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

PRINTED: 04/03/2006
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 _____ B. WING _____	C 03/17/2006

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 159 SS=D	483.10(c)(2)-(5) PROTECTION OF RESIDENT FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the	F 159	F159 1. All resident funds in excess of $50.00 will be deposited in an interest bearing account. This account will be separate from any of the facilities operating accounts. 2. An accounting system has been established to account for all resident funds placed under facility supervision. 3. The facility will notify the resident when their account balance is within $200.00 of the SSI resource limit. 4. The facility will have the resident sign a written authorization explaining how the funds will be accounted for and managed. 5. The total procedure for managing resident funds will be monitored by the office manager and administrator.	04-12-06 04-12-06 04-12-06 04-12-06 04-12-06

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

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.

PRINTED: 04/03/2006
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAI ERVICES
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 _____	C 03/17/2006

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 159	Continued From page 1 SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on medical record review, family and staff interview, and review of facility policies and procedures and financial records, the facility failed to obtain written authorization to manage resident funds for one of one resident (#1) who received a life insurance policy. In addition, the facility failed to separate resident funds from facility funds. The findings were: Medical record review revealed resident #1 was admitted to the facility on 2/9/05 with diagnoses of hemiplegia and aphasia secondary to stroke. It was further documented that several months later, the resident's spouse died leaving a $25,000 life insurance policy. Interview with the bookkeeper on 3/17/06 at 11 AM revealed that on 8/4/05, the facility asked the resident to turn those funds over to the facility to pay for ongoing care. The resident complied and marked the life insurance check with an "X." The facility did not prepare written authorization explaining how the funds were to be accounted for and failed to obtain the resident's mark on such a document. Review of the facility's Resident Trust Policy 3.2 revealed, "Upon written authorization of the resident, Shepherd of the Valley will hold, safeguard, and account for the	F 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536042	A. BUILDING _____ B. WING _____	C 03/17/2006

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 159	Continued From page 2 resident's personal funds." Interview with the resident's family on 3/17/06 at 9:13 AM, revealed that even though the resident was unable to speak, s/he was cognizant enough to handle his/her own affairs. Review of the most recent quarterly Minimal Data Set assessment (1/3/06) confirmed the resident usually makes him/herself understood and has the ability to understand others. Finally, a nursing note dated 4/17/05 documented the resident was generally able to communicate his/her needs; sometimes words are unrecognizable. Review of financial records and interview with the bookkeeper on 3/17/06 at 11 AM revealed the facility did not deposit the proceeds from the life insurance policy in an interest bearing resident account, but rather deposited the funds directly into the facility's operating budget account. Review of the facility Resident Trust Policy 3.3 revealed "Shepherd of the Valley will deposit all funds in a Resident Trust bank account. This account will be separate from all other facility accounts." Interview on 3/17/06 at 11:48 AM with the facility administrator, assistant administrator and director of nursing confirmed the above to be accurate.	F 159		