

## Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

WY0027

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

B. WING:

RECEIVED

WY Dept of Health

NOV 16 2015

(X3) DATE SURVEY  
COMPLETED

10/22/2015

Healthcare Licensing  
and Surveys

NAME OF PROVIDER OR SUPPLIER

SHEPHERD OF THE VALLEY HEALTHCARE CI

STREET ADDRESS, CITY, STATE, ZIP CODE

80 MAGNOLIA  
CASPER, WY 82604

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X5)<br>COMPLETE<br>DATE |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| S2924                    | <p>Ch 11 Sec 6 (a)(iv) Physical Environment</p> <p>(a) The building(s) of the Nursing Care Facility shall be constructed, arranged and maintained to ensure the health and welfare of all residents.</p> <p>(iv) Shower/bath and resident lavatories shall be set to provide water of a temperature not to exceed 110 degrees Fahrenheit.</p> <p>This State Rule and Regulation is not met as evidenced by:<br/>Based on observation and staff interview, the facility failed to ensure the water temperature in resident areas was set to 110 degrees Fahrenheit (F) or less. The findings were:</p> <p>Observation on 10/20/15 beginning at 9:09 AM showed the following concerns with hot water temperatures:</p> <ul style="list-style-type: none"> <li>a. The sink water temperature in resident room 112 was 127.0 degrees F.</li> <li>b. The sink water temperature in resident room 114 was 125.8 degrees F.</li> <li>c. The sink water temperature in resident room 119 was 125.4 degrees F.</li> <li>d. The sink water temperature in resident room 105 was 125.0 degrees F.</li> <li>e. The sink water temperature in resident room 39 was 111.3 degrees F.</li> <li>f. The sink water temperature in resident room 214 was 117.6 degrees F.</li> <li>g. The bath water temperature in the East unit bathtub room was 123.8 degrees F.</li> </ul> <p>Interview with the maintenance director on 10/20/15 at 9:49 AM confirmed the water available for residents had unsafe temperatures by using a brand new facility thermometer to retest the water previously tested by the surveyor. He further revealed the original thermometer he</p> | S2924               | <p>S2924</p> <ol style="list-style-type: none"> <li>1. Resident rooms identified have been checked and water temperatures are within regulatory guidelines.</li> <li>2. All resident rooms have been checked to ensure water temperatures are within regulatory guidelines.</li> <li>3. The Maintenance director and maintenance staff have received education on regulatory guidelines for safe water temperatures for resident rooms.</li> <li>4. Resident rooms will be tested for temperatures per Preventative Maintenance programming. Maintenance Director/designee will report findings to QAPI monthly for at least 3 monthly or until the QAPI deems it no longer necessary.</li> </ol> | 11/27/15                 |

Wyoming Dept of Health, Aging Services, Healthcare Licensing and Surveys  
LABORATORY DIRECTOR FOR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

200411

If continuation sheet 1 of 2

POC accepted. Call to Carly Appleton, WHA on 11/19/15 9:22 am.

DOC = 11/27/15

Jenele Galt 10/26/15

## Healthcare Licensing and Surveys

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|-----------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------|
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|-----------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------|

|                                                                          |                                                                          |
|--------------------------------------------------------------------------|--------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>SHEPHERD OF THE VALLEY HEALTHCARE CE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>60 MAGNOLIA<br>CASPER, WY 82604 |
|--------------------------------------------------------------------------|--------------------------------------------------------------------------|

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|--------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| S2924                    | Continued From page 1<br><br>had been using to test the water temperatures<br>weekly did not register the correct temperature. | S2924               |                                                                                                                          |                          |