaced with an automatic latching mechanism.** **3. Pass through doors from kitchen to staffing dining area have automatic latching mechanisms.** **4. West clean utility corridor door has automatic latching mechanism.** **5. Maintenance Director or designee will audit doors for proper latching on a monthly basis making immediate corrections for noted deficiencies.** **6. Maintenance Director will report to the QA committee monthly audit results until such time the QA committee determines substantial compliance has been realized and/or making recommendations accordingly.**	10/31/14
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 interview, the facility failed to maintain corridor doors as required. Findings include: On 10/7/14 the following corridor doors were not equipped with latches acceptable to the authority having jurisdiction as required. Automatic latching doors are required. · Kitchen door equipped with dead bolt- not automatic latching · Pass through doors to dining area from kitchen, dining area open to corridor, 2 each, not automatic latching. · West clean utility corridor door- automatic latching device not latching Maintenance Staff #1 was present when the deficiency was identified. Failure to maintain corridor doors as required increases the risk of death or injury due to fire. The deficiency affected three of numerous locations requiring corridor doors. Ref: 2000 NFPA 101 Section 19.3.6.3.2	K 018	**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. Dietary Office deadbolt and knob have been replaced with one operation releasing mechanism.** **3. The east wing boiler room and west wing corridor door magnetic locks were removed.** **4. Doors leading out of the smokers courtyard had specialized releasing buttons removed.** **5. Exit door by room 219 was adjusted so that it no longer requires more than 50 lbs force to exit.** **6. South station dining room exterior door bears a "NO exit" sign above the door.** **7. Exit discharge servicing the exit door by room 31 bears a "NO exit" sign.**	
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	K 038		

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K 038	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the means of egress as required. Findings include: On 10/8/14, the following doors were equipped with two locking/ latching devices where two releasing operations were required to operate the door. Doors in the means of egress are required to be operable with not more than one releasing operation. Dietary Office- Dead bolt and Knob Ref: 2000 NFPA 101 Section 19.2.1, 7.2.1.5.4 On 10/6/14. the east wing boiler room and on 10 /7/14, the west wing corridor door were equipped with magnetic locks in the direction of egress that required pushing a button adjacent to the door to release the lock. These doors are required to be operable in the direction of egress without the use of a key, special knowledge or effort under all lighting conditions. The doors with the magnetic locks required special knowledge and effort and were not operable under all lighting conditions. On 10/7/14, two of the three doors providing egress from the smoker ' s courtyard were equipped with magnetic lock in the direction of egress that required pushing a button adjacent to the door to release the lock. The third door was equipped with a keyed lock in the direction of egress. At least one of these doors is required to	K 038	**8. The Maintenance Director or designee conduct quarterly audits to assure that all exits are readily accessible; making immediate corrections when identified. Audit results will be presented to QA committee for review and recommendations until such time that compliance is established.**	**10/31/14**

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K 038	Continued From page 4 be operable in the direction of egress without the use of a key, special knowledge or effort under all lighting conditions. The doors with the magnetic locks required special knowledge and effort and were not operable under all lighting conditions. The door with the keyed lock required a key. None of the doors were compliant. In addition, the path of the means of egress is required to be obvious. Ref: 2000 NFPA 101 Section 19.2.2.2.1, 7.2.1.5.1, 19.2.2.2.4 On 10/7/14 the following doors would not open when an excess of 50 lbs. force was applied. The opening for existing doors in existing buildings shall not exceed 50 lbs. applied to the latch style. · exit door by room 219 · South dining room exterior door- exit sign above door Ref: 2000 NFPA 101 Section 19.2.1, 7.2.1.4.5 exception #1(50lbs) On 10/7/14, the exit discharge serving the exit door by room 31 discharged to a courtyard where access to the public way was prevented by a large gate. The gate was not operable from the egress side. The exit door was indicated by an exit sign. The exit discharge is required to provide unimpeded access to the public way from the exit door. Ref: 2000 NFPA 101 Section 19.2.1, 7.7.4 Maintenance Staff #1 was present when the deficiency was identified.	K 038		

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K 038	Continued From page 5 Failure to maintain the means of egress as required increases the risk of death or injury due to fire. The deficiency affected seven of numerous doors in the means of egress.	K 038	**K 046** **All Emergency generators will be equipped with a remote stop button. The facility will provide documentation of annual 90 minute and monthly 30 second generator load testing. This will be accomplished by:** **1. Facility will request a time-limited waiver for installation of emergency stop buttons for 3 generators (2 outside and 1 inside).** **2. All generators will be equipped with a remote emergency stop button by 12/1/14.** **3. Maintenance Staff will be inserviced to the above deficiency.** **4. The Maintenance Director or designee will conduct monthly inspections of documents assuring that the monthly 30 second and 90 minute annual generator load test is performed and properly documented, making immediate corrections to identified infractions.** **5. The Maintenance Director will report results of audits to the QA team until the team determines appropriate and ongoing compliance is established.**	10/31/14
K 046 SS=E	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 and interview, the facility failed to Findings include: The following generators that provide power for emergency lighting did not have a remote manual stop outside of the room housing the prime mover (diesel or propane motor) or elsewhere on the premises where the prime mover located outside of the building as required. The emergency stop should be mounted outside of the weather enclosure when the generator is located outside. · Date: 10/6/14- East generator room · Date: 10/7/14- smoker courtyard · Date 10/7/14- West generator Ref: 2000 NFPA 101 Section 19.2.9.1, 7.9.2.3; 1999 NFPA 110 Section 3-5.5.6 On 10/7/14, there were no records of the required annual 90 minute test or the 30 second monthly testing required of battery powered emergency lights.	K 046		

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K 046	Continued From page 6 Ref: 2000 NFPA 101 Section 19.2.9.1, 7.9.3 Maintenance Staff #1 was present when the deficiency was identified. Failure to provide emergency lighting as required increases the risk of death or injury due to fire. The deficiency affected two of numerous requirements of emergency lighting.	K 046	**K 050** **Fire drills will be held quarterly under varying conditions.** **This will be accomplished by:** 1. **Maintenance Staff has been inserviced to the deficiency.** 2. **The Maintenance Director or designee will conduct a minimum of quarterly fire drills that are at varying times.** 3. **The Maintenance Director will audit fire drills noting times of the drills to assure that they are varying in a monthly audit. Audit results will be reported to the QA team at which point the team will determine appropriate reporting and ongoing compliance is established.**	10/31/14
K 050 SS=B	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 observation and interview, the facility failed to conduct fire drills as required. Findings include: On 10/7/14 3rd shift fire drills were conducted at 5:30 am for each month from April 2014 to August 2014. 2nd shift drills were conducted between 2:30 pm and 3:30pm each month between May and September 2014. Fire drills are required to be conducted under varying conditions. Time in	K 050		

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K 050	Continued From page 7 the shift is one of the conditions. The shift is 8 hours long. Two of three shifts need to vary the time of drills. Maintenance Staff #1 was present when the deficiency was identified. Failure to conduct fire drills as required increases the risk of death or injury due to fire. Two of three shifts were affected. Ref: 2000 NFPA 101 Section 19.7.1.2	K 050	**K 054** **Smoke detectors will have sensitivity testing every other year.** **This will be accomplished by:** **1. Smoke detectors will have sensitivity testing every other year in accordance with agreement from approved vendor.** **2. Maintenance Staff been inserviced to the deficiency.** **3. The facility administrator will meet with vendor to assure that they will provide smoke detector testing every other year and provide supporting documentation of such.** **4. The Maintenance Director will develop audit tool to track and monitor assuring that vendor performs above mentioned test in timely fashion with provision of supporting documentation.** **5. The Maintenance Director will report to the QA team the audit tool and mechanism for tracking. The QA team will determine ongoing reporting timeline to assure compliance is sustained.**	10/31/14
K 054 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to test smoke detectors as required. Findings include: On 10/7/14 there were no records of smoke detector sensitivity testing. Testing is required on alternate years unless previous testing shows that the detectors have remained within its listed and marked sensitivity range. The interval between testing may then be extended to 6 years. There were no records that indicated that the detectors met this requirement or the alternate year testing. Maintenance Staff #1 was present when the deficiency was identified.	K 054		

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K 054	Continued From page 8 Failure to test smoke detectors as required increases the risk of death or injury due to fire. The deficiency affected all smoke detectors in the building. Ref: 2000 NFPA 101 Section 9.3.4.1, 9.6.1.4; 1999 NFPA 72 Section 7-3.2.1.	K 054	**K 056** **Required sprinkler systems are equipped with water flow and tamer switches. This will be accomplished by:** **1. Regular sprinkler head in East entrance was replaced with a quick response sprinkler head.** **2. Maintenance Staff been inserviced to the deficiency.** **3. The Maintenance Director or designee will conduct quarterly sprinkler head inspections making immediate corrections to identified infractions.** **4. The Maintenance Director will report audit results to the QA team until team establishes compliance.**	10/31/14
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install an automatic sprinkler system as required. Findings include: On 10/7/14, the east entrance was protected with one regular response and two quick response sprinklers. When exiting light hazard areas are converted to use quick response sprinklers, all	K 056		

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K 056	Continued From page 9 sprinklers in a compartment or space are required to be changed. The east entrance was a single compartment that did not meet this requirement. Maintenance Staff #1 was present when the deficiency was identified. Failure to install automatic fire sprinklers as required increases the risk of death or injury due to fire. The deficiency affected one of numerous compartments in the building. Ref: 2000 NFPA 101 Section 19.1.6.2, 19.3.5.1, 9.7.1.1; 1999 NFPA 13 Section 5-3.1.5.2	K 056	**K 104** **Penetrations of smoke barriers by ducts are protected.** **This will be accomplished by:** **1. The hole in East Wing cross corridor above doors by room 131 was properly sealed.** **2. Maintenance Staff been in serviced to the deficiency.** **3. The Maintenance Director or designee will conduct quarterly audits to identify compromised smoke barriers making immediate correction and/or repair when identified. Results of audits will be reported to the QA team until such compliance is established.**	**10/31/14**
K 104 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers as required. Findings include: On 10/7/14 the smoke barrier locations listed below were unsealed where the penetration would not resist the passage of smoke. Penetrations in smoke barriers by conduits are required to be filled with material that will resist the passage of smoke or be protected by an	K 104		

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K 104	Continued From page 10 approved device that is designed for the specific purpose. • East wing above cross corridor doors by room 131- 1 inch diameter hole with com cables unsealed. Maintenance Staff #1 was present when the deficiency was identified. Failure to maintain smoke barriers as required increases the risk of death or injury due to fire. The deficiency affected two of eight smoke compartments. Ref: 2000 NFPA 101 Section 19.3.7.3, 8.3.6.1	K 104		