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, 01 B. WING _____	03/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY CARE CENTER	80 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. 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	K 012	K 012 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CW Administrator — (X6) DATE: 4-21-11

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.

RECEIVED
Wyoming Dept of Health

RC approved w/ Jill Hoyt, CBD, on 5/03/11

FORM CMS-2567(02-99) Previous Versions Obsolete — Event ID: C71521 — Facility ID: WY0027 — If continuation sheet Page 1 of 9

APR 25 2011

Office of Healthcare Licensing and Surveys

APR. 13. 2011 11:27AM NO. 1879 P. 4

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

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

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K 012	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the walls were smoke resistant in 1 of 7 smoke compartments. The findings were: Observation in resident room #207 on 3/28/11 at 2:40 PM showed a 1 ¼ inch circular hole with a coaxial cable running through it. The cover was attached to the cable which had been pulled away from the wall. At the time of the observation the facility manager reported room inspections were conducted on a monthly basis.	K 012	This will be accomplished by; 1. Resident room 207 the two 1 ¾ holes will be patched with 5/8 dry wall coaxial cable will be running in the wall 2. Maintenance and housekeeping will be inseviced to the deficiency 3. The Facilities Director or designee will conduct room inspection monthly 4. The Facilities Director will report inspection results the Quality Assurance team no less then monthly for a period of not less then 90 days	4/1/11
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. This STANDARD is not met as evidenced by:	K 018	K 018 Doors protecting corridor openings in other then required enclosures of vertical opening, exits, or hazardous areas are substantial doors such as those constructed of 1 ¾ inch solid bonded core wood or capable of resisting fire for at least 20 minutes Doors in a sprinklered building are only required to resisting the passage of smoke. There is no inpediment to to 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	

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	535042	A. BUILDING 02 - 01 B. WING	03/29/2011

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

5/03/11

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K 018	Continued From page 2 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 room #59 and #15 on 3/28/11 between 3:30 PM and 4 PM showed the corridor doors rubbed on the ground and the latch bolt did not insert into the strike plate. At 3:32 PM the facility manager reported corridor doors were inspected on a monthly basis. He stated he did not know why those doors had been missed during those inspections.	K 018	K 018 This will be accomplished by; 1. The doors entering rooms 59 and 15 will be properly adjusted so the door do not rub on floor and latch bolt will insert into the strike plate 2. The Facilities director will conduct monthly inspections on all doors to ensure doors are not rubbing on floor and will fully latch into strike plate 3. The Facilities director will report inspection results to the Quality Assurance team no less then monthly for a period of not less then 90 days	4/4/11
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 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 1 of 4 smoke barrier walls were smoke resistant. The findings were: Observation of the central smoke barrier wall near resident room #211 on 3/29/11 at 10:20 AM showed a 1 inch unsealed pipe penetrations in the attic. At the time of the observation the facility	K 025	K025 Smoke barriers are constructed to provide at least a one ½ hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-glazing or by wired glass panels and steel frames. A minimun 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.	

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	535042	A. BUILDING 02 , 01 B. WING	03/29/2011

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5/05/11

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K 025	Continued From page 3 manager reported smoke barriers were inspected on a quarterly basis. He stated he did not know why the penetration was not identified by their inspection protocol.	K 025	1 The central smoke barrier near room #211 will be calk with a fire stop sealant . 2. Maintenance staff will be inserviced to the deficiency.	4/4/11
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 from use areas in 3 of 7 smoke compartments. The findings were: 1. Observation of the basement storeroom on 3/28/11 at 1:57 PM revealed four unsealed cable penetrations located near the stairwell. At the time of observation the facility manager reported hazardous areas were inspected semi-annually. 2. Observation of the central soiled utility room on 3/28/11 at 2:31 PM showed the corridor door was equipped with an automatic closing device. The closing device did not fully latch the door into the door frame, with three attempts.	K 029	3. The facilities director will conduct smoke barrier inspection : 4. The Facilities Director will report inspection results the Quality Assurance team no less then monthly for a period of not less then 90 days K029 One hour fire rated construction (with ¾ hour fire-rated door) 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 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. 1. The basement storeroom all 4 unsealed cable penetrations will be sealed with fire stop sealant 2. The central soiled utility room will be getting a new door so that door will fully latch. The door will in by April 14, 2011	5/8/11

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K 029	Continued From page 4 3. Observation of the liquid oxygen storeroom on 3/28/11 at 4:35 PM showed the corridor door was equipped with an automatic closing device. The closing device did not fully latch the door into the door frame, with three attempts. 4. Observation of the south storeroom near resident room #11 on 3/29/11 at 8:55 AM showed 24 cardboard boxes were being stored in the room. Further review showed the corridor door was a hollow core door, and the door was not equipped with an automatic closing device. At the time of observation the facility manager reported he knew that this room did not meet the separation requirement. Based on observation and staff interview the facility failed to ensure hazardous areas were separated from use areas in 1 of 2 smoke compartments. The findings were: Observation of the east activity office on 3/28/11 at 9:31 AM showed paper supplies were stored on four shelves. The corridor door to this area was equipped with an automatic closing device, but the door was obstructed by a cord. At the time of observation the facility manager reported he continually told the activity manager not to obstruct the door.	K 029	3, The liquid oxygen storeroom door got a new self-closing device so the door will fully latch into door frame 4. The storeroom near room #11 will get a 2 ½ hour fire rated door with self closing device. The will be in casper on the April 14, 2011 5. The rope will be removed from east actives room . 6 All staff will be serviced to the deficiency 7. The facilities director will conduct monthly inspection on all doors leading to hazardous areas to ensure that they are not impeded from properly closing 8. The facilities director will report inspection results to Quality Assurance team no less then monthly for a period of not less then 90 days	5/8/11
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, 9.7.5 This STANDARD is not met as evidenced by:	K 062	K 062 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically 19.7.6, 4.6.12 NFPA 25.9.7.5	

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K 062	Continued From page 5 Based on observation and staff interview the facility failed to ensure sprinkler heads were unobstructed in 1 of 7 smoke compartments. The findings were: Observation of the central mechanical room on 3/28/11 at 1:45 AM showed 5 of 5 sprinkler heads were obstructed by ceiling-mounted lights or sprinkler pipes. The sprinkler heads were located less than 12 inches from the obstructions and the deflectors were above the bottom of the obstructions. One of the obstructions was actually 5 inches below the sprinkler deflector. At the time of observation the facility manager reported an outside sprinkler contractor conducted annual sprinkler inspections. According to the facility manager, the last annual inspection on 12/28/10 did not indicate any heads were obstructed.	K 062	1. The five sprinkler heads in the central mechanical room will be lower so the at least 1 inch below ceiling-mounted lights and sprinkler pipes 2 Maintenance staff will be in serviced to the deficiency. 3 Facility Director or designee will conduct quarterly inspections to ensure that the sprinkler heads are not obstructed. 4 Facilities Director will report the results of the inspection to the Quality Assurance team no less than monthly for a period of not less than 90 days	4/20/11
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover	K 066	K 066 Smoking regulations are adopted and include no less then the following provisions; 1 smoking is prohibited in any room, ward or compartment were flammable liquids combustible gases or oxygen is used or stored and in any other hazardous location and such area is posted with signs that read NO SMOKING or with the international Symbol for no smoking. 2 Smoking by patients classified as not responsible is prohibited except when under direct supervision	

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K 066	Continued From page 6 devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure staff members followed the smoking policy in 1 of 7 smoke compartments. The findings were: Observation of the east exit to the basement classroom on 3/28/11 at 2:02 PM showed 30 cigarette butts were mingled with dried grass and leaves under a hedge. Further review showed the area was designated as non-smoking and was no supplied with any ashtrays. At the time of the observation the facility manager stated he did not know why the facility's non-smoking policies were not being followed.	K 066	3 Ashtrays of noncombustible material and is safe design are provided in all areas where smoking is permitted 4 Metal containers with self-closing cover devices into which ashtray can de emptied are readily available to all areas where smoke is permitted 19.7.4 1 The smoking policies will be changed to more designated smoking areas and ashtrays will be put by all exits. 2 The facilities director will designee and conduct monthly grounds inspections 3 Maintenance will be inseviced to the deficiency 4. The Facilities Director will report inspection results the Quality Assurance team no less then monthly for a period of not less then 90 days	5/8/11
K 147 SS=E	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 wiring did not replace permanent fixed wiring and failed to ensure damaged electrical equipment was replaced in 5 of 7 smoke compartments. The findings were: 1. Observation of the electrical system on 3/28/11	K 147	K 147 Electrical wiring and equipment is in accordance with NFPA 70 , National Code 9.1.2 1 The 3-way electrical adapters an extension cord were removed from rooms 216 and 212 103.	4/1/11

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K 147	Continued From page 7 between 2 PM and 5 PM showed 3-way electrical adapters and extension cords were being used in resident room #216, #212 and the central television room. At the time of the observation the facility manager reported the electrical system was inspected on a monthly basis. He acknowledged the adapters had not been noticed and removed during these inspections. 2. Observation of the electrical system on 3/28/11 at 2:55 PM showed the oxygen concentrator was being stored in the restroom. Further review showed the concentrator was plugged into an electrical outlet in the sleeping room, and the power cord was run under the closed restroom door. At the time of observation the facility manager reported he was aware electrical cords are prohibited from running through door frames, windows or walls. 3. Observation in the west sunroom on 3/29/11 at 8:36 AM showed a burned hole and black charring on the ceiling heat pan. At the time of observation the facility manager reported the ceiling heating unit was not damaged at the time of the last monthly survey. The nursing staff in the area stated they were unaware of any electrical problems with the unit. Based on observation and staff interview the facility failed to ensure temporary wiring did not replace fixed permanent wiring and failed to ensure damaged wiring was replaced in 2 of 2 smoke compartments. The findings were: 1. Observation of the electrical system on 3/29/11 at 9:24 AM showed the power cord to the oxygen concentrator in resident room # 131 was damaged. The outer sheath had been pulled back, and the inner wires were exposed. At the	K 147	2 The concentrator was replaced with new one and plugged the concentrator into the outlet in bathroom. 3 The ceiling heating panel was removed and new heat panel was built in 4 The concentrator was replaced in with new concentrator and plugged into bathroom outlet. Room # 131 5. The facilities director will conduct monthly electrical inspection. 6. The facilities director will report inspection results the Quality assurance team no less then monthly for a period of not less then 90 days	4/20/11 QUARTERLY

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K 147	Continued From page 8 time of the observation the facility manager reported the electrical system was inspected on a monthly basis. He verified this problem was not identified during the facility's inspections. 2. Observation of the electrical system on 3/29/11 at 9:54 AM showed the television in resident room #103 was plugged into a 3-way adapter. At the time of observation the facility manager reported he was aware 3-way electrical adapters were prohibited.	K 147		

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FORM APPROVED
OMB NO. 0938-0391

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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 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 from use areas in 1 of 2 smoke compartments. The findings were:	K 029	Paper supplies have been removed. The rope will be removed from east actives room. All staff will be serviced to the deficiency The facilities director will conduct monthly inspection on all doors leading to hazardous areas to ensure that they are not impeded from properly closing The facilities director will report inspection results to Quality Assurance team no less then monthly for a period of not less then 90 days	4/20/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO/Administrator — (X6) DATE: 4/20/11

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.

RECEIVED
Wyoming Dept of Health
MAY 04 2011
Office of Healthcare Licensing and Surveys

Dr. Mansfield w/ Jill Hurt, CEO, ONS/03/11.

FORM CMS-2567(02-99) Previous Versions Obsolete — Event ID: C71521 — Facility ID: WY0027 — If continuation sheet Page 1 of 3

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FORM APPROVED
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5/03/11

(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 1 Observation of the east activity office on 3/29/11 at 9:31 AM showed paper supplies were stored on four shelves. The corridor door to this area was equipped with an automatic closing device, but the door was obstructed by a cord. At the time of observation the facility manager reported he continually told the activity manager not to obstruct the door.	K 029		
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 wiring did not replace fixed permanent wiring and failed to ensure damaged wiring was replaced in 2 of 2 smoke compartments. The findings were: 1. Observation of the electrical system on 3/29/11 at 9:24 AM showed the power cord to the oxygen concentrator in resident room # 131 was damaged. The outer sheath had been pulled back, and the inner wires were exposed. At the time of the observation the facility manager reported the electrical system was inspected on a monthly basis. He verified this problem was not identified during the facility's inspections. 2. Observation of the electrical system on 3/29/11 at 9:54 AM showed the television in resident room #103 was plugged into a 3-way adapter. At the time of observation the facility manager reported he was aware 3-way electrical adapters were prohibited.	K 147	Electrical wiring and equipment is in accordance with NFPA 70 , National Code 9.1.2 The concentrator was replaced in with new concentrator and plugged into bathroom outlet. Room # 131 The 3-way electrical adapters an extension cord were removed from rooms 216 and 212 103. The facilities director will conduct monthly electrical inspection . The facilities director will report inspection results quarterly to the Quality Assurance team for a period of not less than six months.	4/20/11