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

FORM APPROVED
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	10/23/2015

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 (west and central wing) was a fully sprinklered, one story building of Type V (000) and Type V (111) construction built in 1956 and 1987. The building was equipped with a supervised automatic wet sprinkler system (west wing) and dry sprinkler system (central wing) with an addressable fire alarm system. The west and central wings had a bed capacity of 126 beds, with a total facility capacity of 192 certified Medicare and Medicaid beds with a census of 157.	K 000		
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	K018 1. The doors for rooms #108, #30, have been repaired or replaced. 2. All smoke doors have been checked, repairs or replacements have been completed as indicated. 3. Maintenance staff has been provided education on NFPA guidelines. 4. Random audits will be conducted monthly on smoke doors as per regular preventative maintenance practices by the safety committee. Findings will be reported to the Maintenance Director. 5. The Maintenance Director/designee will report findings to QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	11/27/15

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

Tatiana Johnson Actg Admr 11/16/15

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.

modified POC Accepted via Phone Call with Tatiana Johnson Actng Administrator on 12/3/15 @ 11:06am

34354

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

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	535042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/23/2015

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SHEPHERD OF THE VALLEY HEALTHCARE CENTER	60 MAGNOLIA CASPER, WY 82604

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide doors that resist the passage of smoke in 2 of 7 smoke compartments. The findings were: 1. Observation on 10/20/15 at 3:50 PM revealed the door to room #108 was warped within the frame and required a force in excess of 5 ft-lbs to fully close and latch the door. At the time of the observation the Facility Maintenance Manager acknowledged the excessive force needed to close the door. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.4.5 2. Observation on 10/21/15 at 8:55 AM revealed the door to room #30 would not latch into the door frame. At the time of the observation the Facility Maintenance Manager acknowledged the door would not latch into the door frame. Ref: 2000 NFPA 101, Section 19.3.6.3.2	K 018		
K 029 SS=D	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	K 029		

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K 029	Continued From page 2 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 protected from the corridor with self-closing doors in 1 of 7 smoke compartments. The findings were: Observation on 10/21/15 at 9:15 AM revealed the west wing janitor's closet adjacent to the oxygen storage room was over 50 sqft. The space was used for the storage of chemicals, and other combustible supplies. Further observation revealed the door to the corridor was not provided with a self-closing device. At the time of the observation the Facility Maintenance Manager acknowledged the door was not self-closing. Ref: 2000 NFPA 101, Section 19.3.2.1	K 029	K029 1. The doors the noted housekeeping closet, have been repaired and fitted with a self closing device. 2. All compartment doors have been checked, , have been repaired and fitted with a self closing device as indicated. 3. Maintenance staff has been provided education on NFPA guidelines. 4. Random audits will be conducted monthly on self closing doors as per regular preventative maintenance practices by the safety committee. Findings will be reported to the Maintenance Director. 5. The Maintenance Director/designee will report findings to QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	11/23/15
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 staff interview, the facility failed to arrange exit access so that exits are readily accessible at all times in 3 of 7 smoke compartments. The findings were: 1. Observation on 10/21/15 from 8:40 AM to 10:02 AM revealed the door locks required tight pinching, and more than one releasing operation to make the door operable. This condition was observed at the Valley Store, HR Office, Employee Services Office, Beauty Salon Closet, and the Activities Office. At the time of the observations the Facility Maintenance Manager acknowledged the door locks required more than one operation. 2. Observation on 10/21/15 at 9:45 AM of the El Bonbogen storage closet, adjacent to the nurses station revealed the door lock required tight pinching, and more than one releasing operation to make the door operable. A additional slide lock was also provided approximately 72" above the floor on the left upper corner of the door. At the time of the observation the Facility Maintenance Manager acknowledged the two door locks. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.4	K 038	K038 1. The doors noted have been repaired and fitted with a lever action handles that provide clear means of egress. 2. All doors have been checked, , have been repaired and fitted with lever action handles that provide clear means of egress 3. Maintenance staff has been provided education on NFPA guidelines. 4. Random audits will be conducted monthly on doors as per regular preventative maintenance practices by the safety committee. Findings will be reported to the Maintenance Director. 5. The Maintenance Director/designee will report findings to QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	11/20/15
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 047		

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K 047	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide approved exit signs were the exit was not obvious and clearly identifiable in 1 of 7 smoke compartments. The findings were: Observation of the direction of travel through the corridor exiting the secured unit on 10/21/15 at 9:31 AM revealed the exit adjacent to laundry was not obvious and clearly identifiable. Further observation revealed an exit sign had been present at one time, but had been removed. At the time of the observation the Facility Maintenance Manager acknowledged the exit was not obvious and clearly identifiable. Ref: 2000 NFPA 101, Sections 19.2.10.1 and 7.10.1.2	K 047	K047 1. The exit sign has been replaced to identify means of egress. 2. All exit routes have been reviewed and signs noted providing clear means of egress. 3. Maintenance staff has been provided education on NFPA guidelines. 4. Random audits will be conducted monthly on exit as per regular preventative maintenance practices by the safety committee. Findings will be reported to the Maintenance Director. 5. The Maintenance Director/designee will report findings to QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	11/27/15
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	K 056		

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K 058	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that the facility has complete sprinkler coverage in 1 of 7 smoke compartments. The findings were: Observation of the beauty salon storage closet on 10/21/15 at 9:55 AM revealed that a sprinkler head had been installed, but at some point removed and not replaced. Interview with the Facility Maintenance Manager at the time of the observation confirmed the closet was not provided with a sprinkler, and was not aware of it's removal. Ref: 2000 NFPA 101, Section 19.3.5.1	K 056	K058 1. The beauty salon closet has been fitted with a new sprinkler head. 2. All closets have been reviewed for further deficiencies, repairs made as indicated. 3. Maintenance staff has been provided education on NFPA guidelines. 4. Random audits will be conducted monthly on fire sprinklers as per regular preventative maintenance practices by the safety committee. Findings will be reported to the Maintenance Director. 5. The Maintenance Director/designee will report findings to QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	11/27/15
K 062 SS=D	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: Based on observation and staff interview, the facility failed to ensure that automatic sprinkler systems are installed, and continuously maintained per the requirements of NFPA 13 and NFPA 25. The finding were: 1. Observation of the sprinkler head located in	K 062		

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K 062	Continued From page 6 the closet of the Director of Nursing office on 10/20/15 at 3:25 PM revealed a missing escutcheon ring with a resulting gap around the sprinkler piping penetration the ceiling. The Facility Maintenance Manager acknowledged the escutcheon was not installed. Ref: 2000 NFPA 101, Sections 19.3.5.1 and 9.7.1.1 1999 NFPA 13, Section 3-2.7.2 2. Observation of the east sprinkler riser room on 10/21/15 at 8:25 AM revealed the fire riser had been modified from the original installation for the addition of a reduce principle backflow preventer and valves. No hydraulic design information sign was provided. At the time of the observation the Facility Maintenance Manager indicated that he was unaware of the date of modification, but would provide the required information. Ref: 2000 NFPA 101, Sections 19.3.5.1 and 9.7.1.1 1999 NFPA 13, Sections 5-15.4.6.2 and 10-5 3. Observation of the west sprinkler riser room on 10/21/15 at 9:11 AM revealed the fire riser had been modified from the original installation for the addition of a reduce principle backflow preventer and valves. No hydraulic design information sign was provided. At the time of the observation the Facility Maintenance Manager indicated that he was unaware of the date of modification, but would provide the required information. Ref: 2000 NFPA 101, Sections 19.3.5.1 and 9.7.1.1 1999 NFPA 13, Sections 5-15.4.6.2 and 10-5	K 062	K062 1. The sprinkler head and missing escutcheon ring identified in the DON office has been repaired. Hydraulic design information has been obtained and posted for east and west sprinkler rooms. 2. Other areas have been reviewed for compliance. Hydraulic design information will be posted at riser sites and maintained in permanent records. 3. Maintenance staff has been provided education on NFPA guidelines. 4. Random audits will be conducted monthly on fire sprinklers and check fire riser rooms for proper documentation as per regular preventative maintenance practices by the safety committee. Findings will be reported to the Maintenance Director. 5. The Maintenance Director/designee will report findings to QAPI monthly for a total of 3 months for recommendations, changes, and continuance 11/27/15	

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K 076 K 076 SS=D	Continued From page 7 NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide an adequate medical gas storage area per NFPA 99. The findings were: Observation of the oxygen storage room on 10/21/15 at 9:10 AM revealed concentrators and card board boxes being stored within the space. At the time of the observation the Facility Maintenance Manager acknowledged the combustible materials being stored within the location. Ref: 2000 NFPA 101, Section 19.3.2.4 1999 NFPA 99, Section 4-3.1.1.2	K 076 K 076	1. The oxygen rooms have been cleaned of all combustible materials. . 2. The facility currently has only one area for oxygen storage. 3. Maintenance staff has been provided education on NFPA guidelines. All staff have been educated on oxygen room storage and debris. 4. Random audits will be conducted 3x weekly of oxygen room by safety committee. Findings will be reported to the Maintenance Director. 5. The Maintenance Director/designee will report findings to QAPI monthly for a total of 3 months for recommendations, changes, and continuance	11/27/15

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	535042	A. BUILDING 02 - EAST BUILDING 02 B. WING	10/23/2015

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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 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 (East Wing) was a fully sprinklered, two story building of Type II (111) construction built in 1979. The building was equipped with a supervised automatic wet sprinkler system with an addressable fire alarm system. The East Wing had a bed capacity of 66 beds, with a total facility capacity of 192 certified Medicare and Medicaid beds with a census of 167.	K 000	K052 1. The sprinkler heads/escutcheons in rooms #217, #210, basement closet have been repaired or replaced. 2. All sprinkler heads/escutcheons have been checked, repairs or replacements have been completed as indicated. 3. Maintenance staff have been provided education on NFPA guidelines.	
K 062 SS=D	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: Based on observation and staff interview, the facility failed to ensure that automatic sprinkler systems are installed, and continuously maintained per the requirements of NFPA 13 and NFPA 25. The finding were: 1. Observation of the sprinkler head located in the bathroom of room #217 on 10/20/15 at 2:55 PM revealed a missing escutcheon ring with a resulting gap around the sprinkler piping penetration the ceiling. The Facility Maintenance	K 062	4. Random audits will be conducted monthly on sprinkler head/escutcheons as per regular preventative maintenance practices by the safety committee. Findings will be reported to the Maintenance Director. 5.The Maintenance Director/designee will report findings to QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	11/29/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/16/15

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POC Accepted via Phone Call with Tatiana Johnson Acting Administrator on 12/3/15 @ 11:06am

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K 062	Continued From page 1 Manager acknowledged the escutcheon was not installed. Ref: 2000 NFPA 101, Sections 19.3.5.1 and 9.7.1.1 1999 NFPA 13, Section 3-2.7.2 2. Observation of the sprinkler head located in the closet of room #201 on 10/20/15 at 3:10 PM revealed fire caulking covering the majority of the sprinkler head and bulb. At the time of the observation the Facility Maintenance Manager acknowledged the fire caulking on the sprinkler. Ref: 2000 NFPA 101, Sections 19.3.5.1 and 9.7.5 1998 NFPA 25, Section 2-2.1.1 3. Observation of the sprinkler head located in the basement men's bathroom closet on 10/21/15 at 10:20 AM revealed a missing escutcheon ring with a resulting gap around the sprinkler piping penetration the ceiling. The Facility Maintenance Manager acknowledged the escutcheon was not installed. Ref: 2000 NFPA 101, Sections 19.3.5.1 and 9.7.1.1 1999 NFPA 13, Section 3-2.7.2	K 062		