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 05/03/2013

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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jill Holt	Administrator	5-25-13

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.

6/4/13 This POC accepted between Jill Holt, Administrator and Tony Madden, Surveyor.

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

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and review of facility investigations, the facility failed to ensure 1 of 3 investigations was thorough and complete. The findings were: Review of the facility investigation, dated 4/11/13, which related to an allegation of physical abuse between two married residents (#2, #3) showed it was not thoroughly investigated. According to the investigation, resident #2 was observed to have a black eye on 4/10/13. The facility investigation consisted solely of an interview with a family member, who was not present at the time of the incident, and who denied resident #3 could have been responsible for the injury to resident #2. There was a lack of documented interviews with the two residents involved, with staff who were working on the date of the incident, or with other residents who may have seen or heard something. Interview on 5/3/13 at 10:30 AM with the social worker who was responsible for the investigation revealed she was not sure how the resident received the black eye. She was uncertain why the investigation of this case did not include more interviews and verified there could have been more questioning. During the interview, the social worker remembered the nurse had interviewed the resident at the time of the allegation, and she should have included the interview in her investigation. Review of an undated nurses "Investigation" written by RN #1 showed on 4/10/13 resident #2 was witnessed to have bruising to the right eye area. The note further	F 225	**F225** **All facility investigations alleging abuse will be thoroughly investigated. This will be accomplished by:** **2. Residents #2 and #3 investigation is unable to be completed.** **3. a. The facility revised and implemented a formal investigation process to ensure investigations are thorough and complete.** **b. The facility Director of Nursing and local Ombudsmen will complete abuse investigation training with the facility leadership team and all licensed nurses on or before 6/6/2013.** **c. The facility Director of Nursing or designee will complete written audits on facility abuse investigations making immediate corrections, revisions with subsequent retraining as indicated.**	

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F 225	Continued From page 2 showed when the resident was asked by LPN #1 how s/he got the bruise, the resident made a fist and gestured that the fist hit him/her in the face. The "Investigation" made by RN #1 listed the diagnoses of dementia for both residents, and noted that staff had reported resident #3 showed increased irritability, decreased patience, and verbal criticism toward resident #2. Further review of the facility investigation failed to show a conclusion made in regard to substantiating or not substantiating abuse for this situation. The facility did implement new safety interventions to monitor the behaviors of resident #3 more closely and to have the door to the couples room remain open at all times with both of the residents agreeing to this.	F 225	**4. Results of the written audits will be taken to the facility Quality Assurance and Assessment Committee monthly x 3 months. After that time, the audits will be conducted as directed by the QA Team until it is determined the facility has achieved ongoing compliance.** **Completion date: 6/15/2013**	