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

PRINTED: 07/05/2013
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 _____	06/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY HEALTHCARE CENTER	90 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: IP: Infection Preventionist RN: Registered Nurse CNA: Certified Nursing Assistant MDS: Minimum Data Set MAR: Medication Administration Record Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide adequate lighting in 1 of 4 sample resident (#125) rooms on the West secured unit, and in 1 of 2 resident lounges in the West secured unit. The findings were: 1. Observation of resident #125's room on 6/18/13 at 8:53 AM revealed that the overhead fluorescent light was not functional. The light in the room was noted to be dim. That same day at 10:33 AM CNAs #1 and #2 who were providing personal care to the resident in his/her room noted that the light did not work, and CNA #2 stated "We'll have to tell them [maintenance]." Observation of resident #125's room on 6/19/13 at 5:10 PM revealed the light continued to be non-functional, and the room continued to be	F 256	F 256 Facility must provide adequate and comfortable lighting levels in all areas. This will be accomplished by: 1. Lighting in room 31 and West lounge area has been replaced. 2. Inservice training to all staff regarding the procedure for reporting inadequate lighting. 3. Maintenance Director or designee will audit lighting monthly, taking immediate corrective action for noted infractions. 4. Maintenance Director will report results of audits to the monthly QA meeting x 3 months at which point the QA Committee will determine if substantial compliance has been achieved and make appropriate recommendations.	7/26/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 7-12-13

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.

Changes made per phone call with Jill Witt, Administrator on 7/25/13 at 10:40 am. POC accepted. Janeece Colvin, ONVC

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F 258	Continued From page 1 dimly lit. 2. Observation on 6/18/13 at 9:15 AM of the resident lounge near the nurses' station on the West secured unit revealed that 1 of the 4 overhead lights was dim and flickering, and that another was not lit at all. This resulted in one half of the lounge being dimly lit. Ten residents were noted to be in the lounge at the time. Interview with the maintenance director on 6/20/13 at 10 AM confirmed the lights were in need of attention, and revealed the facility was in the process of upgrading all of the overhead lights. Additional interview with the maintenance director on 6/20/13 at 12 noon revealed there was not a routine schedule for changing light bulbs, the nursing staff or housekeeping staff in the West unit would communicate their needs by submitting a work order.	F 258		
F 309 SS=D	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 psyohosocial 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 and resident and staff interview, the facility failed to ensure 2 of 21 sample residents (#118, #18) received physician ordered care and services. The findings were:	F 309	**F 309** **Each resident will receive the facility musts 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 #118 is offered a "high fiber diet with daily fiber supplementation" and is receiving prescribed proton pump inhibitor.** **2. DON will review the current policy and procedure for obtaining post consult orders/notes, making revisions if necessary.** **3. DON will review and if necessary revise the policy for noting orders ensuring that the orders are properly entered into the computer for MAR population.** **4. Resident #18 pre and post pain assessments are documented on the MAR.** **5. Nursing staff will be educated on the above infractions.** **6. Unit Manager's will conduct weekly audits of MAR's to assure that pre and post pain**	

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F 309	Continued From page 2 1. Review of the medical record showed resident #118 had diagnoses including multiple sclerosis, swallowing difficulties and depression. Interview with the resident on 6/19/13 at 11 AM revealed s/he saw a consultant gastroenterologist (GE) on 5/24/13 at which time a colonoscopy was performed. The resident stated the doctor told him/her "your colon is basically non functioning due to the MS." The following concerns were noted: a. Review of the medical record on 6/19/13 at 11:10 AM failed to show any report from the consultant GE. Interview with medical records staff member #1 at that time confirmed the report was not in the medical record. She further stated she would request a fax copy be sent from the consultant. b. Review of the consultant report on 6/19/13 at 2:12 PM revealed the GE's plan included a "high fiber diet with daily fiber supplementation." Interview with the dietary manager on 6/19/13 at 2:15 PM revealed the resident was not receiving a high fiber diet and her department had not received a "high fiber" diet change order from nursing. c. Further review of the medical record revealed the physician prescribed the medication omeprazole (a proton pump inhibitor) for the resident on the day of the colonoscopy (5/24/13). Review of the May 2013 MAR indicated the medication was administered from 5/24/13 through the end of the month. Review of the June 2013 MAR however revealed the medication was not administered during the first six days in June. d. Interview with RN #2 on 6/19/13 at 3 PM revealed several things that may have happened: nursing staff missed giving the medication,	F 309	**management is assessed and documented.** **7. Unit managers will audit resident records for receipt and implementation of all physician orders.** **8. Unit managers will audit resident orders to assure that they are properly entered into the computer and populated on the MAR.** **9. Results of the above audits will be reported to the monthly QA committee for a minimum of 3 months at which point the team will determine appropriate reporting until ongoing compliance is established.**	7/26/13

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F 309	Continued From page 3 nursing staff did give the medication but forgot to initial the MAR, and/or there was a computer problem which resulted in the omeprazole not being printed on the June MAR and the transcription error was not discovered until 6/7/13. 2. Review of the medical record showed resident #18 had diagnoses including Parkinson's, Paralysis Agitans and Lewy Body Dementia. Review of the April and May 2013 physician's recapitulation of orders showed an order for Hydrocodone-Acetaminophen 5-325 milligrams 1-2 tabs every 4 hours as needed for pain. Review of the April 2013 MAR showed the medication was administered 24 of the 30 days; however, the pre and post-pain assessments were only documented for 10 of the 30 days. Review of the May 2013 MAR showed the medication was administered 25 of the 31 days, however, the pre and post-pain assessments were only documented on 11 of the 31 days. Interview with RN #3 on 6/18/13 at 2:30 PM revealed "the pre and post-pain assessments should have been documented on the MAR."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review	F 312		

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F 312	Continued From page 4 and staff interview, the facility failed to provide appropriate incontinence care for one sample resident (#144) during 1 of 4 observations of incontinence care. The findings were: Resident # 144 was admitted to the facility on 6/7/12 with diagnoses to include non-Alzheimer's dementia and multiple sclerosis. Review of the resident's 2/6/13 significant change MDS assessment revealed the resident required the physical assistance of two or more persons with toileting, and the resident was always incontinent of urine and bowel. Observation of personal care for resident #144 on 6/18/13 at 9:03 AM revealed that one of the two CNAs (CNA #2) providing incontinence care for the resident wiped the resident's perineal area from back to front. Interview with CNA #2 at that time verified she had wiped "the sides" of the perineal area from back to front. According to Smith, S., Duell, D., and Martin, B. (2008) Clinical Nursing Skills (7th Edition). Upper Saddle River, NJ: Pearson Education, the accepted practice for providing perineal care is to always wipe the area from front to back, cleansing the anal area last in order to prevent cross-contamination. Interview with the nurse manager, RN #1, on 6/20/13 at 10:10 AM confirmed the facility expectation is that perineal cleansing is performed from front to back.	F 312	F 312 Residents who are unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This will be accomplished by: 1. Nursing Staff will be inserviced to the above deficiency. 2. Resident #144 will receive proper incontinent care utilizing acceptable practices. 3. Nursing Administration team will audit perineal care weekly, with immediate corrective action for noted infractions. 4. Nursing Administration will report results of the weekly audits to the monthly QA committee a minimum of 3 months at which point the team will determine appropriate subsequent reporting until ongoing compliance is established.	7/26/13
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 6 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	F 441 The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. This will be accomplished by: 1. Infection Control Nurse(s) have been inserviced to the above infraction. 2. All staff will receive inservice instruction to the above deficiency as it relates to proper hand-washing. and maintenance care for Res # 144. 3. Nursing Administration will develop a program that includes surveillance records for infections and antibiotic usage. including Res # 103 and # 135. 4. The program will include a standardized tracking tool with data elements that include identifying symptoms, noting the onset date of symptoms, whether cultures were submitted and reports received, and whether the infection clinically resolved. 5. The program will also include the tracking of data elements that will identify trends based on resident location, type of infection and whether there are increasing numbers of infections.	

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F 441	Continued From page 8 Based on review of surveillance documents and medical records, observation, and staff interview, the facility failed to maintain a complete and accurate infection control program. This failure was evident in the failure to track current infections and antibiotic treatment for 2 of 7 (29%) sample residents (#102, #135) with infections, incomplete data collection for 15 of 42 (36%) resident infections tracked in the last 3 months, and a failure to accurately identify trends among infections occurring in April and May 2013. The findings were: 1. Facility infection surveillance records were reviewed with the IP on 6/19/13 beginning at 12:10 PM. These documents and accompanying interview with the IP revealed the following discrepancies: a. Surveillance records for infection and antibiotic usage data collected in April and May 2013 were incomplete. In April 2013, of 18 residents identified with infections 4 (21%) lacked one or more data elements on the facilities standardized tracking tool; omissions were discovered in identifying symptoms, noting the date of onset of symptoms, whether cultures were submitted and reports received, and whether the infection was clinically resolved. Similarly, 11 of 23 (48%) residents tracked for infections or antibiotic usage in May 2013 also lacked one or more of critical surveillance data elements. The IP acknowledged in interview on 6/19/13 at 12:20 PM the surveillance records for April and May 2013 were incomplete. She further stated the surveillance forms used for tracking infections and antibiotic treatment were designed to capture critical data and were expected to be complete and accurate.	F 441	6. The program will address practice and process surveillance relative to the trends identified. 7. Unit Managers will conduct weekly audits that address facility staff utilizing proper hand hygiene prior to assisting in the meal service. In the event infractions are noted, immediate corrective action will be deployed. 8. The Infection Control Practitioner will report the data collected from surveillance and trending reports to the monthly QA meeting. 9. Unit Managers will report results of weekly dining rooms to the monthly QA meeting x 3 months at which point the team will determine appropriate subsequent reporting until ongoing compliance is established.	7/26/13

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F 441	Continued From page 7 b. Of 7 sample residents with infections documented in their medical records over the past 90 days, 2 residents (#135 and #102) were not identified on the surveillance logsheets. Both residents had been transferred to the local hospitals for diagnosis and treatment of infections; resident #102 was admitted on 4/8/13 and resident #135 was admitted 6/12/13, both returned to the nursing home after a 3-day admission. Both residents had microbiologic cultures performed during their hospitalization and each was reported to have the same uncommon bacterial isolate, Providencia stuartii, from either a urine specimen (resident #102) or blood culture (resident #135). The facility failed to track either resident for infection or antibiotic usage once readmitted to the nursing home. The facility IP stated in interview on 6/19/13 at 12:30 PM that she did not have copies of culture reports from either resident's hospital stay and, further, was not aware they each had the same uncommon bacterial isolate. c. Review of the monthly reports summarizing resident infections for April and May 2013 on 6/19/13 at 12:45 PM revealed each month was summarized by a statement "No trends were identified in the type of infections or location." The IP stated in interview on 6/19/13 at 12:55 PM the monthly infection report was submitted to the facility Quality Assurance and Performance Improvement (QAPI) committee for review and consideration. Reviewing the actual numbers of infections and their location within the facility for data collected in April and May 2013 uncovered several potential trends among residents. Of 8 new infections reported among residents in April 2013, 5 (62%) were clustered in a single unit (East). Further, urinary tract infections (UTIs)	F 441		

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F 441	Continued From page 8 showed a 450% increase in May 2013 compared to the previous month. The IP acknowledged in interview on 6/19/13 at 2:10 PM that she had not identified the clusters of infections nor the significant increase in UTIs when preparing the monthly summaries for April and May 2013. She further stated this type of information should be submitted to the QAPI committee for assessment and action if needed. 2. Interview with the staff development coordinator on 6/19/13 beginning at 2:20 PM revealed she was newly assigned the role of collecting surveillance data for assessing staff compliance with infection prevention practices, such as hand hygiene, perineal care, wound care, use of personal protection equipment, and housekeeping activities. She acknowledged she was not currently performing compliance monitoring among facility staff. She further stated she did not know when process surveillance was last conducted nor what the outcomes were in areas with the potential for transmitting infections among residents. Observations during the survey showed facility staff failed to use appropriate perineal cleansing techniques during 1 of 4 observations: a. Observation of personal care for resident #144 on 6/18/13 at 9:03 AM revealed that one of the two CNAs (CNA #2) providing incontinence care for the resident wiped the resident's perineal area from back to front. Interview with CNA #2 at that time verified she had wiped "the sides" of the perineal area from back to front. Interview with the nurse manager, RN #1, on 6/20/13 at 10:10 AM confirmed the facility expectation is that perineal cleansing is performed from front to back.	F 441		

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F 441	Continued From page 9 3. For 2 of 2 meal observations, evening meal on 6/17/13 and lunch meal on 6/18/13, facility staff made no attempt to perform or provide hand hygiene to residents prior to serving food. The lack of resident hand hygiene prior to eating was consistent across 3 seperate dining areas: East, Central, and South. The staff development coordinator stated in interview on 6/19/13 at 3:10 PM that the facility had not identified resident hand washing. She acknowledged that washing hands before eating was a prudent practice.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe and sanitary environment in 1 of 1 walk-in freezers. The findings were: Observation on 6/17/13 at 3:35 PM showed the interior of the walk-in freezer in the main kitchen had large amounts of accumulated ice around the door frame, on the floor, ceiling, and on the plastic curtain in the entrance. Observation on 6/20/13 at 9:45 AM showed the freezer remained in the same condition with the accumulated ice. Interview with the maintenance director on 6/20/13 at 12:20 PM revealed the maintenance staff had replaced the seals around the freezer	F 465	F 465 The facility will provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. This will be accomplished by: 1. Ice will be removed from interior door frame of the walk-in freezer. 2. Maintenance and dietary staff will be inserviced to the above deficiency. 3. Director of Maintenance will seek outside consultation from specialized refrigeration services to determine what is best course of action to prevent future excessive ice build up and implement the recommendation. 4. Maintenance has placed order for a freezer replacement door, door insert, door jam/panels. 5. Director of Dietary or designee will monitor daily the freezer for ice build up taking immediate corrective action if ice build up is noted. 6. Director of Dietary will report frequency of of ice build up to the monthly QA meeting x 3 months at which point the team will determine appropriate subsequent reporting until ongoing compliance is established.	7/26/13

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F 465	Continued From page 10 door after the previous years survey (4/26/12); however, the ice buildup had continued to be a problem. He further stated that the door needed to be replaced to create a tighter seal; however, at that time there had been no parts or replacement door ordered.	F 465	F 513 The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This will be accomplished by: 1. Nursing Personnel & Medical Records personnel will be inserviced to the above deficient practice. 2. DON will review the current policy and procedure for obtaining post consult orders/notes, making revisions if necessary. 3. Unit managers will audit resident records for receipt and implementation of all physician orders. 4. Results of the above audits will be reported to the monthly QA committee for a minimum of 3 months at which point the team will determine appropriate reporting until ongoing compliance is established.	7/26/13
F 513 SS=D	483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview the facility failed to ensure a diagnostic procedure report was included in the medical record for 1 of 21 sample residents (#118). The findings were: Review of the medical record showed resident #118 had diagnoses including multiple sclerosis (MS), swallowing difficulties and depression. Interview with the resident on 6/19/13 at 11 AM revealed the resident's physician referred the resident to a consultant gastroenterologist (GE). The resident was examined by a GE on 5/24/13 and a colonoscopy was performed at that time. The resident stated the doctor told him/her "your colon is basically non-functioning due to the MS." Review of the medical record on 6/19/13 at 11:10 AM failed to show a report from the consultant GE. Interview with the medical records staff member #1 at that time revealed the report was not in the medical record. She further stated she	F 513		

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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 _____	06/20/2013

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

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F 613	Continued From page 11 would request a fax copy be sent from the consultant.	F 613		
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 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: Based on staff interview and infection control document review, the facility failed to develop and implement an effective quality plan to sustain the correction of identified infection control practices. These practices were found to be non-compliant	F 520	F 520 The facility will maintain a quality assessment and assurance committee that develops and implements an effective quality plan to sustain the correction of identified infection control practices. This will be accomplished by: 1. The Quality Assurance team will be inserviced to the above infraction. 2. The QA Team will incorporate Infection control surveillance with focus on "clusters of infections" and trending of certain types of infections. 3. The Administrator will monitor the program x 3 months to assure compliance, making necessary adjustments until compliance is achieved.	7/26/13

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F 520	Continued From page 12 during 5 of 5 re-certification surveys. The findings were: Review of the infection program documentation showed surveillance and monitoring for residents with infections was lacking. The IP acknowledged in interview on 6/19/13 at 2:10 PM that she had not identified the clusters of infections nor the significant increase in UTIs that were present when preparing the monthly summaries for April and May 2013. She further stated this type of information should be submitted to the Quality Assurance and Program Improvement Committee for assessment and action if needed. Review of the facility compliance report (Casper 3 report) showed the previous four surveys (April 2009, March 2010, March 2011 and April 2012) the infection control program was cited as a deficient area. Interview with the administrator and the director of clinical services on 6/20/13 at 10:40 AM verified a report on infections was included as part of their monthly quality assurance committee meetings; however, the information was not being effectively evaluated.	F 520		