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 _____	**02/14/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITION AND WELLNESS	**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 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on February 13-14, 2019. Requirements for Long Term Nursing Homes Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 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 1958 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 facility had 192 certified Medicare and Medicaid beds with a census of 161 residents.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain reliability of the means of egress in accordance with the 2012 NFPA 101,	K 211	1.The blankets were immediately removed from the panic hardware of the egress door.	3/19/19

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

Electronically Signed | 03/14/2019

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 211	Continued From page 1 Life Safety Code. Failure to maintain means of egress as required could cause delayed egress resulting in injury or death. The deficiency affected 1 of approximately 12 facility exits. The findings were: Observation on 2/13/2019 at 1:43 PM in the south dining room revealed several blankets hanging on the panic hardware of the egress door, which obstructed visibility of the exit. Interview with facility staff revealed that the blankets had been there for several days. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.1; 7.1.10.1;7.1.10.2.1 .	K 211	2. Administrator or designee has been educated facility staff to ensure that aisles, passageways, corridors, exit discharges, exit locations and accesses are free from obstructions. 3. Maintenance Director or designee will randomly audit a minimum of 5 egress doors a minimum of 3X/week x 4 weeks, then weekly X 4 weeks, then monthly X 2 months to ensure there is no obstruction and make immediate correction should such be noted. 4. Results of audits will be reviewed at monthly QAPI meeting to address findings and determine continuation.	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide emergency lighting in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 110, Standard for Emergency and Standby Power Systems. Failure to provide emergency lighting as required could	K 291	1.The Maintenance Director has tested (conductance or Reserve Capacity) the lead acid batteries of the emergency lighting system and recorded the results. 2. Administrator or designee has been	3/19/19

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K 291	Continued From page 2 delay egress resulting in injury or death. The deficiency affected 1 of numerous requirements of the emergency lighting system. The findings were: Document review on 2/14/2019 at 9:40 AM revealed the required monthly testing and recording of electrolyte specific gravity or conductance results (Reserve Capacity "RC") of the lead acid batteries in connection with the emergency power supply system (generator) were not completed as required. The emergency power supply system provides power for emergency lighting. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.9.1; 7.9.2.4; 4.6.12.1 2010 NFPA 110, Section: 8.3.7.1	K 291	educated facility maintenance staff to conduct a monthly test lead acid batteries of the emergency lighting system and to document the results. 3. Maintenance Director or designee will perform a monthly audit all the conductance or Reserve Capacity emergency lighting system batteries to assure there is monthly testing x 3 months and make immediate correction should a deficit be noted. 4. Results of audits will be reviewed at monthly QAPI meeting to address findings and determine continuation.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting	K 321		3/19/19

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K 321	Continued From page 3 partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous area enclosures as required could result in injury or death during an emergency. The deficiency affected 2 of numerous hazardous areas in the facility. The findings were: 1. Observation on 2/13/2019 at 1:33 PM in the central supply room revealed a space greater than 50 square feet filled with combustible material. Further observation revealed the door leading to the corridor was a self-closing door, which was being held open by a wooden door chock.	K 321	1. The wooden door chock was immediately removed from the central supply room. The self closing door to the corridor in the central laundry area has been adjusted to close and latch. 2. Administrator or designee has been educated facility staff to not place anything in front of or under doors to prevent the self closing. Education to report and repair or adjust any failure of a self closing door to close and latch. 3. Maintenance Director or designee will audit a minimum of 5 random doors a minimum of 3X/week x 4 weeks, then	

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K 321	Continued From page 4 Interview with the facility maintenance staff at the time of observation acknowledged the wooden door chock, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. 2. Observation on 2/13/2019 at 3:40 PM in the central laundry revealed an area larger than 100 square feet. Further observation revealed the self closing door to the corridor would not close and latch. Interview with the facility maintenance staff at the time of observation acknowledged the door would not close, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.2 .	K 321	weekly X 4 weeks, then monthly X 2 months to ensure there is no obstruction and make immediate correction should such be noted. 4. Results of audits will be reviewed at monthly QAPI meeting to address findings and determine continuation.	
K 331 SS=D	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted.	K 331		3/19/19

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K 331	Continued From page 5 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain interior wall finish in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain interior wall finish as required could result in fire and smoke spread resulting in injury or death. The deficiency affected less than 10 percent of the facility. The findings were: Observation on 2/13/2019 at 1:30 PM in the corridor adjacent to the ice cream parlor revealed two walls covered in wood paneling. Interview with the facility maintenance staff revealed the paneling was installed during the previous 12 months, and they could not provide documentation demonstrating that the wall finish material satisfied the classification requirements of the Life Safety Code. Interview with the facility maintenance staff at the time of observation acknowledged the wood paneling, and indicated they were unaware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.3.2; 10.2 .	K 331	1. The wood paneling in the corridor adjacent to the ice cream room has been removed and replaced with a material that satisfies the flame spread requirements. 2. Administrator or designee has been educated the maintenance staff to ensure interior wall material finish will satisfy the flame spread requirements. 3. Maintenance Director or designee will audit the facility to ensure all the identified wall covering product that was installed in the last calendar year has been completely removed. 4. Results of audits will be reviewed at monthly QAPI meeting to address findings and determine continuation.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353		3/19/19

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K 353	Continued From page 6 Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire sprinkler systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to maintain fire sprinkler systems as required could result in injury or death during an emergency. The deficiency affected 1 of numerous maintenance and testing requirements. The findings were: Observation on 2/13/2019 at 2:03 PM at the wet sprinkler system riser revealed one of the gauges had not been replaced or recalibrated during the previous 5 years. Further observation revealed a date on the gauge of 9/1/13. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency,	K 353	1. The sprinkler system gauge identified has been replaced. 2. Administrator or designee has been educated the maintenance staff to ensure the fire sprinkler system is properly maintained. 3. Maintenance Director or designee will audit all sprinkler system gauges monthly X 3 and replace or recalibrate them in accordance with NFPA 25. 4. Results of audits will be reviewed at monthly QAPI meetings X 3 months to address findings and determine continuation.	

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K 353	Continued From page 7 and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.5 2011 NFPA 25, Section: 5.3.2 .	K 353		
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be 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 shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	K 741		3/19/19

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K 741	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoking areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain smoking areas as required could cause a fire resulting in injury or death. The deficiency affected 1 of 2 smoking areas (Resident and Staff). The findings were: Observation on 2/13/2019 at 2:34 PM at the resident's smoking area revealed a trash can full of combustible material. Further observation revealed numerous discarded cigarette butts in the trash can among the combustible material. Interview with the facility maintenance staff at the time of observation acknowledged the cigarette butts in the trash can, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.7.4	K 741	1. The trash can with combustible material has been removed from the smoking area. 2. Administrator or designee has been educated all staff to ensure that trash cans do not have combustible materials when disposing of cigarette butts/ashes. 3. Maintenance Director or designee will audit Maintenance Director or designee will audit the smokers area garbage cans a minimum of 3X/week x 4 weeks, then weekly X 4 weeks, then monthly X 2 months to ensure there is no obstruction and make immediate correction should such be noted. 4. Results of audits will be reviewed at monthly QAPI meetings X 4 months to address findings and determine continuation.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or	K 923		3/19/19

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K 923	Continued From page 9 gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain gas cylinder storage in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to maintain gas cylinder storage as required could result in injury or death. The deficiencies affected 2 of numerous rooms in the facility. The findings were: Observation on 2/13/2019 at 1:27 PM in room 60 revealed an oxygen cylinder sitting unsecured on	K 923	1. The oxygen cylinder in room 60 and in the basement have been removed. 2. Administrator or designee has been educated all staff that gas cylinders (oxygen) must be properly stored and secured. 3. Maintenance Director or designee will audit Maintenance Director or designee	

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K 923	Continued From page 10 the floor. Further observation in the basement revealed a second oxygen cylinder unsecured sitting on the floor. Interview with the facility maintenance staff at the time of observation acknowledged the unsecured oxygen cylinders, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 99, Section: 11.6.2.3	K 923	will audit a minimum of 5 random spaces a minimum of 3X/week x 4 weeks, then weekly X 4 weeks, then monthly X 2 months to ensure there is no obstruction and make immediate correction should such be noted. 4. Results of audits will be reviewed at monthly QAPI meetings X 4 months to address findings and determine continuation.	

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on February 14, 2019. Based upon the findings of the survey team, it was determined the facility was in compliance with all requirements.	E 000		

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

Electronically Signed | 03/11/2019

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