PRINTED: 10/31/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	pp c 10/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY HEALTHCARE CENTER	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
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing LPN-Licensed Practical Nurse RN-Registered Nurse QAPI- quality assessment and performance improvement Less commonly used abbreviations will be annotated in each deficiency.	F 000	**F 309. Each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This will be accomplished by:** **1. Resident # 167, 11, 101, and 132 records are unable to be corrected as the events have passed.** **2. The Policy and Procedure for post fall assessment was reviewed and revised.** **3. All residents who suffer a fall will be assessed with documentation completed by a facility nurse to include vital signs, utilizing a newly created post fall assessment tool.** **4. Nursing staff will be inserviced to proper fall assessments to include head injury signs/symptoms and neurological assessments.** **5. The facility will implement a fall committee to review falls assessments and documentation on a weekly basis.** **6. The Nursing Administrative team will audit all post fall assessments and documentation**	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure nursing assessment and monitoring was adequately provided to recognize the early signs and symptoms of a traumatic brain injury for 1 of 1 sample residents (#167) who sustained a head injury (subarachnoid hemorrhage). In addition, 4 of the 8 medical records reviewed (#11, #101, #132, #167) revealed post fall assessments were incomplete and/or there were missed vital signs. The findings were:	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11-4-11

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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NOV 07 2011
Wyoming Department of Health
Office of Healthcare Licensing and Surveys

pp 11/10/11 @ 10am POC accepted via phone / Deb Nardeman, DON.
Pat Pinner

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F 309	Continued From page 1 1. Review of the nursing note dated 10/1/11 and interview with RN #1 on 10/18/11 at 5:30 PM revealed the following sequence of events: Resident #167 injured his/her head when s/he fell in the TV room on 10/1/11 at 7 AM. The initial post fall assessments at 7 AM and 7:15 AM revealed the resident's vital signs and neurological assessments were within normal parameters. At that time the nursing staff began to record the neurological assessment and vital signs on the neurological assessment form as directed by the facility's policy and protocol for falls resulting in a head injury. This protocol included assessments every fifteen minutes for the first hour, every thirty minutes for two hours, every hour for four hours, every four hours for eight hours, and every eight hours for forty-eight hours. The timed neurological assessments were to include vital signs and assessments of pupil responses, mental status, and extremity movements. However, from 7:15 AM until 10 PM that day (fourteen and a half hours), the resident's vital signs were only taken at 9 AM and 6 PM; the neurological assessments were not performed. In addition, there was no documentation regarding the description of the injured area on the resident's head. During the interview with RN #1, she stated the assessments and documentation were not done due to staff reassignments and "staff were busy that day." Review of the 10/2/11 nursing notes and interview with LPN #1 on 10/18/11 at 10:45 AM revealed the following sequence of events: the vital signs and neurological assessments were completed at 1 AM, 4 AM and 6:45 AM and documented as within normal limits. The resident	F 309	**to include neurological assessments and vital signs when warranted. Infractions will be identified with immediate corrective action.** 7. **The audit results will be introduced at the QA meeting for review x 90 days. After that time, the audits will be conducted as directed by QA until it is determined the facility has achieved ongoing/compliance.**	11/16/11

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F 309	Continued From page 2 requested and received pain medication for a headache at 12:30 AM. At 1 AM, the resident stated the pain medication had not provided relief. At 3:15 AM the resident complained that the headache had worsened. At that time the resident ignored his/her gluten free dietary restrictions and ate a sandwich. At 3:35 AM, the resident vomited the undigested sandwich and again requested medication to relieve his/her headache. At 3:45 AM, the nurse assessed the left side of the resident's head and documented,"...found a bruise measuring approximately 3 inches long and 1 1/2 to 2 inches wide. A bump also noted in this area that was raised about 1/2 inch high, area very tender to touch, res [resident] flinched and jerked head away when attempted to measure the bump." At 4:45 AM, the resident "appeared to be sleeping." LPN #1 assessed the resident at 6:45 AM, but the next nursing assessment was not completed until 11:45 AM (five hours later) by RN #1. During the interview on 10/18/11 at 5:30 PM, RN #1 stated the nurses did not assess the resident from 6:45 AM to 11:45 AM because the resident was sleeping. The RN also stated CNA #1 "checked on" the resident at least two or three times during that time period and did not report any changes in the resident's condition. At 11:45 AM the CNA reported the resident was unresponsive. The resident was immediately transported to the hospital and diagnosed as having a subarachnoid hemorrhage (traumatic brain injury). This was almost twelve hours after the resident first complained of a headache. Review of the medication records for the July, August, and September 2011 showed no evidence that the resident had ever requested medication for or complained about a headache prior to 10/2/11.	F 309		

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F 309	Continued From page 3 2. Eight randomly selected sample records were reviewed for post fall assessments. Review of the August, September and October 2011 quality improvement "Falls Management" records showed the following information had been collected for the eight residents: staff did neurological checks for all unwitnessed falls and those falls involving the head, follow up monitoring and charting was done every shift for seventy-two hours and vital signs were documented. However, review of the post fall assessments for 4 of the 8 medical records (resident's #167, #11, #101, #132) revealed incomplete assessments and/or missed vital signs. Review of the medical record for resident #11 showed the 10/4/11 post fall assessments were incomplete. Review of the medical record for resident #167 showed the tasks were not performed after s/he fell on 10/1/11. Review of the medical record for resident #101 showed the 10/13/11 post fall assessments were incomplete. Review of the medical record for resident #132 showed the post fall neurological assessments and vital signs were not performed according to the facility's policy after s/he fell on 10/13/11. 3. During the interview on 10/19/11 at 12:10 PM, the administrator stated the quality improvement "Falls Management" information was a checklist and had not been revised to identify whether or not tasks were completed or done correctly. 4. The facility was unable to provide evidence of a monitoring system for ensuring that neurological assessments and documentation were completed according to the facility policy.	F 309		

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F 309	Continued From page 4 5. According to White, Lois, RN, PhD, Duncan, Gena, RN, MSEd, MSN, and Baumle, Wendy, RN, MSN (2010). Foundations of Adult Health Nursing, third edition, Neuroglial System, page 319,"Intracranial hemorrhage is a common complication of any head injury. Subdural hematomas (bleeding in the brain, subarachnoid hemorrhage) cause immediate pressure on the brain. Subdural hematomas are acute, within forty-eight hours of injury. Common symptoms are headache, drowsiness, slow mentation and confusion." 6. According to the March 2008 Centers of Disease Control and Prevention publication entitled, "Brain Injury In Seniors", the signs and symptoms of a traumatic brain injury for an older adult who has a fall related injury include a headache that gets worse or does not go away; repeated vomiting or nausea; increased confusion, restlessness, or agitation; and inability to awaken.	F 309		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of	F 520		

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F 520	Continued From page 5 action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: The facility failed to revise their QAPI program to ensure identified problems regarding post fall assessments and early recognition of the signs and symptoms of traumatic brain injury were addressed appropriately. In addition, mandatory education was not provided for 3 of 8 nursing staff (LPN #2, CNA #2, CNA #3) whose attendance records were reviewed; nor was a system implemented in the QAPI program for ensuring all staff received the mandatory education. The findings were: Review of the nursing note dated 10/1/11 and interview with RN #1 on 10/18/11 at 6:30 PM revealed the following sequence of events: Resident #167 injured his/her head when s/he fell in the TV room on 10/1/11 at 7 AM. The initial post fall assessments at 7 AM and 7:16 AM revealed the resident's vital signs and neurological assessments were within normal parameters. At that time the nursing staff began to record the neurological assessment and vital signs on the neurological assessment form as	F 520	**F 520** **If a facility must maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility; and at least 3 other members of the facility's staff. This will be accomplished by:** 1. **The Quality Assurance process will promptly identify system issues in the facility.** 2. **The facility revised their in-service follow-up methodology to identify staff who are not in attendance so that education/information can be properly disseminated.** 3. **Post Fall Assessment Audits will provide a system in which to ensure competency of staff in recognizing early signs and symptoms of a traumatic brain injury. The Audits will also monitor for proper documentation of such assessments. The audits will be reviewed at the monthly QA & A meeting with necessary corrective action identified and implemented.**	

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F 520	Continued From page 6 directed by the facility's policy protocol for falls resulting in a head injury. This protocol included assessments every fifteen minutes for the first hour, every thirty minutes for two hours, every hour for four hours, every four hours for eight hours, and every eight hours for forty-eight hours. The timed neurological assessments were to include vital signs and assessments of pupil responses, mental status, and extremity movements. However, from 7:15 AM until 10 PM that day (fourteen and a half hours), the resident's vital signs were only taken at 9 AM and 6 PM; the neurological assessments were not performed. In addition, there was no documentation regarding the description of the injured area on the resident's head. During the interview with RN #1, she stated the assessments and documentation were not done due to staff reassignments and "staff were busy that day." Review of the 10/2/11 nursing notes and interview with LPN #1 on 10/18/11 at 10:45 AM revealed the following sequence of events:" the vital signs and neurological assessments were completed at 1 AM, 4 AM and 6:45 AM and documented as within normal limits. The resident requested and received pain medication for a headache at 12:30 AM. At 1 AM, the resident stated the pain medication had not provided relief. At 3:15 AM the resident complained that the headache had worsened. At that time the resident ignored his/her gluten free dietary restrictions and ate a sandwich. At 3:35 AM, the resident vomited the undigested sandwich and again requested medication to relieve his/her headache. At 3:45 AM, the nurse assessed the left side of the resident's head and documented,"...found a bruise measuring	F 520	**4. The QA Team will meet monthly until such time that the program is understood and efficiently administered.** **5. The process will be monitored by the Administrator with corrections/amendments incorporated, ongoing.**	**11/16/11**

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F 520	Continued From page 7	F 520		

approximately 3 inches ling and 1 1/2 to 2 inches wide. A bump also noted in this area that was raised about 1/2 inch high, area very tender to touch, res [resident] flinched and jerked head away when attempted to measure the bump." At 4:45 AM, the resident "appeared to be sleeping." LPN #1 assessed the resident at 6:45 AM, but the next nursing assessment was not completed until 11:46 AM (five hours later) by RN #1. During the interview on 10/18/11 at 5:30 PM, RN #1 stated the nurses did not assess the resident from 6:45 AM to 11:45 AM because the resident was sleeping. The RN also stated CNA #1 "checked on" the resident at least two or three times during that time period and did not report any changes in the resident's condition. At 11:45 AM the CNA reported the resident was unresponsive. The resident was immediately transported to the hospital and diagnosed as having a subarachnoid hemorrhage (traumatic brain injury). This was almost twelve hours after the resident first complained of a headache. Review of the medication records for the July, August, and September 2011 showed no evidence that the resident had ever requested medication for or complained about a headache prior to 10/2/11.

Interview with the administrator and DON on 10/19/11 at 12:10 PM revealed they investigated and reviewed the above events and determined staff needed education and training regarding neurological assessments and identifying signs and symptoms of traumatic brain injury. They stated all nursing staff were required to attend the education and training provided on 10/11/11. They further stated work assignments had been revised to ensure a qualified professional nurse was on duty at all times to assess residents with

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F 620	Continued From page 8 head injuries. The following concerns were identified: a. Review of the 10/11/11 inservice sign in sheet and random interviews conducted on 10/18/11 and 10/19/11 revealed three of eight nursing staff, LPN #2, CNA #2 and CNA #3, had not received the mandatory education and training. b. There was no evidence of a system for ensuring all direct care staff received the required education. c. There was no evidence of implementation of periodic competency evaluations to ensure staff were able to recognize early signs and symptoms of a traumatic brain injury. d. Eight randomly selected sample records were reviewed for post fall assessments. Review of the August, September and October 2011 quality improvement "Falls Management" records showed the following information had been collected for the eight residents: staff did neurological checks for all unwitnessed falls and those falls involving the head, follow up monitoring and charting was done every shift for seventy-two hours and vital signs were documented. However, review of the post fall assessments for 4 of the 8 medical records (resident's #167, #11, #101, #132) revealed incomplete assessments and/or missed vital signs. Review of the medical record for resident #167 showed the tasks were not performed after s/he fell on 10/1/11. Review of the medical record for resident #11 showed the 10/4/11 post fall assessments were incomplete. Review of the medical record for resident #101 showed the 10/13/11 post fall assessments were incomplete. Review of the medical record for resident #132 showed the post fall neurological assessments	F 620		

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F 520	Continued From page 9 and vital signs were not performed according to the facility's policy after s/he fell on 10/13/11. e. During the interview on 10/19/11 at 12:10 PM, the administrator stated the quality improvement "Falls Management" information was a checklist and had not been revised to identify whether or not tasks were completed or done correctly. f. The facility was unable to provide evidence of a monitoring system for ensuring that neurological assessments and documentation were completed according to the facility policy. According to White, Lois, RN, PhD, Duncan, Gena, RN, MSEd, MSN, and Baumle, Wendy, RN, MSN (2010). Foundations of Adult Health Nursing, third edition, Neuroglial System, page 319,"Intracranial hemorrhage is a common complication of any head injury. Subdural hematomas (bleeding in the brain, subarachnoid hemorrhage) cause immediate pressure on the brain. Subdural hematomas are acute, within forty-eight hours of injury. Common symptoms are headache, drowsiness, slow mentation and confusion." According to the March 2008 Centers of Disease Control and Prevention publication entitled, "Brain Injury in Seniors", the signs and symptoms of a traumatic brain injury for an older adult who has a fall related injury include a headache that gets worse or does not go away; repeated vomiting or nausea; increased confusion, restlessness, or agitation; and inability to awaken.	F 520		