| 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**<br>B. WING _____ | **10/29/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS** | **60 MAGNOLIA**<br>**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 |
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| E 000 | Initial Comments<br><br>An Emergency Preparedness Survey was conducted by Healthcare Licensing and Surveys on 10/28/2024 and 10/29/2024. Based on the findings of the survey, the facility is in compliance with 42 CFR 483.73. | E 000 | | |
| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 10/28/2024 and 10/29/2024.<br><br>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.<br><br>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 155 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90. | K 000 | | |
| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 10/28/2024 and 10/29/2024.<br><br>Requirements for Long Term Care Facilities | K 000 | | |

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

Electronically Signed | 11/25/2024

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 000 | Continued From page 1<br>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.<br><br>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 (east wing) and an addressable fire alarm system. The facility had 192 certified Medicare and Medicaid beds with a census of 155 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90. | K 000 | | |
| K 321 SS=D | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>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.<br>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.<br>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.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet) | K 321 | | 12/6/24 |

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| K 321 | Continued From page 2<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain hazardous area enclosures as required. Failure to maintain hazardous area enclosures may result in the spread of fire and smoke, leading to injury or death. The deficiency affected one of numerous hazardous area in the facility. The findings were:<br><br>Observation on 10/28/2024 at 3:30 PM at the electrical room revealed a fire door that, when drop tested with no initial motion, failed to close and latch. Further observation revealed that the door was not equipped with a self-closing or automatic-closing device as required. Additional observation revealed that the door closer had been removed as evidenced by the holes in the door and door frame where the closer was once installed.<br><br>Interview with the maintenance manager at the time of observation confirmed the deficiency, and indicated that he was not aware of the requirement.<br><br>Interview with the facility administrator at the time of exit confirmed the deficiency.<br><br>Ref: 2012 NFPA 101, Sec. 19.3.2.1.2, and Sec. 8.4 | K 321 | Maintenance replaced the closure to the door that was missing the closure.<br><br>Audit performed by AED and Maintenance Department on 11/04/24 to ensure doors in facility needing closures, had closures on them. Any needed corrections were done at that time.<br><br>Staff educated on door closures and the need for certain doors to close automatically and latch.<br><br>Maintenance Director/Designee will audit random doors weekly for four weeks then monthly for 2 months. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary. | |

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| K 345 SS=D | Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>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.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review 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 a failure of equipment during an emergency, leading to injury or death. The deficiency affected one of numerous testing requirements. The findings were:<br><br>Document review on 10/29/24 starting at 8:25 AM revealed that the facility was able to produce documentation demonstrating the Fire Alarm System had been tested. However, the documentation did not provide a location and pass/fail test for the alarm notification devices as required.<br><br>Interview with the maintenance manager at the time of observation confirmed the deficiency, and indicated that he was not aware of the requirement.<br><br>Interview with the facility administrator at the time of exit confirmed the deficiency. | K 345 | Fire Alarm System was tested documenting location and pass/fail test for the alarm notification devices and documentation was provided by company.<br><br>Audit performed by AED and Maintenance Department on 11/04/2024 to ensure mandatory testing occurred according to compliance and regulation. Any needed corrections were done at that time.<br><br>Staff educated on fire alarm systems to ensure they are tested per regulation.<br><br>Maintenance Director/Designee will audit the facility weekly for four weeks then monthly for 2 months to ensure there are appropriate testing according to regulation. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary. | 12/6/24 |

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| K 345 | Continued From page 4<br>Ref: 2012 NFPA 101, Sec. 19. 3.4.1, 9.6.1.3; 2010 NFPA 72, Table 14.4.5, A.14.6.2.4 (7.14) | K 345 | | |
| K 372 SS=E | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain a smoke-proof membrane as required by NFPA 101, Life Safety Code. Failure to maintain a smoke-proof membrane as required could result in the propagation of smoke and fire through annular spaces. The deficiency could affect all residents, staff, and visitors in the facility. The findings were:<br><br>1. Observation on 10/28/2024 at 2:42 PM revealed a ceiling tiles throughout the facility that were not properly seated in the acoustic tile ceiling grid. Additionally, several ceiling tiles were removed for maintenance and not placed back after completion of work.<br><br>2. Observation on 10/28/2024 in the bulk laundry | K 372 | Missing and/or damaged ceiling tiles were immediately replaced. The hole in the gypsum board ceiling was replaced.<br><br>Audit performed by AED and Maintenance Department on 11/04/24 to ensure ceiling tiles and/or ceilings were intact. Any needed corrections were done at that time.<br><br>Staff educated on ensuring ceiling tiles are in place and if one is missing and/or damaged to replace it immediately.<br><br>Maintenance Director/Designee will audit the facility weekly for four weeks then monthly for 2 months to ensure there are | 12/6/24 |

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| K 372 | Continued From page 5<br>area revealed an approximate 2' x 2' hole in the gypsum board ceiling that had been cut out due to a leaking roof, exposing the plenum space above.<br><br>Interview with the maintenance manager at the time of observation confirmed the deficiency, and indicated that he was aware of the requirement.<br><br>Interview with the facility administrator at the time of exit confirmed the deficiency.<br><br>Ref: 2012 NFPA 101 Sec. 19.3.2.5.3, 19.3.7.3, 8.5 | K 372 | no missing ceiling tiles. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary. | |
| K 761<br>SS=F | Maintenance, Inspection & Testing - Doors<br>CFR(s): NFPA 101<br><br>Maintenance, Inspection & Testing - Doors<br>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.<br>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.<br>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.<br>Written records of inspection and testing are maintained and are available for review.<br>19.7.6, 8.3.3.1 (LSC)<br>5.2, 5.2.3 (2010 NFPA 80)<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review and staff interview, the facility failed to perform annual inspections of fire doors in accordance with the 2012 NFPA 101, Life Safety Code, and 2010 NFPA 80, Standard | K 761 | Fire doors were tested and documented as completed, by Maintenance Director.<br><br>Audit performed by AED and Maintenance | 12/6/24 |

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| K 761 | Continued From page 6<br>for Fire Doors and Other Opening Protectives. The failure to perform annual inspections of fire doors as required could result in injury or death due to in increased risk of fire. The deficiency affected the entire facility. The findings were:<br><br>Document review and staff interview on 10/29/2024 starting at 8:35 AM revealed that the facility was unable to provide documentation demonstrating that the annual inspection of fire doors had occurred. 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. Written records of inspection and testing are maintained and are available for review.<br><br>Interview with the maintenance manager at the time of observation indicated that the doors had been inspected, but he was not aware that documentation needed to be kept. The maintenance manager confirmed the deficiency.<br><br>Interview with the facility administrator at the time of exit confirmed the deficiency.<br><br>Ref: 2012 NFPA 101, Sec. 19.7.6, 8.3.3.1, NFPA 80, Sec. 5.2, 5.2.3 | K 761 | Department on 11/04/2024 to ensure fire doors were tested and will then be tested yearly per regulation. Any needed corrections were done at that time.<br><br>Staff educated on fire doors being tested annually and the need for documentation of the testing, per regulation.<br><br>Maintenance Director/Designee will audit the facility weekly for four weeks then monthly for 2 months to ensure there are appropriate testing according to regulation. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary. | |
| K 918 SS=E | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying | K 918 | | 12/6/24 |

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| K 918 | Continued From page 7<br>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.<br>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 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.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review and staff interview, the facility failed to maintain main and feeder circuit breakers in accordance with 2012 NFPA 99, Heath Care Facilities Code. Failure to maintain main and feeder circuit breakers as required could result in faulty or inoperable equipment. The deficiency affected the facilities | K 918 | Circuit Breaker testing that was out of compliance, will be done by on 12/4/24 and documented as having been conducted.<br><br>Audit performed by AED and Maintenance Department on 11/04/2024 to ensure | |

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| K 918 | Continued From page 8<br>main and backup electrical systems. The findings were:<br><br>Document review on 10/29/2024 starting at 8:35 AM revealed the facility was not able to provide documentation demonstrating an established plan to inspect the facility's main and feeder circuit breakers. Main and feeder circuit breakers shall be inspected annually, and a program for periodically exercising the components shall be established according to manufacturer's recommendations.<br><br>Ref: 2012 NFPA 99 Ch.10 Sec. 4.4.1.2 | K 918 | circuit breaker testing will be conducted moving forward. Any needed corrections were done at that time.<br><br>Staff educated on regulation for circuit breaker testing and documentation of the testing, per regulation.<br><br>Maintenance Director/Designee will audit the facility weekly for four weeks then monthly for 2 months to ensure there are appropriate testing according to regulation. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary. | |