STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING **01, 02** B. WING _____	**08/31/2022**

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 by Healthcare Licensing and Surveys on 08/31/2022.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing,	E 041		10/7/22

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

Electronically Signed | 09/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 041	Continued From page 1 and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.	E 041		

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E 041	Continued From page 2 (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to record monthly generator battery tests in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Failure to perform monthly generator battery tests as required could result in power loss during an emergency. The deficiency affected facility-wide reliability of the emergency power system. The findings were: Document review and interview with the facility maintenance manager on 08/31/2022 at 11:25 AM revealed that records of monthly generator battery specific gravity or conductance tests were missing for the months of July, August, and September of 2021. Interview with the facility maintenance manager at	E 041	E041 S/S = F: Hospital CAH and LTC Emergency Power 1)Monthly battery tests for months July, August, and September of 2021 were not completed. 2)Audit of monthly battery testing was completed by Maintenance Director/Designee and any discrepancies that were amended at time of discovery. 3)Staff were educated on expectations on monthly requirements for battery testing of the generator. 4)ED/Designee will make an audit on battery testing to ensure compliance. The audit will be weekly for 4 weeks and then monthly for 2 months. 5)Date of compliance is 10/7/2022	

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E 041	Continued From page 3 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 21.5.1.1, 9.1, 9.1.3.1 2010 NFPA 110, Sections 8.3.7.1	E 041		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 08/30/2022 and 08/31/2022. Requirements for Long Term Care Facilities Section 42 CFR 483.90(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 157 residents.	K 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 08/30/2022 and 08/31/2022.	K 000		

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K 000	Continued From page 4 Requirements for Long Term Care Facilities Section 42 CFR 483.90(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 (east wing) was a fully sprinklered one story building of Type II (111) construction built in 1979. The building was equipped with a supervised wet sprinkler system (west wing) and an addressable fire alarm system. The facility had 192 certified Medicare and Medicaid beds with a census of 157 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 fire barrier doors in the means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain fire barrier doors as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected one (1) of several fire barrier doors. The findings were: Observation on 8/30/2022 at 3:54 PM at the fire	K 211	K211 S/S=D Means of Egress – General 1) The egress doors observed by the surveyor have been corrected to code. 2) An audit of egress doors in the facility was completed to ensure compliance and safety throughout the facility, any discrepancies we corrected at time of discovery. 3) Staff were educated on the expectations of egress door policies to be	10/7/22

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K 211	Continued From page 5 barrier doors by room 134 door revealed that when tested the door with fire hardware on the south side of the exit, failed to open when a force in excess of 35 lbs was applied. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.2.2.2.1; 7.2.1.7(1)	K 211	followed. 4) ED/Designee will audit egress doors for compliance weekly for 4 weeks, then monthly for 2 weeks. 5) Date of compliance on 10/7/2022	
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the	K 222		10/7/22

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K 222	Continued From page 6 Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 222		

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K 222	Continued From page 7 Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could increase egress time from the building during an emergency, resulting in injury or death. The deficiency affected one (1) of numerous doors. The findings were: Observation on 08/30/2022 at 2:00 PM at the exit door for rapid recovery revealed that, when tested, the force applied to open the door was measured to be in excess of 35 lbf. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.1; 7.2.1.4.5.1 2. Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected one (1) of numerous doors. The findings were: Observation and interview on 08/31/2022 at 10:19 AM at the north-east exit door from the secured unit were found that the door was equipped with a number pad to unlock the door. Staff in the area were unable to immediately provide the required	K 222	K222 S/S=E: Egress Doors 1)The egress doors observed by the surveyor have been corrected to code with correct push force and signage. 2)Entry doors within facility were audited to ensure compliance. 3)Staff were educated on the expectations of egress door policies to be followed. Correct signage for the egress doors were ordered the day of survey observations. 4)ED/Designee will audit egress doors for compliance weekly for 4 weeks, then monthly for 2 weeks. 5)Date of compliance on 10/7/2022	

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K 222	Continued From page 8 code of egress. Further interviews revealed that the door is also equipped with a delayed egress system, but that no sign was posted. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.4(2); 7.2.1.6.1.1(4) 3. Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected one (1) of numerous doors. The findings were: Observation on 08/31/2022 at 8:48 AM at the exit located to the north of the south unit dining revealed that the door was equipped with a delayed egress system. Signage for the delayed egress system indicated that the door would unlock at 30 seconds, however the door opened at 15 seconds. Additional observation on 08/31/2022 at 9:17 AM at the delayed egress door by electrical transfer equipment room, which is utilized for employee entrance and exit also revealed that the door would open at 15 seconds in lieu of the 30 second time frame as identified by the sign. Interview with the facility maintenance manager at	K 222		

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K 222	Continued From page 9 the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.4(2); 7.2.1.6.1.1(4)	K 222		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a	K 222		10/7/22

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K 222	Continued From page 10 complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: 1. Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress from the building during an emergency resulting in injury or death.	K 222	K222 S/S=E: Egress Doors 1) The egress doors observed by the surveyor are corrected to code with correct signage. 2) An audit of egress doors in the building was complete to ensure	

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K 222	Continued From page 11 The deficiency affected one (1) of numerous doors. The findings were: Observation and interview on 08/30/2022 at 3:32 PM at the east entrance door revealed that the door was equipped with a delayed egress system that activated with a wander guard system. Signage for the delayed egress system indicated that the door would unlock at 30 seconds, however the door opened at 15 seconds. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.4(2); 7.2.1.6.1.1(4)	K 222	compliance, any discrepancies found were corrected at the time of discovery. 3) Staff were educated on the expectations of egress door policies to be followed. 4) ED/Designee will audit egress doors for compliance weekly for 4 weeks, then monthly for 2 weeks. 5) Date of compliance on 10/7/2022	
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 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.	K 223		10/7/22

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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
K 223	Continued From page 12 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 doors with self-closing devices in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain doors with self-closing devices as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous doors with self-closing devices. The findings were: Observation on 08/31/2022 at 9:02 AM at the laundry area's mechanical closet door revealed that the self-closing door failed to operate as designed. When drop tested with no initial motion the door failed to shut and latch. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.1, 7.2.1.8	K 223	K223 S/S=D: Doors with Self-Closing Devices 1) Self-closure doors that did not close correctly have been corrected. 2) An audit of the self-closing doors in the building was complete to ensure compliance. Any discrepancies were amended at the time of discovery. 3) Staff were educated on the expectations of self-closure door policies to be followed. 4) ED/Designee will audit self-closure doors for compliance weekly for 4 weeks, then monthly for 2 weeks. 5) Date of compliance on 10/7/2022	
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 closes all such doors throughout the smoke	K 223		10/7/22

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K 223	Continued From page 13 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 doors with self-closing devices in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain doors with self-closing devices as required could result in injury or death during an emergency. The deficiency affected two (2) of numerous doors with self-closing devices. The findings were: Observation on 08/30/2022 at 3:48 PM at the admission director's office door revealed that the self-closing door failed to operate as designed. When drop tested with no initial motion the door failed to shut and latch. Additional observation at 4:10 PM at the door closest to the nurses station (east most door) separating the dining and activities areas revealed that the self-closing door failed to shut and latch when dropped tested with no initial motion. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.1,	K 223	K223 S/S=D Doors with Self-Closing Devices 1) Self-closure doors observed by surveyor have been corrected to meet compliance and regulation. 2) An audit of facility self-closing doors in the building was complete to ensure compliance. Any discrepancies found, were corrected at the time of discovery. 3) Staff were educated on the expectations of self-closure door policies to be followed. 4) ED/Designee will audit self-closure doors for compliance weekly for 4 weeks, then monthly for 2 weeks. 5) Date of compliance on 10/7/2022	

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K 223	Continued From page 14 7.2.1.8	K 223		
K 300 SS=F	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1-hour rated fire barriers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain 1-hour rated fire barriers as required could increase the chance of fire spread throughout the facility, resulting in injury or death. The deficiency affected all staff, residents, and visitors within the vicinity of the identified areas. The findings were: Observation on 08/30/2022 at 3:58 PM above the ceiling at the fire barrier doors of the Krampert wing revealed fire barrier penetrations that were not properly protected with an approved assembly. Further observation of fire barriers throughout the facility revealed inadequate sealing of penetrations through rated assemblies due to deterioration resulting from the installation of new sealant over existing sealant material. Interview with the facility maintenance manager at	K 300	K300 S/S=F: Protection – Other 1) Penetrations that revealed fire barriers were correctly sealed. Inappropriate sealant was removed and appropriate sealant placed. 2) An audit of the fire barriers in the building was completed to ensure compliance and safety throughout the facility and concerns were corrected. 3) Staff were educated on the expectations of fire barriers and correct installation of appropriate sealant. 4) ED/Designee will audit fire barriers and correct penetrations to ensure proper protection with adequate sealing for compliance weekly for 4 weeks, then monthly for 2 weeks 5) Date of compliance on 10/7/2022	10/7/22

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K 300	Continued From page 15 the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.5; 7.2.4.3	K 300		
K 300 SS=D	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1-hour rated fire barriers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain 1-hour rated fire barriers as required could increase the chance of fire spread throughout the facility resulting in injury or death. The deficiency affected all staff, residents, and visitors within the vicinity of the identified areas. The findings were: Observation on 08/30/2022 at 3:58 PM above the ceiling at the fire-rated doors by room 134 revealed penetrations through the fire barrier that were not properly protected with an approved	K 300	K300 S/S=D Protection – Other 1) Observed penetrations through the fire barriers that were not properly protected with an approved through-stop assembly have been corrected. 2) An audit of facility fire barriers in the building was completed to ensure compliance, any discrepancies found were amended at the time of discovery. 3) Staff were educated on the expectations to maintain 1-hour rated fire barriers as required. 4) ED/Designee will audit fire barriers and corrected penetrations to ensure	10/7/22

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K 300	Continued From page 16 through-stop assembly. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.5; 7.2.4.3	K 300	proper protection with adequate sealing for compliance weekly for 4 weeks, then monthly for 2 weeks. 5) Date of compliance on 10/7/2022	
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. 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	K 321		10/7/22

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K 321	Continued From page 17 (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: 1. Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with the 2012 NFPA, Life Safety Code. Failure to maintain hazardous areas as required may result in an increased risk of fire spread throughout the facility. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 08/30/2022 at 1:13 PM at the basement boiler room revealed that the self-closing door was propped in the open position. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 19.3.2 2. Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with the 2012 NFPA, Life Safety Code. Failure to maintain hazardous areas as required may result in an increased risk of fire spread throughout the facility. The deficiency affected one (1) of numerous rooms in the facility. The findings were:	K 321	K321 S/S=D: Hazardous Areas – Enclosure 1) Signs were put up to ensure the doors in observed area are not being propped open in observed area. Self-closing device to the fire door was installed, observed penetrations were corrected with appropriate sealant. The penetration in the ceiling was corrected. 2) Doors with required self-closing devices were audited for proper closure and correction of any penetrations. Any deficiencies found were amended at the time of discovery. An audit of inappropriate orange sealant in the building was removed and resealed with approved sealant. An audit of the fire barriers in the building was completed to ensure compliance and safety throughout the facility and concerns were corrected at time of discovery. 3) Staff were educated on the importance of maintaining hazardous areas to ensure compliance. 4) ED/Designee will audit the door signs to non-entrance doors, the self-closure of basement fire doors, penetrations to fire doors, and the ceiling area penetrations that were corrected to ensure compliance. Audits will be weekly for 4 weeks then monthly for 2 months to ensure compliance.	

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K 321	Continued From page 18 Observation on 08/30/2022 at 2:27 PM at the basement file storage and mechanical room revealed that the self-closing device had been removed from the fire-rated door, which also resulted in open penetrations of the door. Additionally, it was observed that the facility had utilized a non-rated orange spray foam to seal penetrations of the fire-rated assembly in lieu of an approved fire-rated sealant. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 19.3.2 3. 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 may result in an increased risk of fire spread, or inhabit the reaction time of sprinkler systems, which could result in injury or death during an emergency. The deficiency affected one (1) of numerous rooms. The findings were: Observation on 08/31/2022 at 8:54 AM in the laundry room found an approximate area of four (4) foot by eight (8) foot area missing from the smooth ceiling. In the event of a fire, heat and smoke could bypass the fire protection systems. Interview with the facility maintenance manager at the time of observation acknowledged the	K 321	5) Date of compliance on 10/7/2022	

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K 321	Continued From page 19 deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K 321		
K 324 SS=D	Ref: 2012 NFPA 101: Section 19.1.1.1.3, 4.6.12.1 Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 324		10/7/22

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K 324	Continued From page 20 Based on observation and staff interview, the facility failed to protect cooking equipment in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Failure to properly protect cooking equipment could lead to equipment damage or improper protection by fire suppression systems, resulting in injury or death during an emergency. The deficiency affected the kitchen and all staff within. The findings were: Observation on 08/31/2022 at 9:53 AM in the kitchen revealed a wheeled gas-fired cooktop located beneath the grease hood and fire suppression system. Further observation revealed that no means was provided to ensure that the cooktop is returned to the approved location beneath the fire suppression system after being moved for service or cleaning. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.3.2.5.5 and 9.2.3 2011 NFPA 96, Section 12.1.2.3	K 324	K324 S/S=D: Cooking Facilities 1) The wheeled gas-fired cooktop was moved to an appropriate location. 2) Appropriate markings on the ground were placed for proper return of kitchen equipment for when moved for service or cleaning for appropriate return. 3) Staff educated on the standard for ventilation control and fire protection of commercial cooking operations and importance of appropriate placed kitchen equipment with floor markings. 4) ED/Designee will audit floor markings and ensuring kitchen equipment is in appropriate areas to ensure ventilation control and fire protection of commercial cooking operations compliance. Audits will be weekly for 4 weeks then monthly for 2 months to ensure compliance. 5) Date of compliance on 10/7/2022	
K 325 SS=E	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:	K 325		10/7/22

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K 325	Continued From page 21 * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store Alcohol-Based Hand-Rub (ABHR) in accordance with the 2012 NFPA 101, Life Safety Code and the 2012 NFPA 30, Flammable and Combustible Liquids Code . Failure to store ABHR as required could lead to an increased fire risk within the facility, resulting in injury or death during an emergency. The deficiency affected one (1) of several storage rooms in the facility. The findings were: Observation on 08/31/2022 at 9:26 AM at the storage room near the ice cream parlor revealed that there was in excess of 5 gallons of ABHR stored in an unrated room. Total quantity of ABHR	K 325	K325 S/S=E: Alcohol Based Hand Rub Dispenser 1) The excess hand sanitizer was relocated to an appropriate area to meet compliance. 2) Any storage room that stores alcohol-based hand sanitizer will have a sign indicating the requirement of appropriate amount to be stored in one location of 100 or less sq. ft. 3) Staff were educated about appropriate amounts of hand sanitizer stored in a storage area that is less than 100 sq. ft. An audit was complete to ensure all storage areas did not contain	

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K 325	Continued From page 22 was approximately eight (8) gallons, in addition to several boxes of alcohol wipes which contained an unlisted volume of alcohol. The storage room was less than one hundred (100) sq ft in area, and the door had a self-closing device. However, the room was unrated. Interview with the facility maintenance manager 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: Section 19.3.2.3(7) 2012 NFPA 30 Sections 9.7.1, 9.7.2, Tables 9.6.2.1, 9.7.2	K 325	inappropriate storage of hand sanitizer, any areas of concerns addressed. 4) An audit will be completed weekly for 4 weeks and then monthly for 2 months to ensure that alcohol-based hand sanitizers maintain appropriate storage for compliance. 5) Date of compliance by 10/7/2022	
K 325 SS=E	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source	K 325		10/7/22

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SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS	**60 MAGNOLIA** **CASPER, WY 82604**

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K 325	Continued From page 23 * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install Alcohol Based Hand Rub (ABHR) dispenser in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly install ABHR dispenser could lead to an increased fire risk within the facility, resulting in injury or death in the event of a fire. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 08/30/2022 at 3:19 PM in between rooms 101 and 102 revealed a ABHR dispenser installed above and within one (1) inch horizontal distance from the side of an ignition source, with source being an electric receptacle. Observation on 08/30/2022 at 4:46 PM in between rooms 116 and 117 revealed a ABHR dispenser installed above and within one (1) inch horizontal distance from the side of an ignition source, with the source being an electric receptacle. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement.	K 325	K325 S/S=E Alcohol Based Hand Rub Dispenser 1) The alcohol-based hand rub dispensers observed are re-located to meet compliance. 2) An audit was complete to ensure facility dispensers of hand sanitizers are placed at an appropriate distance from an ignition source. 3) Staff educated of appropriate placement of and dispensers in ordinance to ignition sources. 4) An audit will be completed weekly for 4 weeks and then monthly for 2 months to ensure that alcohol-based hand sanitizers maintain compliance. 5) Date of compliance by 10/7/2022	

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	535042	A. BUILDING **01, 02** B. WING _____	**08/31/2022**

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SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS	**60 MAGNOLIA** **CASPER, WY 82604**

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K 325	Continued From page 24 Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.2.6(8)(a)	K 325		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code, Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency affected the fire alarm system. The finding was: Document review on 08/31/2022 at 11:00 AM revealed that the fire alarm system batteries were inspected once in the last twelve (12) months. The fire alarm system batteries are required to be inspected every six (6) months. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time	K 345	K345 S/S=D Fire Alarm System – Testing and Maintenance 1) The fire alarm batteries were inspected and are now up to date. Batteries had not been tested twice in the last 12 months. 2) An audit was complete to test and inspect facility fire alarm batteries to meet compliance. 3) Staff were educated about the requirement of battery inspections every 6 months for compliance and regulation. 4) An audit will be completed weekly for 4 weeks and then monthly for 2 months to ensure that fire alarm batteries are inspected for compliance. 5) Date of compliance by 10/7/2022	10/7/22

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K 345	Continued From page 25 of exit acknowledged the deficiency. REF: 2010 NFPA 72 Table 14.3.1(3)(d)	K 345		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 72, National Fire Alarm Code. Failure to maintain fire detection systems as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous requirements for the fire alarm system. The findings were: Observation on 08/30/2022 at 3:40 PM at the fire annunciator panel revealed that the Underwriter's Laboratory (UL) certification for the fire alarm expired on 31 March 2022. Further observation revealed that a current certification was not in the fire alarm system documentation. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement.	K 345	K345 S/S=D Fire Alarm System – Testing and Maintenance 1) In the fire annunciator panel, the Underwriter's Laboratory (UL) certification has been updated to meet compliance. 2) An audit was created to ensure the certification is updated as appropriate. 3) Staff were educated about the requirement of having the Underwriter's Laboratory (UL) certification for the fire alarm available and updated. 4) An audit will be completed weekly for 4 weeks and then monthly for 2 months to ensure that the fire alarm system remains updated for compliance. 5) Date of compliance by 10/7/2022	10/7/22

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K 345	Continued From page 26 Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA Sections 19.3.4.1; 9.6.1.3 2010 NFPA 72 Section 26.3.4.3	K 345		
K 351 SS=F	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 was throughout the facility. The findings were:	K 351	K351 S/S=F Sprinkler System – Installation 1) The observed sprinklers were corrected to meet compliance. The medical record storage in the basement was corrected to meet regulations and compliance. 2) An audit was complete to inspect	10/7/22

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K 351	Continued From page 27 Observation on 08/30/2022 at 2:12 PM in the Rapid Recovery Unit Manager's Office back area revealed a fire sprinkler head with the escutcheon missing, exposing the annular space. Additional observation on 08/31/2022 at 8:37 AM found a sprinkler and escutcheon assembly offset of the ceiling tile hole, creating a gap and exposing the annular space above. Additionally, it was observed throughout the facility that escutcheons would be down from the ceiling, but present. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware 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 2. Based on observation and staff interview, the facility failed to maintain 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. The failure to maintain sprinkler systems as required could result in injury or death during an emergency. The deficiency affected all staff in the area of the observation. The findings were: Observation on 08/30/2022 at 2:33 PM in the basement records storage revealed objects stacked close to the ceiling within several inches of the sprinkler head. Interview with the facility maintenance manager at	K 351	facility sprinklers in the building and correct deficiencies if discovered at that time. 3) Staff were educated about the importance of not having any gaps by the sprinklers, the placement of the sprinklers, and appropriate distance from storage and sprinkler heads. 4) An audit will be completed weekly for 4 weeks and then monthly for 2 months to ensure that the sprinklers maintain compliance. 5) Date of compliance by 10/7/2022	

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K 351	Continued From page 28 the time of observation acknowledged the deficiency, and indicated they were aware 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 5.2.1.2	K 351		
K 351 SS=F	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: 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	K 351	K351 S/S=F Sprinkler System – Installation 1) The sprinklers observed were corrected to meet compliance.	10/7/22

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K 351	Continued From page 29 properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency was throughout the facility. The findings were: Observation on 08/30/2022 at 3:10 PM in room 107 closet revealed a fire sprinkler head with the escutcheon not fully covering the hole in the ceiling, exposing the annular space. Further observation at 3:11 PM in room 106 bathroom revealed that the sprinkler and escutcheon was down from the ceiling exposing the annular space above. Additionally, it was observed throughout the facility that escutcheons would be down from the ceiling, but present. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were aware 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	2) An audit was complete to inspect facility sprinklers, any discrepancies were corrected at the time of discovery. 3) Staff were educated on the importance on maintaining compliance for sprinklers. 4) An audit will be completed weekly for 4 weeks and then monthly for 2 months to ensure that the sprinklers maintain compliance. 5) Date of compliance by 10/7/2022	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire extinguishers in	K 355	K355 S/S=E Portable Fire Extinguishers 1) The observed fire extinguishers were	10/7/22

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K 355	Continued From page 30 accordance with the 2010 NFPA 10, Standard for Portable Fire Extinguishers and the 2012 NFPA 101, Life Safety Code. Failure to maintain fire extinguishers as required may lead to injury or death during an emergency. The deficiencies affected multiple fire extinguishers throughout the facility. The findings were: Documentation review on 08/31/2022 at 11:35 AM revealed that multiple fire extinguishers were due for their 6 year hydrostatic test. It was observed throughout the survey that these devices were still in service. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the director of nursing at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101: Section 19.3.5.1.2, 9.7.4.1 2010 NFPA 10: Section 7.3.1.2.1	K 355	serviced for hydrostatic testing. 2) An audit was complete to ensure all fire extinguishers in the building are up to date on the hydrostatic testing to meet compliance. 3) Staff were educated about the requirement of hydrostatic testing of the fire extinguishers. 4) An audit will be completed weekly for 4 weeks and then monthly for 2 months to ensure that the fire extinguishers maintain compliance. 5) Date of compliance by 10/7/2022	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire extinguishers in accordance with the 2010 NFPA 10, Standard for	K 355	K355 S/S=E Portable Fire Extinguishers 1) The observed fire extinguishers were serviced for hydrostatic testing.	10/7/22

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K 355	Continued From page 31 Portable Fire Extinguishers and the 2012 NFPA 101, Life Safety Code. Failure to maintain fire extinguishers as required may lead to injury or death during an emergency. The deficiencies affected multiple fire extinguishers throughout the facility. The findings were: Documentation review on 08/31/2022 at 11:35 AM revealed that multiple fire extinguishers were due for their 6 year hydrostatic test. It was observed throughout the survey that these devices were still in service. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101: Section 19.3.5.1.2, 9.7.4.1 2010 NFPA 10: Section 7.3.1.2.1	K 355	2) An audit was complete to ensure all fire extinguishers in the building are up to date on the hydrostatic testing to meet compliance. 3) Staff were educated about the requirement of hydrostatic testing of the fire extinguishers. 4) An audit will be completed weekly for 4 weeks and then monthly for 2 months to ensure that the fire extinguishers maintain compliance. 5) Date of compliance by 10/7/2022	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511		10/7/22

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K 511	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect gas-fired equipment in accordance with the 2012 NFPA 101, Life Safety Code, and the 2012 NFPA 54, National Fuel Gas Code. Failure to maintain gas-fired equipment could lead to system damage and failure, resulting in injuries to staff or residents. The deficiency affected the kitchen, and all staff working within. The findings were: Observation on 08/31/2022 at 9:52 AM in the kitchen revealed a gas-fired cooktop. Further observation revealed that the cooktop was on casters, and was not provided with the required restraint to protect the flexible gas piping when the cooktop is moved for service or cleaning. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 54, Section 9.6.1.2	K 511	K511 S/S=D Utilities – Gas and Electric 1) The cooktop was provided required protectant. 2) Kitchen was audited to ensure appropriate restraint for protection of the flexible gas piping of the cooktop is in place to meet compliance and regulation. 3) Staff were educated about the requirement of protecting gas-fired equipment. 4) ED/Designee will audit weekly for 4 weeks and then monthly for 2 months to ensure that the protection of gas-fired accordance is in compliance. 5) Date of compliance by 10/7/2022	
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for	K 753		10/7/22

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K 753	Continued From page 33 product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain interior decorations in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain interior decorations as required can contribute to the spread of fire in an emergency, and result in injury or death. The deficiencies affected one (1) of numerous rooms throughout the facility. The findings were: Observation on 08/31/2022 at 9:37 AM in the Dietary Director's office revealed that completed puzzles and other decorations covered approximately 45 percent of the aggregate wall area within the room. Additional observation revealed that the puzzles had been glued together and thumbtacked to the wall, and were not enclosed within frames. Interview with the facility maintenance manager 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.	K 753	K753 S/S=D Combustible Decorations 1) The observed room with excessive wall decorations had excess puzzle and other decor removed. 2) Audit of building décor is complete to ensure compliance in facility. 3) Staff were educated about the requirement of interior decorations. 4) ED/Designee will audit facility walls weekly for 4 weeks and then monthly for 2 months to ensure that the interior wall decorations maintain compliance. 5) Date of compliance by 10/7/2022	

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K 753	Continued From page 34 REF: 2012 NFPA 101, Sections 19.7.5.6 (1); 19.7.5.6 (4)(c)	K 753		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to document the inspection and testing of the fire doors installed throughout the facility in accordance with the 2012 NFPA 101, Life Safety Code. Failure to inspect and test fire doors as required could lead to failure in the event of an emergency, resulting in injury or death for all staff, residents, or visitors in the affected areas. The deficient practice affected the entire facility. The findings were: Document review and staff interview on 08/31/2022 at 11:40 AM revealed that the facility had failed to inspect and test fire-rated doors throughout the facility for 2022, with the last	K 761	K761 S/S=F Maintenance, Inspection & Testing – Doors 1) Observed doors were inspected to meet compliance. 2) Maintenance Director received Fire Door Training, an audit of facility doors was completed. 3) Staff was educated of importance of annual fire door inspections. 4) ED/Designee will audit all fie doors to ensure compliance weekly for 4 weeks then monthly for 2 months. 5) Compliance Date of 10/7/2022	10/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING **01, 02** B. WING _____	**08/31/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS	**60 MAGNOLIA** **CASPER, WY 82604**

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K 761	Continued From page 35 annual inspection having occurred in March of 2021. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Section 8.3.3.1 CMS S&C 17-38-LSC	K 761		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to document the inspection and testing of the fire doors installed throughout the facility in accordance with the 2012 NFPA 101, Life Safety Code. Failure to inspect and test fire	K 761	K761 S/S=F Maintenance, Inspection & Testing – Doors 1) Observed doors were inspected to meet compliance. 2) Maintenance Director received Fire	10/7/22

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K 761	Continued From page 36 doors as required could lead to failure in the event of an emergency, resulting in injury or death for all staff, residents, or visitors in the affected areas. The deficient practice affected the entire facility. The findings were: Document review and staff interview on 08/31/2022 at 11:40 AM, revealed that the facility had failed to inspect and test fire-rated doors throughout the facility for 2022, with the last annual inspection having occurred in March of 2021. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Section 8.3.3.1 CMS S&C 17-38-LSC	K 761	Door Training, an audit of facility doors was completed. 3) Staff was educated of importance of annual fire door inspections. 4) ED/Designee will audit all fie doors to ensure compliance weekly for 4 weeks then monthly for 2 months. 5) Compliance Date of 10/7/2022	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised	K 918		10/7/22

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K 918	Continued From page 37 under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to record monthly generator battery tests in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Failure to perform monthly generator battery tests as required could result in power loss during an emergency. The deficiency affected facility-wide reliability of the emergency power system. The findings were: Document review and interview with the facility maintenance manager on 08/31/2022 at 11:25 AM revealed that records of monthly generator battery specific gravity or conductance tests were missing for July, August, and September of 2021.	K 918	K918 S/S=F Electrical Systems – Essential Electric Systems 1) The missing months of generator testing could not be found. 2) An audit has been completed to ensure generator battery testing meets compliance. 3) Staff educated of expectations and requirements for monthly generator battery testing. 4) ED/Designee will audit generator battery testing to ensure compliance weekly for 4 weeks then monthly for 2 months 5) Compliance Date of 10/7/2022	

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K 918	Continued From page 38 Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 21.5.1.1, 9.1, 9.1.3.1 2010 NFPA 110, Sections 8.3.7.1	K 918		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the	K 918		10/7/22

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K 918	Continued From page 39 components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to record monthly generator battery tests in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Failure to perform monthly generator battery tests as required could result in power loss during an emergency. The deficiency affected facility-wide reliability of the emergency power system. The findings were: Document review and interview with the facility maintenance manager on 08/31/2022 at 11:25 AM revealed that records of monthly generator battery specific gravity or conductance tests were missing for July, August, and September of 2021. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 21.5.1.1, 9.1, 9.1.3.1	K 918	K918 S/S=F Electrical Systems – Essential Electric Systems 1) The missing months of generator testing could not be found. 2) An audit has been completed to ensure generator battery testing meets compliance. 3) Staff educated of expectations and requirements for monthly generator battery testing. 4) ED/Designee will audit generator battery testing to ensure compliance weekly for 4 weeks then monthly for 2 months 5) Compliance Date of 10/7/2022	

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K 918	Continued From page 40 2010 NFPA 110, Sections 8.3.7.1	K 918		
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 70, National Electrical Code. The failure to maintain electrical systems as required could result in injury or death. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 08/31/2022 at 10:32 AM in the secure unit kitchen revealed obstructions in front of the electrical panel. A working space of three (3) feet in front of the panel is to be maintained. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.5.1.1; 9.1.2 2011 NFPA 70, Section: 210.8(B)(5)	K 919	K919 S/S=D Electrical Equipment – Other 1) The observed obstruction blocking the electrical panel was removed immediately. 2) Long-term markings on the floor are in place with a sign to ensure compliance. An audit for all electrical systems in the building is complete to ensure required space free of obstruction. 3) Staff educated of not allowing any obstruction of space within 3 feet from the electrical panels in accordance to the National Electrical Code policies. 4) ED/Designee will audit electrical systems working space to ensure compliance weekly for 4 weeks then monthly for 2 months. 5) Compliance Date of 10/7/2022	10/7/22

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K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 70, National Electrical Code. The failure to maintain electrical systems as required could result in injury or death. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 08/30/2022 at 3:12 PM in the storage room adjacent to room 105 revealed obstructions, in the form of oxygen concentrators, in front of the electrical panel and partial blocking access. A working space of three (3) feet in front of the panel is to be maintained. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.5.1.1; 9.1.2 2011 NFPA 70, Section: 210.8(B)(5)	K 919	K919 S/S=D Electrical Equipment – Other 1) The observed obstruction blocking the electrical panel was removed immediately. 2) Long-term markings on the floor are in place with a sign to ensure compliance. An audit for facility electrical systems in the building is complete to ensure required space free of obstruction. 3) Staff educated on not allowing any obstruction on space within 3 feet from the electrical panels in accordance to the National Electrical Code policies. 4) ED/Designee will audit electrical systems working space to ensure compliance weekly for 4 weeks then monthly for 2 months. 5) Compliance Date of 10/7/2022	10/7/22