Reviewed and approved 7/26/06. Discussed c Jill Nolt, Assist Administrator on 7/26/06 @ 10:56 am
Linda Brown RA

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

PRINTED: 07/13/2006
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 06/29/2006

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 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy review, the facility failed to ensure immediate notification of family and/or physician during one resident's (#175) significant change of	F 157	F 157 The facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status, a need to alter treatment significantly; or a decision to transfer or discharge a resident from the facility. This will be accomplished by: A) Director of Nursing will update change of condition notification policy. B) All nurses will receive and review the updated notification policy. C) Mandatory inservicing for nurses will be provided by the Director of Nursing to discuss in detail the updated policy D) A Quality Monitoring tool (Condition Change Audit) will be implemented to ensure resident change of condition was noted to physician and family/respon party within acceptable time frame. The audit tool will be completed by the Director of Nursing and/or designee. E) Deficient areas of practice will be corrected with instruction to responsible care giver, follow-up on notification to the missed persons. F) Results of Quality monitoring tool will be reported to Quality Assurance team no less than quarterly. System deficits will be addressed with remedies imposed by the QA team members.	7/24/06 8/14/06 8/14/06 8/14/06 8/14/06 8/14/06

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

Keith Shattuck — Administrator — 7-21-06

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.

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F 157	Continued From page 1 condition. The resident sample included five sample and five closed records. In addition, the facility failed to consult a physician when one (#176) of two sample residents required a significant alteration in treatment. The findings were: 1. Findings related to lack of notification: Medical record review revealed a face sheet (dated 3/30/06) that showed resident #175 was admitted to the facility on 3/28/06. Review of the nursing admission assessment record revealed the resident was admitted at 1:55 PM with 4 liters of oxygen and had a blood oxygen saturation level of 86% to 87% (normal saturation levels require greater than 88%, without oxygen). The admission document completed by an RN revealed the resident was "pink" in color and was compliant with oxygen use. The assessment was signed as complete at 2:45 PM. Review of nurses' notes revealed that at 6 PM a second nurse, RN #1 assessed the resident as "dusky in color [with] mottled color of face ... " At 7:45 PM, RN #1 documented the resident had dyspnea (difficulty breathing), oxygen saturation levels of 50% to 70%, and was receiving 6 liters of oxygen. Further record review failed to reveal documentation of physician and/or family notification with the resident's change in condition as documented at 7:45 PM. Although documentation revealed further decline in the resident's status by 9 PM, when the resident's color was "mottled" and "pupils react sluggishly - marked dyspnea," review of the record failed to reveal the family and/or the physician were notified of the significant change of condition. Documentation after the resident's death at 9:40	F 157		

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F 157	Continued From page 2 PM showed both the physician and family were called. Review of the record with the assistant administrator and the director of nursing (DON) on 6/29/06 at 3:09 PM confirmed the documentation was not in the record. Review of the facility's policy titled "Notification of Change in Condition," (no number, no date) revealed both the physician and responsible party were to be notified of a substantial change in a resident's physical, mental, or psychosocial status. The procedure showed notification of the physician and responsible party were to be documented in the resident's record. Interview with RN #1 on 6/28/06 at 6:30 PM revealed the resident was admitted and died at the facility later on the same day. The nurse further stated the sequence of events impeded her ability to call the physician before the resident died. The nurse stated she thought the family had been called. 2. Findings related to failure to consult a physician for a significant alteration in treatment: Closed medical record review for resident #176 revealed a face sheet dated 4/27/06 that showed the resident was admitted on 4/26/06 and had diagnoses which included a left bundle branch block (damage to the heart's nervous system), hypertension, congestive heart failure and atrial flutter. Review of the resident's advanced directives, dated 4/26/06, revealed he/she requested resuscitation efforts if his/her heart or breathing stopped. Further review revealed nurses' notes dated 4/26/06 which documented that at 8 PM the resident stated he/she was experiencing severe mid-chest pain	F 157		

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F 157	Continued From page 3	F 157		

radiating to both sides. Documentation showed RN #1 contacted the physician and administered medications as ordered with documentation of the last medication given at 8:30 PM. At 8:35 PM, when the nurse entered the resident's room, the resident was without respirations, blood pressure, and pulse. The nurse's assessment documented the resident' s pupils were fixed and dilated. The record review failed to reveal resuscitation efforts were initiated. Interview and record review with assistant administrator and DON on 6/29/06 at 3:09 PM confirmed the documentation was not in the record. The assistant administrator stated that facility staff were trained to initiate cardiopulmonary resuscitation (CPR) and call 9-1-1.

Interview with RN #1 on 6/29/06 at 4:16 PM revealed that when the resident was found non-responsive, the nurse administered a precordial thump and gave a few breaths, but the resident had already expired and she did not continue CPR.

Review of the facility's policy titled "Advanced Directives" (no number, no date) instructed staff to initiate CPR and call 9-1-1 for all residents who wish to be resuscitated.

According to "Nursing Interventions and Clinical Skills," second edition, copyright 2000, CPR continues until "the rescuer is relieved, the client regains cardiopulmonary function independently, or the physician directs that CPR be discontinued."

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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 medical record review, staff interview, and policy review, the facility failed to ensure care policies were followed when providing care for two (#175, #176) of 10 sample residents. The findings were: 1. Medical record review revealed a face sheet (dated 3/30/06) that showed resident #175 was admitted to the facility on 3/28/06. Further review revealed nursing assessments of the resident's medical condition had changed from the time of the initial nursing assessment at 2:45 PM when the resident was assessed as "pink" and requiring four liters of oxygen, to "dyspnea" (difficulty breathing) and on 6 liters of oxygen at 7:45 PM. Assessments in the nurses' notes documented further decline and then the death of the resident at 9:40 PM. Further record review failed to reveal documentation that physician and/or family was notified when the residents condition on 3/28/06 changed. Documentation at 9:40 PM revealed both the physician and family were not called until after the resident's death. Review of the record with the assistant administrator and the director of nursing (DON) on 6/29/06 at 3:09 PM confirmed there was no documentation of notification of physician or responsible party as the resident's condition began to change. Review of the facility's policy titled "Notification of Change in Condition," (no number, no date) revealed both the physician and responsible party will be notified of a substantial	F 281	F 281 The services provided or arranged by the facility will meet professional standards. This will be accomplished by: 1) Director of Nursing will update "Change of Condition" notification policy. — 7/24/06 2) All nurses will receive and review the updated notification policy. — 8/14/06 3) Mandatory inservicing for nurses will instruct nurses to the facility Change of Condition policies as well as Advanced Directive protocols. — 8/14/06 4) Nursing staff will initiate CPR and activate 911 emergency response systems in the event a resident is assessed to be without vital signs and have indicated a desire to receive CPR resuscitation. — 8/14/06 5) Nursing Staff will notify the physician and responsible party as soon as possible after resuscitation efforts have been initiated. Documentation of notification will be placed in the resident's medical record. — 8/14/06 6) Nursing staff will maintain current BLS/CPR certification and follow resuscitation guidelines established by the American Heart Association standard. — 8/14/06 7) A Quality Monitoring Tool will be implemented to ensure resident change of condition was noted to resident's responsible party and physician within appropriate time frame. The audit tool will be completed by the Director of Nursing and/or designee. — 8/14/06 8) Deficient areas of practice will be immediately noted and corrected (if possible) with instruction to the person responsible for failure to follow policy. — 8/14/06 9) Results of Quality Monitoring Tool will be reported to the Quality Assurance team no less than quarterly. System deficits will be addressed with remedies imposed by the QA team members. — 8/14/06	

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F 281	Continued From page 5 change in the resident's physical, mental, or psychosocial status. The procedure indicated notification was to be documented in the resident's record. Refer to F157 for further information. 2. Medical record review for resident #176 revealed a face sheet dated 4/27/06 that showed the resident was admitted on 4/26/06 and had diagnoses including a left bundle branch block (damage to the heart's nervous system), hypertension, congestive heart failure and atrial flutter. Review of the resident's advanced directives, dated 4/26/06, revealed the resident had requested resuscitation efforts if his/her heart or breathing stopped. Further review revealed nurses' notes, dated 4/26/06, documented that at 8 PM the resident stated he/she was having severe mid-chest pain radiating to both sides. Documentation showed physician contact and medication efforts were made to relieve the resident ' s distress. At 8:35 PM, when the nurse entered the resident's room, the resident was without respirations, blood pressure, or pulse. The nurse's assessment documented the resident's pupils were fixed and dilated. The record review failed to reveal any resuscitation efforts had been initiated. Interview and record review with the assistant administrator and DON on 6/29/06 at 3:09 PM confirmed there was no documentation of any CPR in the record. The assistant administrator stated facility staff were trained to initiate cardiopulmonary resuscitation (CPR) and call 9-1-1. Interview with RN #1 on 6/29/06 at 4:16 PM revealed when the resident was found, she administered a precordial thump and gave a few	F 281		

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F 281	Continued From page 6 breaths, but the resident had expired and, therefore, she did not continue CPR. Review of the facility's policy titled "Advanced Directives" (no number, no date) revealed staff were to initiate CPR and call 9-1-1 for all residents who wish to be resuscitated. According to "Nursing Interventions and Clinical Skills," second edition, copyright 2000, CPR is to continue until " the rescuer is relieved, the client regains cardiopulmonary function independently, or the physician directs that CPR be discontinued."	F 281		
F 286 SS=D	483.20(d) RESIDENT ASSESSMENT - USE A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure all resident assessments completed in the past 15 months were in the resident record for one (#139) of five sample residents. The findings were: Medical record review for resident #139 revealed the resident's most recent quarterly Minimum Data Set (MDS) assessments were in the active record, but the initial MDS assessment was missing. Interview at 8:36 AM on 6/29/06 with MDS coordinator #1 revealed the assessment was not in the record. At 8:45 AM, MDS coordinator #1 stated the assessment was found in the resident's purged medical record. When	F 286	F 286 The facility will maintain all resident assessments completed within the previous 15 months in the resident's active record. This will be accomplished by: A) Resident #139 record will have all resident assessments available for the last 15 months. — 7/21/06 B) The facility chaplain will audit all current resident clinical records to ensure that resident assessments for the last 15 months are available in the designated place of storage and available to necessary staff. Any records discovered to be out of compliance will be immediately corrected. — 8/14/06 C) MDS coordinators will audit records quarterly to assure that resident assessments are available in designated place of storage, remedy deficient areas and report findings to the Quality Assurance Committee no less than quarterly. — 8/14/06	

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F 286	Continued From page 7 interviewed the MDS coordinator stated files in the medical records office were not accessible to all staff.	F 286		
F 309 SS=G	483.25 QUALITY OF CARE 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 medical record review, staff interview, and facility policy review, the facility failed to ensure one (#176) of one closed sample residents with resuscitation orders received cardiopulmonary resuscitation. The findings were: Closed medical record review for resident #176 revealed a face sheet, dated 4/27/06, which showed the resident was admitted on 4/26/06 and had diagnoses which included a left bundle branch block (damage to the heart's nervous system), hypertension, congestive heart failure and atrial flutter. Review of the resident's advanced directives dated 4/26/06 revealed he/she requested resuscitation efforts if his/her heart or breathing stopped. Further review revealed nurses' notes dated 4/26/06 which documented at 8 PM the resident stated he/she was having severe mid-chest pain radiating to both sides. Documentation showed RN #1	F 309	F 309 The facility will ensure that all residents receive care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with comprehensive assessment and plan of care. This will be accomplished by: A) All residents will receive CPR if they have indicated this desire in their advanced directive. — 8/14/06 B) All nurses will be inserviced to the facility policy regarding resuscitation procedures by the Director of Nursing. — 8/14/06 C) All nurses will maintain current BLS/CPR certification and follow resuscitation guidelines in accordance with American Heart Association standards. — 8/14/06 D) The Director of Nursing will audit all records of deceased residents to assure that advanced directives were honored and documented. Immediate inservice will be provided to any Nurse noted to have failed to follow facility policy. — 8/14/06 E) The Director of Nursing will report any areas of deficiency or concern to the Quality Assurance Committee no less than quarterly.	

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F 309	Continued From page 8 contacted the physician and administered medications as ordered with documentation of the last medication given at 8:30 PM. At 8:35 PM when the nurse entered the resident 's room, the resident was without respirations, blood pressure, and pulse. The nurse's assessment documented the resident's pupils were fixed and dilated. The record review failed to reveal resuscitation efforts. Interview and record review with assistant administrator and DON on 6/29/06 at 3:09 PM confirmed the lack of documentation to indicate CPR had been initiated in the record. The assistant administrator stated that facility staff were trained to initiate cardiopulmonary resuscitation (CPR) and call 9-1-1. Interview with RN #1 on 6/29/06 at 4:16 PM revealed when the resident was found, she administered a precordial thump and gave a few breaths, but the resident had expired and therefore, she did not continue CPR. Review of the facility's policy titled "Advanced Directives" (no number, no date) instructs staff to initiate CPR and call 9-1-1 on all residents who wish to be resuscitated. According to "Nursing Interventions and Clinical Skills," second edition, copyright 2000, CPR is to continue until "the rescuer is relieved, the client regains cardiopulmonary function independently, or the physician directs that CPR be discontinued."	F 309		