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 _____	R-C 04/28/2006

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
F 176 SS=D	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to assure one of one residents (#4) who self-administered medications was assessed for this practice. The findings were: Observation on 4/27/06 at 8:47 AM showed resident #4 seated in the south dining room. The resident held several pills which s/he proceeded to take without supervision from either licensed nurse, as both were passing medications to residents on the other side of the room. According to the 4/18/06 quarterly Minimum Data Set assessment, the resident had moderately impaired cognition (decisions poor, required cues /supervision). Review of the medical record showed the resident was not assessed or care planned for self-administration of medications. Interview with the director of nursing and the staff development coordinator on 4/27/06 at 4:30 PM confirmed lack of an assessment.	F 176	F 176 Residents may self-administer medications if the interdisciplinary team has determined this practice is safe. This will be accomplished by: A) Resident #4 will receive medication administered by the nurse with nurse supervision. 5/15/06 B) Nurses will be inserviced regarding facility policy on the supervision of medication administration. 5/15/06 C) All residents will have the benefit of nursing supervision of medication unless the I.D.T. has determined that self-administration is appropriate. 5/15/06 D) The Director of Inservice/Education will randomly observe resident medication administration, and if inadequate administration is noted, immediate in-servicing and corrective action will be taken. 5/15/06 E) The Director of Inservice/Education will document audit results on a quality monitoring tool reporting results to the Quality Assurance committee no less than quarterly. 5/15/06 F) The QA committee will take appropriate action based on the results of the audit.	

MAY 16 2006

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

Keith Skatrud — Administrator — 5-15-06

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.

5/18/06 11:30 AM POC accepted & additions per telephone conversation with Keith Skatrud, Administrator. J. Hedges, RN, RS

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 _____ 5/18/06	R-C 04/28/2006

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
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED HOLD POLICY & READMISSION Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to provide written notice of the bed-hold policy for one of one residents (#171) transferred from the facility. The findings were: According to the nursing notes, resident #171 was transferred and admitted to the hospital on 4/16/06. The notes lacked documentation the resident received written notice of the facility's bed-hold policy, either during the transfer or after the resident's admission to the hospital. Interview with the assistant administrator on 4/27/06 at 3:38 PM and the administrator on 4/27/06 at 4:45 PM	F 205	F 205 At the time of resident transfer to a hospital or therapeutic leave, this nursing facility will provide to the resident or representative, written notice which specifies the duration of the bed-hold policy. This will be accomplished by: A) Resident transfer records for hospitalization or therapeutic leave will include a copy of the bed-hold policy.	5/15/06
			B) The facility chaplain will utilize a monitoring tool to audit all hospitalized or residents on therapeutic leave records to assure that the bed-hold policy information was provided. Immediate re-inservice will be provided when deficient practice is noted.	5/15/06
			C) The chaplain will report the results of audit to the Quality Assurance committee no less than quarterly.	5/15/06

→ given to the resident and family member or legal representative at the time of transfer or therapeutic leave.

D) The QA committee will take appropriate action based on the results of the audit.

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F 205	Continued From page 2 confirmed the resident did not receive notice of the bed-hold policy upon transfer from the facility.	F 205		

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F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and medical record review, the facility failed to provide comprehensive pain assessments for three of three residents (#3, #5, #17) with pain. The	F 272	F 272 The facility will conduct initial and periodic comprehensive pain assessments. This will be accomplished by: A) Resident #3, and 5 will be comprehensively assessed for pain. B) Resident # 171 no longer lives in the facility. — 5/15/06 C) All residents will be comprehensively assessed for pain on admission and quarterly by staff nurses. — 5/15/06 D) MDS Coordinators will monitor with a quality monitoring tool, for completion of pain assessments during care plan reviews. — 5/15/06 E) Director of Nursing will provide immediate inservice/corrective action when pain assessment process is deficient. — 5/15/06 F) MDS Coordinators will report results of quality monitoring tool to the Quality Assurance committee no less than quarterly. — 5/15/06 G) Each resident who exhibits acute pain will be assessed immediately by the staff nurse. H) The QA committee will take appropriate action based on the results of the quality monitoring tool.	~~4/27/06~~

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F 272	Continued From page 4 findings were: 1. Review of the 3/16/06 Annual MDS assessment for resident #3 revealed s/he had daily moderate pain. Review of the medical record showed a physician's order dated 2/21/06 for "Vicodin 5/500 1 tab BID as needed (PRN) if Tylenol doesn't control." Review of the March and April Medication Administration Records (MARs) revealed the resident received the PRN Vicodin daily. Further review of the medical record revealed there was no evidence of a pain assessment. Interview with the DON on 4/27/06 at 4:35 PM confirmed a pain assessment was not completed for the resident. 2. Interview with resident #5 on 4/26/06 at 3:05 PM revealed s/he had just requested medication for pain in the right knee. The resident stated s/he recently fell and injured the knee and leg, but could only take pain medication every four hours. Review of the 2/16/06 significant change Minimum Data Set (MDS) assessment showed the resident had daily pain of moderate intensity. However, review of the medical record revealed the last pain assessment was completed on 5/25/05, 11 months ago. A current, comprehensive pain assessment for the resident's knee and leg pain was lacking. Interview with registered nures (RN) #1 on 4/26/06 at 4:20 PM confirmed a pain assessment was not completed. 3. According to the admission MDS assessment dated 4/6/06, resident #171 was documented as having excruciating, daily pain in the back and hip. However, medical record review showed a comprehensive pain assessment was lacking.	F 272		

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F 272	Continued From page 5 Interview with the director of nursing on 4/27/06 at 4:30 PM confirmed a pain assessment was not completed.	F 272		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and medical record review, the facility failed to assure staff maintained professional standards of practice related to oxygen administration for two of two (#5, #138) residents for whom oxygen was ordered but not administered. The findings were: 1. Review of the most recent "Physician's Orders" sheet, dated 3/20/06, revealed resident #5 was to receive continuous oxygen at 2 liters per minute (LPM). In addition, oxygen saturation levels were to be obtained weekly. Review of the medical record showed the saturation levels were not recorded. Observation on 4/26/06 at 3:05 PM showed resident #5 did not use oxygen. Interview with registered nurse (RN) #12 on 4/26/06 at 4:20 PM revealed the resident had not used oxygen "for a long time." The RN reviewed the order sheet and verified the orders for continuous oxygen and weekly saturation levels were still current as they had not been removed from the sheet or discontinued since the 3/20/06 date. Interview with RN #21 on 4/27/06 at 10:30 AM verified weekly saturation levels were not obtained or documented.	F 281	F 281 The services provided or arranged by the facility will meet professional standards. This will be accomplished by: A) Resident #5 and #138 will have updated physician orders consistent with current physical needs assessed i.e., accurate oxygen orders. — 5/15/06 B) MDS Coordinators will audit all resident physician oxygen orders during care planning process (quarterly and with change of condition) and update orders accordingly. — 5/15/06 C) The Director of Nursing will implement a quality monitoring tool to audit records for accurate oxygen orders offering immediate re-inservicing and corrective action when warranted– completed quarterly and reported no less than quarterly at the Quality Assurance meeting. — 5/15/06 D) The QA committee will take appropriate action based on the results of the audit.	~~2/27/06~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 6 2. Observation on 4/26/06 at 2:30 PM and again at 4:45 PM revealed resident #138 was not utilizing oxygen. Review of the medical record showed a physician's order dated 6/2/05 for " O2 [oxygen] sats [saturation] weekly titrate to 89% by Contrad. " Review of the Medication Administration Record (MAR) for March and April 2006 revealed no evidence the weekly saturations were done. Interview with the DON on 4/27/06 at 11:17 AM confirmed the company "Conrad" obtained the weekly saturations levels, but this information was not documented in the MARs, or available anywhere in the medical record. 3. According to the 3rd edition of "Nursing Interventions & Clinical Skills" by Elkin, Perry and Potter, 2004, the nurse "is responsible for verifying that the MAR is accurate...by comparing each medication to the original order, including...dose...and times to be given. If an order seems incorrect or inappropriate, the nurse needs to consult the prescriber." Review of "Clinical Nursing Skills Basic to Advanced Skills," sixth edition, by Smith, Duell, and Martin verified the physician must be contacted for clarification with an order that "is illegible or is questionable for any reason."	F 281		

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SHEPHERD OF THE VALLEY	60 MAGNOLIA CASPER, WY 82604

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F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure staff followed the care plan regarding range of motion exercise (ROM) for 1 (#2) of one sample residents receiving ROM. The findings were: Review of the February, March, and April 2006 restorative nursing documentation revealed resident #2 should receive bilateral lower extremity ROM exercises with 10 repetitions each three times per week. During these three months, with the exception of the week of 2/13/06, the exercises were not provided three times per week as required. There was no evidence of any resident refusals. Interview with the DON on 4/27/06 at 3:20 PM confirmed the resident was supposed to have the exercises three times per week, and they were not done.	F 282	F 282 The services provided or arranged by the facility will be provided by qualified persons in accordance with each residents' written plan of care. This will be accomplished by: A) Resident #2 will receive range of motion in accordance with written plan of care. B) Restorative C.N.A.'s and MDS coordinators will compare and review all resident plans of care with restorative treatment modules to assure consistency and accuracy each month. C) The Director of Nursing will develop a Quality Monitoring tool to randomly audit Plans of Care and restorative nursing documentation providing in-servicing and corrective action as warranted. D) The Director of Nursing will report to the Quality Assurance team no less than quarterly the results of audit.	5/15/06 5/15/06 5/15/06 5/15/06
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by:	F 323	E) The QA committee will take appropriate action based on the results of the audit.	~~2/27/06~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 8 Based on observation, staff interview, and review of Material Safety Data Sheets (MSDS) the facility failed to ensure a safe environment in various areas of the facility. The findings were: Observation on 4/26/06 revealed the following concerns on the central unit: a. At 1:10 PM the custodian closet opposite the nurses' station was unlocked. The closet door was clearly marked, "Danger - Hazardous." Underneath that sign was another marked, "Authorized Personnel Only." A strong chemical odor was present in the closet, and a container of sanitizer and one of disinfectant were mounted on the wall for automatic dispensing. A second container of disinfectant was sitting on the floor. Interview with licensed practical nurse #2 on 4/26/06 at 1:12 PM revealed the closet should be kept locked. Observation at 1:15 PM revealed the closet was still unlocked. Interview with housekeeper #10 at that time confirmed the door should be locked at all times. Review of the Material Safety Data Sheet (MSDS) sheets for both products showed they were harmful to humans. b. The room labeled "Dental Office" was unlocked at 1:18 PM. Among other items, it contained scissors, sterilizer equipment, alcohol, records, and Cavicide (disinfectant/cleaner) that was labeled, "Harmful to humans. Keep out of reach of children. May cause eye irritation." Review of the MSDS showed Cavicide can cause eye damage and can be "harmful or fatal if swallowed." c. At 1:23 PM the door to an office was open; the office contained two desks, each with scissors and other supplies that were available to anyone who entered.	F 323	F 323 The facility will ensure that resident environment Remains free of accident hazards as is possible. This will be accomplished by: A) Custodians will be inserviced to keep custodian closets locked when unattended. — 5/15/06 B) The dental office will have additional locking cabinets installed to store harmful chemicals. — 5/15/06 C) The Dental Hygienist will be inserviced to need to keep door locked when not in attendance of the room. — 5/15/06 D) All office personnel will be inserviced to securely store scissors out of sight. — 5/15/06 E) Shower/tub rooms have additional locking storage cabinets installed to store chemicals and sharps containers. — 5/15/06 F) Bath C.N.A.'s will be inserviced to securely lock chemicals/sharps containers when not in tub room. — 5/15/06 G) Charge nurses will observe tub rooms for proper securing of chemicals/sharps. If inadequate security is noted, immediate re-inservicing and corrective action will ensue. — 5/15/06 H) The Director of Nursing will randomly observe offices, dental hygienist office, custodial closets, tub rooms for adherence to safety expectations. — 5/15/06 I) A quality monitoring tool will be used to document above findings and reported quarterly to the Quality Assurance committee by the Director of Nursing. — 5/15/06	

J) The QA committee will take appropriate action based on the results of the audit.

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 _____ 5/10/04	R-C 04/28/2006

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

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F 323	Continued From page 9 Observation of the East unit on 4/26/06 revealed the following concerns: a. The padlock on the cabinet in the shower room next to resident room 102 was unlocked. Among other items, the cabinet contained a razor and antiseptic packets. In addition, a gallon bottle of "Classic Whirlpool Disinfectant" was on a ledge and an uncapped gallon bottle of "Body Wash and Shampoo" was sitting on the floor. An unlabeled squirt bottle of green liquid was beside the gallon of body wash. According to the MSDS, "Classic Whirlpool Disinfectant" causes eye irritation and may be harmful if swallowed. The shampoo and body wash cause eye and skin irritatation and gastric distress if ingested. b. At 2:40 PM, the cabinet in the shower room by resident room 122 was unlocked and the door was open. A partially full sharps container and an empty bottle of "Classic Whirlpool Disinfectant" were stored in the cabinet. A 3/4 full gallon bottle of "Classic Whirlpool Disinfectant" was sitting on the floor of the shower room. See above for MSDS information for the whirlpool disinfectant. 3. Observation on 4/26/06 at 6:05 PM, revealed the door to the tub room in the secure unit was partially open. There was a one-half gallon of shampoo and body wash next to the tub, and approximatley three quarters of a gallon of skin lotion on a table. According to the MSDS for the shampoo and body wash it was an eye and skin irritant, and would cause gastric distress if ingested. Review of the MSDS for the body lotion showed "For external use only. Avoid contact with eyes. In case of eye irritation flush with water and contact physician. Keep out of reach of children." During the observation, all staff members were	F 323		

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F 323	Continued From page 10 assisting residents in the dining room. However, as residents were done eating they were allowed out of the dining area to freely wander about the unit. Interview with RN #1 on 4/26/06 at 6:10 PM revealed it was acceptable for the tub room door to be unlocked as long as the chemicals where locked in the cabinent. Interview with the DON on 4/27/06 at 11:20 AM confirmed access to these products might pose a hazard to residents on the secure unit. 4. Observation of the south tub room on 4/26/06 at 6:35 PM revealed a door leading into the room was open and no staff were in the vicinity. A biohazard container half-full of diposable razors was on a table next to the tub. The lid was open, allowing residents access to the razors.	F 323		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535042	A. Building B. Wing	4/28/2006

Name of Facility	Street Address, City, State, Zip Code
SHEPHERD OF THE VALLEY HEALTHCARE CENTER	60 MAGNOLIA CASPER, WY 82604

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0221 Reg. # 483.13(a) LSC	Correction Completed 02/27/2006	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 02/27/2006	ID Prefix F0248 Reg. # 483.15(f)(1) LSC	Correction Completed 02/27/2006
ID Prefix F0253 Reg. # 483.15(h)(2) LSC	Correction Completed 02/27/2006	ID Prefix F0278 Reg. # 483.20(g) - (l) LSC	Correction Completed 02/27/2006	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 02/27/2006
ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 02/27/2006	ID Prefix F0492 Reg. # 483.75(b) LSC	Correction Completed 02/27/2006	ID Prefix F0514 Reg. # 483.75(l)(1) LSC	Correction Completed 02/27/2006
ID Prefix F0520 Reg. # 483.75(o)(1) LSC	Correction Completed 02/27/2006	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: Schmitt	Date: 5/1/06
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/12/2006				