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

PRINTED: 12/29/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/13/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor #: 18185 The regulatory reference is 42 CFR 483.70 (a) except where a different regulation may be specifically referenced. K3: Building: Original Building: Type V (000) single story with a complete automatic supervised dry sprinkler system East Wing: Type II (111) single story with a partial wet sprinkler system and no coverage in resident closets. Krampert Wing: Type V (111) two story with a complete automatic supervised dry sprinkler system K6: Date of Plan Approval: Original Building: 1958 East Wing: 1979 Krampert Wing: 1987 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=180;SNF/NF=180 K9: The facility meets the Life Safety Code standards based on an acceptance of a plan of corrections "NFPA" National Fire Protection Association	K 000	ADDITIONS & ACCEPTANCE OF THIS POC WITH JILL ELLIOTT, ASST. ADMINISTRATOR, ON 1/18/06 @ 1:45 PM VIA TELECONFERENCE.	
K 014 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2	K 014		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Keith W. Kentrud — TITLE: Administrator — (X6) DATE: 1-4-05

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 014	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations, the facility failed to provide flame retardant interior decorations in accordance with NFPA 101 Section 19.3.3.1 and 10.3.5. The findings were: 1. Observation on 12/13/05, between 7:40 AM and 8:47 AM revealed the following locations had live pine tree boughs formed into wreaths without flame-retardant treatment: a. The corridor door to resident room #116. b. The corridor door to the assistant administrators office.	K 014	1. The live pine boughs have been removed. 2. Prior to the next holiday season notice will be sent to all resident families informing them of acceptable interior decorations. Staff will also be make aware of NFPA requirements for interior decorations. 3. The Director of Housekeeping will monitor all interior decorations to insure compliance.	1-27-06
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	1. All doors in the facility will be checked to assure they have no more than a 1/8 inch gap anywhere around the door. 2. All doors with a self closing device will be checked to make sure they latch properly. 3. Above referenced inspections will be included on the daily maintenance inspection log. 4. The Maintenance Director will monitor the inspection process.	1-27-06

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K 018	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations, the facility failed to protect the corridor system in accordance with NFPA 101 Section 19.3.6.3 and 4.6.12.2 respectively. The findings were: 1. Observation on 12/13/05 between 8:03 AM and 9 AM revealed the corridor doors to resident rooms #27 and #204 had gaps between the top edge of the doors and the door frames which were greater than the allowed 1/8th of an inch. 2. Observation on 12/13/05 between 9:21 AM and 10:45 AM revealed the corridor doors to the nursing staff coordinator's office, the medical director's office, and the chaplain's office were equipped with self-closing devices which were not able to fully latch the doors into the frames;	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025	1. All smoke barrier walls will be inspected for penetrations, any penetrations found will be repaired to meet compliance. 2. Any future work done on smoke barrier walls will be monitored by the Maintenance Director.	1-27-06

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K 025	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations, the facility failed to provide 4 of 12 smoke barriers which were smoke resistant in accordance with NFPA 101 Section 19.3.7.3. The findings were: 1. On 12/13/05, between 11:22 AM and 1:29 PM., the following locations had unsealed cable penetrations in the vertical smoke barrier wall above the ceiling tile. a. The smoke barrier near resident room #108. b. The smoke barrier near the main entrance. c. The smoke barrier near resident room #10. d. The smoke barrier near the copy room.	K 025		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations, the facility failed to protect 1 of 12 smoke barrier double doors in accordance with NFPA 101 Section 19.3.7.3.	K 027 1. 2. 3.	All smoke barrier doors will be inspected to make sure no gaps in the doors exceed 1/8 inch. Inspection of smoke barrier doors will be included in routine maintenance inspections. The inspection of smoke barrier doors will be monitored by the Maintenance Director	1-27-06

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K 027	Continued From page 4 The findings were: 1. On 12/13/05 at 10:17 AM, the double smoke barrier doors near resident room #42 had a gap greater than the allowed 1/8th of an inch between the meeting edges of the doors.	K 027		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations the facility failed to separate 4 of 17 hazardous areas from other spaces by smoke-resistant doors in accordance with NFPA 101 Section 19.3.2.1. The findings were: 1. At 10:21 AM on 12/13/05, the self-closing device on the corridor door to the west wing bio-hazard room did not fully latch the door into the door frame. 2. The following hazardous locations did not have self-closing devices on the doors: a. At 3:27 PM on 12/12/05, the back door to	K 029	1. Maintenance will install self-closing devices on all doors which separate hazardous areas from other spaces. 2. Th is process will be monitored by the Maintenance Director. 3. THE SELF-CLOSING DEVICE ON THE BIO-HAZARD CORRIDOR DOOR WILL BE ADJUSTED SO THE DOOR WILL FULLY LATCH IN THE DOOR FRAME.	1-27-06

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K 029	Continued From page 5 the laundry linen storage room. b. At 10:05 AM on 12/13/05, the corridor door to the medical records store room. c. At 10:29 AM on 12/13/05, the corridor door to the store room near the ice cream parlor.	K 029		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility had exterior roofs which were not built of non-combustible or limited combustible material and they did not have sprinkler coverage in accordance with NFPA 101 Section 19.3.5.3, NFPA 13 Section 5-1.1, and 5-13.8.1. The findings were: 1. Observation on 12/12/05 and 12/13/05, between 1:10 PM and 10:15 AM revealed the exterior roofs of the following were wider than 4 feet, constructed of 2 inch by 8 inch wood (pine)	K 056	1. Exterior over hang roofs wider than 4 feet will be made to comform with NEPA 101 Section 19.3.5.3 and NEPA 13 Section 5-1.1, and 5-13.8.1 Some of the roofs not in compliance will be torn down, other roofs will have a sprinkler system installed. 2. All bathrooms will be checked for sprinkler coverage. The bathroom in room 5 will have a sprinkler installed. All walk in refrigerator units will be checked for sprinkler coverage. 3. The Maintenance Director and Administrator will monitor all work in reference to K 056. 4. A 30 DAYS WAIVER REQUEST WILL BE SUBMITTED WITH MILESTONE & A COMPLETION DATE.	~~6-27-06~~ 1-27-06

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K 056	Continued From page 6 rafters with plywood ceilings attached to the bottom of the rafters, plywood roof decking attached to the top of the rafters, asphalt shingles, and did not have sprinkler coverage: a. The south east canopy/roof over the staff smoking area. b. The canopy/roof outside the Gordon Anderson room. c. The canopy/roof outside of resident room #7 and #8. d. The canopy/roof outside of resident room #16 and #17. e. The canopy/roof outside of resident room #28 and #29. f. The canopy/roof over the compactor pathway. g. The canopy/roof outside the west employee locker room Maintenance staff verified that all the canopies were constructed of the same material. 2. Observation on 12/12/05, at 7:55 AM revealed the bathroom in resident room #5 did not have sprinkler coverage. 3. Observation on 12/13/05, at 10:39 AM revealed the two walk-in refrigerator units in the kitchen did not have sprinkler coverage.	K 056		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062		

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K 062	Continued From page 7 Based on observations the facility failed to maintain the installed sprinkler system in accordance with NFPA 13 Section 5-6.5.2.3 and NFPA 25 Section 2-2.1.1 respectively. The findings were: 1. Observation on 12/12/05, at 1:16 PM revealed the sprinkler head in the corridor near the main entrance had a damaged deflector plate. 2. Observation on 12/13/05, at 10:31 AM revealed one of three sprinkler heads in the kitchen dishwasher room had signs of corrosion. 3. Observation on 12/13/05, between 8:31 AM and 9:17 AM,revealed resident rooms #208, #215, and #220 had mesh on the top panel of the privacy curtain which measured less than the allowed 1/2 inch on the diagonal.	K 062	1. All sprinkler heads will be checked for damage or corrosion and those heads will be replaced. All privacy curtains will be checked to make sure the mesh measures at least ½ inch on the diagonal. 2. The Maintenance Director will monitor the inspection of sprinkler heads. The Housekeeping Director will monitor the installation of any new privacy curtains to insure compliance. 3. The Maintenance Director and Administrator will monitor all work in reference to ~~K-056~~. K-062.	1-27-06
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are tested monthly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to test the installed emergency generator in accordance with NFPA 110 Section 6-4.2. The findings were: 1. The facilities two diesel powered emergency	K 144		

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K 144	Continued From page 8 electrical generators were being tested on a monthly basis at less than the required 30 percent of the name plate rating and the generators had not been tested annually by a load bank test. a. At 1:05 PM on 12/12/05, the east generator was rated at 125 Kilowatts and the monthly full load test ran at 8.6 Kilowatts which is 6 percent of the name plate. b. At 11:15 AM on 12/13/05, the central generator was rated at 150 Kilowatts and the monthly full load test ran at 22.2 Kilowatts which is 14 percent of the name plate. These Kilowatts were supplied by facility maintenance staff.	K 144	1. The two emergency generators will be tested monthly, ~~at 30% of the name plate rating~~. Steward and Stevenson will conduct the annual load bank test. 2. This test procedure and the load bank test will be monitored by the Maintenance Director. 3. Generator tests will be placed on the maintenance inspection reports.	1-27-06
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations on 12/13/05 between 8:12 AM and 9:33 AM, the facility failed to provide an electrical system installed in accordance with NFPA 70 Section 400-8. The findings were: 1. Temporary three way adapters were being used in resident room #15 and in the payroll office, substituting permanent fixed wiring:	K 147	1. Maintenance will check all rooms and remove any temporary three way adapters. 2. The Maintenance Director ill insure all electrical systems are in accordance with NFPA 70 Section 400-8.	1-27-06