

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

PRINTED: 03/22/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/27/2021
NAME OF PROVIDER OR SUPPLIER SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E 000	Initial Comments	E 000			
K 000	An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on January 27, 2021. Based on the findings, it was determined the facility was in compliance with all requirements. INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on January 27, 2021. 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 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility (west and central wings) was a fully sprinklered one story building with a partial basement of Type V (000) and Type V (111) construction built in 1958 and 1987. The building was equipped with a supervised wet sprinkler system (west wing) and a dry sprinkler system (central wing), and an addressable fire alarm system. The facility had 192 certified Medicare and Medicaid beds with a census of 111 residents.	K 000			
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically	K 223		2/22/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/12/2021

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.

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

PRINTED: 03/22/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/27/2021
NAME OF PROVIDER OR SUPPLIER SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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 223	Continued From page 1 closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire doors in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 80, Standard for Fire Doors and Other Opening Protectives. Failure to maintain fire doors as required could result in injury or death during an emergency. The deficiencies affected two (2) of numerous fire doors in the facility. The findings were: 1. Observation on 1/27/21 at 9:50 AM in the east side sitting room revealed a fire door blocked by a floor fan. Further observation revealed the fan prevented the fire door from fully closing when tested. 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, Section: 7.2.1.15.2 2010 NFPA 80, Section: 5.2.4.2(6) 2. Observation on 1/27/21 at 10:16 AM in the E11 custodian room revealed a fire door that failed to	K 223	1) Cart and wet floor sign were immediately removed from in front of the exit door. Facility wide audit was conducted to ensure no other fire doors were blocked from closing correctly and that doors latches properly when closing. 2) Audit performed by AED and Maintenance Department to ensure all fire doors and exits are free from obstruction and latch and close properly. Any needed corrections were done at that time. 3) Staff educated on ensuring doorways are clear and fire doors are not blocked. 4) Maintenance Director/Designee will audit random exits weekly for four weeks then monthly for 2 months. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.		

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

PRINTED: 03/22/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/27/2021
NAME OF PROVIDER OR SUPPLIER SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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 223	Continued From page 2 fully close and latch when tested. 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, Section: 7.2.1.15.2 2010 NFPA 80, Section: 5.2.4.2(8)	K 223			
K 929 SS=D	Gas Equipment - Precautions for Handling Oxyg CFR(s): NFPA 101 Gas Equipment - Precautions for Handling Oxygen Cylinders and Manifolds Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99) 11.6.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain medical gas cylinders in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to maintain medical gas cylinders as required could result in injury or death. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 1/27/21 at 10:02 AM in the transportation office revealed an oxygen cylinder sitting on the floor unsecured.	K 929	1) Oxygen tank was immediately removed and put in secure storage. Facility wide audit was conducted to ensure no other oxygen tanks were unsecured within the facility. 2) Audit performed by AED and Maintenance Department to ensure all oxygen tanks were secure in secure oxygen storage. Any needed corrections were done at that time. 3) Staff educated on ensuring oxygen	2/22/21	

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

PRINTED: 03/22/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/27/2021
NAME OF PROVIDER OR SUPPLIER SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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 929	Continued From page 3 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 99, Section: 11.6.2.3	K 929	tanks are kept in secure storage when not in use. 4) Maintenance Director/Designee will audit the facility weekly for four weeks then monthly for 2 months to ensure there are no oxygen tanks left out of secure storage when not in use. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.		