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

PRINTED: 11/03/2016
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	10/19/2016

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 783.70 (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 fully sprinklered, one story building of Type V (000) and Type V (111) construction built in 1958 and 1987. The building was equipped with a supervised automatic wet sprinklered 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 166.	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers in patient sleeping areas in accordance with NFPA 101 in 1 of 9 smoke compartments. The findings were: Observation on 10/19/2016 at 1:40 PM of the Secure Unit and Nursing Station revealed that the continuity of the smoke barrier was not	K 025	K025 **Corrective Actions** The area in question will be modified to create a continuous community smoke barrier. **Others Potentially Affected** All residents on the West and Elbogen Units have the potential to be affected by this practice. **Systemic Changes** The Maintenance Department will be educated on NFPA Regulations regarding smoke compartments and smoke barriers. **Monitoring** The Maintenance Director or designee will conduct a monthly audit on facility smoke compartments to ensure compliance to NFPA and Life Safety Requirements. The results of these audits will be submitted monthly to QAPI Committee for further action if necessary.	12/02/16 12/02/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 11/11/2016

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.

ACCEPTED POC VIA PHONE CALL WITH ADMINISTRATOR MICHAEL SPEIDEL ON 12-8-16.
36540

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K 025	Continued From page 1 continuous through all concealed spaces in smoke compartments containing patient bedrooms. Additional observation revealed that the nursing station was not resistant to the passage of smoke and fire due to the service access opening in the wall. Interview with the Facility Maintenance Manager at the time of the observation acknowledged that the nursing station opening was part of the smoke barrier. Further interview revealed that he was not aware of the requirement. Ref: 2000 NFPA 101, Sections 19.3.6.5, 19.3.7.3 and 8.3.2	K 025	K038 **Corrective Actions** 1. Hand rails were placed on the ramp outside of physical therapy, at the exit of Rapid Recovery. 2. The door at the exit of Rapid Recovery, adjacent to Maurice Griffith Boarding Home will be repaired to comply with Life Safety Regulations 3. The Key pad on the exit door in the basement will be replace with a standard door knob. 4. The doors to the HR Director, Kitchen Storage area, SCU Nurse's Station, and the Exit Door in the basement will have single operation door knobs installed. 5. The signage going to the Smoking Courtyard will be brought into compliance with the Life Safety Code. **Others Potentially Affected** All residents have the potential to be affected by these practices. 1. All facility entrances will be audited by Maintenance Director or designee to ensure that all ramps requiring hand rails are compliant with Life Safety Code. Any issues will be resolved.	12/02/16
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 and staff interview, the facility failed to provide exits that are readily accessible at all times in accordance with NFPA 101. The findings were: 1. Observation on 10/19/2016 at 11:35 AM of the ramp outside physical therapy, and at 12:50 PM of the exit at the Rapid Recovery and adjacent to the Marcie Griffith Boarding Home, revealed that the ramps were not provided with hand rails. Further observation revealed the rise was greater than 6 inches. Interview with the Facility Maintenance Manager at the time of the observations acknowledged removing the split rail fence at the Rapid Recovery Exit, and not being aware that each side of the ramp requires hand rails.	K 038		

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K 038	Continued From page 2 2. Observation on 10/19/2016 at 2:50 PM of the door at the Rapid Recovery Unit adjacent to the Marcie Griffith Boarding Home revealed that the door required more than 30 pounds of force to open. Interview with Facility Maintenance Manager at the time of the observation acknowledged the excessive force to open the door. 3. Observation on 10/19/20 at 3:10 PM of the exit door leading from the basement revealed that the door was locked using a key pad. Further observation and interview of staff revealed that the staff did not know, and could not locate, the code to open the door. Interview with the Facility Maintenance Manager at the time of observation acknowledged the code was not known and could not be located. 4. Observation on 10/19/16 at 11:19 AM and 1:19 PM of the Kitchen storage room and the SCU nurses station and HR Directors office, respectively, revealed that the doors required more than one releasing operation to make the doors operable. Interview with the Facility Maintenance Manager at the time of the observation acknowledged that the doors required more than one releasing operation. 5. Observation on 10/19/2016 at 11:22 AM of the exit door to the smoking courtyard revealed a sign reading "Not an Exit". Interview with the Facility Maintenance Manager at the time of observation acknowledge the sign's language was not in accordance with the Life Safety Code. Ref: 2000 NFPA 101, Sections 19.2.1, 19.2.2.2.1,	K 038	2. All exit doors will be audited by Maintenance Director or designee to ensure that they require less than 30 pounds of force to open. Any identified issues will be resolved. 3. Maintenance Director or designee to audit all key pad doors to ensure staff's knowledge of codes. Any issues discovered will be resolved. 4. A visual audit of locking systems on all facility doors will be conducted by the Maintenance Director or designee to ensure all doors have single operation locking devices installed per NFPA Life Safety Code Standard. 5. All signage in resident courtyards and common areas will be audited to ensure they are in compliance with Life Safety Code. Any issues discovered will be resolved. **Systemic Changes** The Maintenance Department will be educated on the NFPA requirements regarding: ramps and hand rails; force pressure limits required for exit doors; coded door locks; single operation door openers; and common area/courtyard signage.	12/02/16

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K 038	Continued From page 3 19.2.2.6 and Chapter 7.	K 038	K038 **Monitoring** A weekly audit will be completed on all ramps and hand rails, all exit doors, coded doors and ten random doors to ensure the openers are single operation; common area signage x 30 days, then monthly x 90 days until compliance has been determined to have been met by the QAPI Committee.	12/02/16
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide exit and directional signage in accordance with NFPA 101 in 2 of 9 smoke compartments. The findings were: 1. Observation on 10/19/16 at 11:30 AM of the exit sign near physical therapy revealed that the sign was not illuminated. Interview with the Facility Maintenance Manager at the time of the observation acknowledged that the bulbs were burned out. 2. Observation on 10/19/16 at 10:35 AM of the East corridor adjacent to the Activities room and Room 128, looking down the corridor in the direction of egress, revealed that no exit signage was provided. Interview with the Facility Maintenance Manager at the time of the observation acknowledged that the sign was missing. Ref: 2000 NFPA 101, Section 19.2.10 and 7.10.5.	K 047	**K047** **Corrective Actions** The Exit Sign by the therapy room was repaired. Exit signage was provided on the East Corridor, adjacent to the Activities Room. **Others Potentially Affected** All residents have the potential to be affected by this practice. A visual audit of all exit signage will be conducted by Maintenance Director or designee to ensure signage exists and is functioning properly. **Systemic Changes** The Maintenance Department will be educated on the NFPA requirements regarding exit signage requirements.	12/02/16
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care	K 064		

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K 064	Continued From page 4 occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide portable fire extinguishers in accordance with NFPA 10, in 2 of 9 smoke compartments. The findings were: 1. Observation on 10/19/2016 at 11:01 AM and 1:35 PM of the East Pantry and West Pantry, respectively, revealed that the East fire extinguisher was mounted at a height of 66 inches above the floor, and the West fire extinguisher was mounted at a height of 70 inches above the floor. Interview with the Facility Maintenance Manager at the time of the observations acknowledged the installed height of the fire extinguishers. 2. Observation on 10/19/16 at 11:15 AM of the smoking area revealed a fire extinguisher that was resting unsecured on a table. Interview with the Facility Maintenance Manager at the time of the observation acknowledged that the fire extinguisher was not mounted in a secured manor. Ref: 2000 NFPA 101, Sections 19.3.5.6 and 9.7.4.1 1998 NFPA 10, Section 1-6.9, 1-6.10	K 064	K047 **Monitoring** A weekly audit on exit signage will be conducted by the Maintenance Director or designee x 30 days, then monthly x 90 days, until compliance has been determined to have been met by the QAPI Committee. **K064** **Corrective Actions** The fire extinguisher in the East Pantry and West Pantry were remounted to conform to NFPA regulations. The unsecured fire extinguisher in the smoking area was securely mounted in an appropriate location. **Others Potentially Affected** All residents have the potential to be affected by this practice. A visual audit of all facility fire extinguishers will be conducted by the Maintenance Director or designee to ensure that all extinguishers are mounted at the appropriate height and are secured properly.	12/02/16 12/02/16
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 147	**Systemic Changes** The Maintenance Department will be educated on properly securing and proper height of fire extinguishers per NFPA guidelines.	

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K 147	Continued From page 5 facility failed to maintain electrical equipment in accordance with NFPA 70. Observation on 10/19/16 at 2:04 PM of room 17 Bathroom revealed that the GFI combination light switch had been painted over. Further observation revealed that when tested it would not function properly. Interview with the Facility Maintenance Manager at the time of the observation acknowledged the painted GFI receptacle and lack of proper operation.	K 147	K064 **Monitoring** A weekly audit will be completed on ten random fire extinguishers, so they are properly secured at the appropriate height x 30 days, then monthly x 90 days, until compliance has been determined to have been met by the - QAPI Committee. K147 **Corrective Actions** The GFI combination light switch in room was replaced and repaired. **Others Potentially Affected** All residents have the potential to be affected by this practice. A visual audit of all GFI combination light switches will be conducted by the Maintenance Director or designee to determine compliance to NFPA Electrical code. All found not compliant will be repaired or replaced. **Systemic Changes** The Maintenance Department will be educated on the requirements of GFI combination light switches. **Monitoring** A weekly audit on compliance and functioning of ten random GFI combination light switches will be conducted by the Maintenance Director or designee weekly x 30 days, then monthly x 90 days, until compliance has been determined to have been met by the QAPI Committee.	12/02/16 12/02/16