STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING **01** B. WING _____	**08/05/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITATION 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
E 000	Initial Comments An Emergency Preparedness Survey was conducted on August 5, 2021. Based on the findings, it was determined the facility was in compliance with all requirements. .	E 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on August 4th and August 5th 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 110 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	K 211		8/20/21

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

Electronically Signed | 08/17/2021

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K 211	Continued From page 1 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 provide a surface free from a change in elevation in a means of egress in accordence with the 2012 NFPA 101, Life Safety Code. The failure to maintain surfaces free from changes in elevation could result in injury or death. The deficiency affected one (1) exit discharge out of numerous exits in the facility. The findings were: Observation on 8/4/2021 at 1:38 PM of the exit ramp by the outside stairway leading to the basement revealed that the ramp had experienced uplifing, which caused there to be an elevation change of approximately 1-1/4 inches. This exceeded the maximum allowable height of 1/2 inch. Interview with the facility maintenance manager 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; 7.1.6.2 .	K 211	1) Appropriate equipment was rented to fix concrete ramp outside of basement exit near room 207, and concrete was fixed on 8/10/21. 2)Audit performed by Maintenance Department to ensure concrete ramps and/or pathways, were within regulatory requirements. Any needed corrections were done at that time. 3)Maintenance Staff educated on ensuring concrete ramps and/or pathways are within regulatory requirements and/or what to do if they find that they are noncompliant. 4)Maintenance Director/Designee will audit the facility 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. 5)Date of Compliance: 8/20/21	
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	K 223		9/17/21

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K 223	Continued From page 2 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 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 self-closing doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain self-closing doors as required could delay or prevent egress resulting in injury or death during an emergency. The deficiency affected five (5) of numerous self-closing corridor doors within the facility. The findings were: 1. Observation on 8/4/2021 at 2:23 PM by the assistant executive directors office revealed the rated smoke doors with self closing device failed to shut completely leaving a gap between the doors. Interview with the facility administrator 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. 2. Observation on 8/4/2021 at 2:58 PM at the soiled utility room across from room 58 revealed	K 223	1) Self-Closing Device was fixed on rated smoke doors by Assistant ED□s office to ensure there was no gap left between the doors. Self-Closing Device was fixed to ensure Soiled Utility Room door and Central Supply door shut properly. Fire doors in the fire-rated wall by room 59 as well as the fire doors by the dietary office, will be fixed to ensure they latch when tested. Alumitech Window and Door Solutions, will fix the fire rated doors on 9/17/21 due to company□s scheduling and availability. 2) Audit performed by Maintenance Department to ensure doors requiring an automatic door closure installed, were within regulatory requirements. Any needed corrections were done at that time. 3) Maintenance Staff educated on ensuring automatic door closures are within regulatory requirements and/or what to do if they find that they are noncompliant. 4) Maintenance Director/Designee will	

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K 223	Continued From page 3 a door that failed to latch when released with no initial movement. Additional observation found the central supply door also failed to latch when tested. Interview with the facility administrator 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. 3. Observation on 8/4/21 at 3:03 PM at the rated fire doors in the fire-rated wall by room 59 failed to latch when released with no initial movement. Further observation found that the fire doors by the dietary office also failed to latch when tested. REF: 2012 NFPA 101: Section 7.2.1.8.2 .	K 223	audit the facility 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. 5) Date of Compliance: 9/17/21	
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 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.	K 321		8/20/21

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K 321	Continued From page 4 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 areas in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain hazardous areas as required could delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 8/4/2021 at 2:02 PM at room 219 revealed a large amount of combustible storage in a non-rated room. The room was sprinkled, but doors were not self-closing. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.2 .	K 321	1)Automatic Door Closure was installed on room 219 due to PPE storage use. 2)Audit performed by Maintenance Department to ensure doors requiring an automatic door closure installed, were within regulatory requirements. Any needed corrections were done at that time. 3)Maintenance Staff educated on ensuring automatic door closures are within regulatory requirements and/or what to do if they find that they are noncompliant. 4)Maintenance Director/Designee will audit the facility 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. 5)Date of Compliance: 8/20/21	

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K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: 1. Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency effected one (1) of numerous sprinklers the facility. The findings were: Observation on 8/4/2021 at 1:45 PM in room 208 revealed a fire sprinkler head with with a foreign substance on the sprinkler bulb and deflector. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated they were unaware of the requirement.	K 351	1)Sprinkler head and sprinkler bulb and deflector in room 208, were immediately cleaned. Sprinkler head bulb was replaced by Western States Fire Protection on 8/12/21. Fire Sprinkler in room 100 was properly repaired with new hanging bracket. Escutcheons are used to cover the annular space around the sprinkler head. 2)Audit performed by Maintenance Department to ensure sprinkler head bulbs were within regulatory requirements. Any needed corrections were done at that time. 3)Maintenance Staff educated on ensuring sprinkler head bulbs are within	8/20/21

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K 351	Continued From page 6 Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2010 NFPA 13, Sections: 6.2.6.2.1, 6.2.6.2.2 2. Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency effected one (1) of numerous sprinklers the facility. The findings were: Observation on 8/04/2021 at 4:45 PM in room 100 revealed a fire sprinkler head with an escutcheon that was not flush to the ceiling, exposing the annular space above. Escutcheons shall be used to cover the annular space around the sprinkler head. Interview with the facility administrator at the time of observations acknowledged the deficiencies, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2010 NFPA 13, Sections: 6.2.7.1	K 351	regulatory requirements and/or what to do if they find that they are noncompliant. 4)Maintenance Director/Designee will audit the facility 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. 5)Date of Compliance: 8/20/21	