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

PRINTED: 01/30/2015
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 01/16/2015

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 000	INITIAL COMMENTS A survey was conducted by the Office of Healthcare Licensing and Surveys on 1/14/15 through 1/16/15. The survey was prompted by complaint intakes WY-1924, WY-1953, and WY-1964.	F 000	F281 The services provided or arranged by the facility will meet professional standards of quality. This will be accomplished by:	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS 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 interview and policy review, the facility failed to ensure professional standards of quality were met during random observations which affected 1 sample resident (#48) and 1 non-sample resident (#147). The failure was in regards to intravenous (IV) medication administration and narcotic management. The findings were: 1. Observation on 1/15/15 at 4:05 PM showed resident #48 was sitting in a recliner in the main living area of the south unit, and had an intravenous (IV) infusion running. The south unit manager stated the IV had the antibiotic medication rocephin; however, the 250 milliliter (ml) IV bag of normal saline (ns) was unlabeled, and did not include the medication, dose, date and time of administration, or the initials of the staff member who administered the medication. Additionally, the south unit manager was observed flushing the IV with 10 ml of ns, and then attaching another unlabeled bag of 1000 ml ns to the IV, and administered it to the resident.	F 281	1. No immediate corrective action could be taken for Resident # 48 labeling of IV medication. Resident # 147's narcotic count has been reconciled and is correct. 2. The Director of Nursing (DON) will in-service nurses and medication aides to the deficient practice. 3. The DON or designee will audit 3 medication passes per week to ensure IV medications are labeled appropriately and that narcotics are signed out at the time of administration, and accounted for. Immediate corrective action will be deployed when/if deficient practice is noted. 4. Audits will be conducted weekly X 4 weeks and then monthly X 3 months. At that time, the QA team will review audit results for further review and recommendations and/or continuation/discontinuation of audit.	2/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 2/4/15

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.

POC accepted. DOC 2/23/15. Message left for [illegible] on 2/17/15 3:10pm [signature]

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

PRINTED: 01/30/2015
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 01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY HEALTHCARE CENTER	80 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 281	Continued From page 1 Interview at that time with the south unit manager verified the two bags of ns were unlabeled, and they should have been labeled at the time of administration, and that she was in a hurry when she administered the medication. Interview at that time with the director of nursing (DON) showed the facility expectation was that medications, including IV forms, were to be labeled appropriately, according to professional standards. Review of the facility policy titled "Continuous Infusion of Medications and Solutions" dated July 1, 2012 showed "...Label medication/solution container and administration set with: Date and Time, Nurse's Initials..." According to the seventh edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell and Martin, 2008, page 1077, the IV solution should be labeled with resident identification, solution type, additives and expiration date. 2. Observation on 1/15/15 at 4:15 PM showed a narcotic discrepancy for resident #147. Review of the narcotic log book for the south unit showed the tramadol 50 mg card should have had 2 pills left. Observation of the tramadol 50 mg card showed it had one pill left. Interview at that time with the south unit manager revealed the card only had one pill, and that it was given earlier that day to the resident by another nurse; however, the medication had been dispensed by the south unit manager, who had given the narcotic to the assigned nurse to administer to the resident. Interview at that time with the DON revealed the facility expectation was the nurse who dispenses the medication is the nurse who should be administering the medication. According to the seventh edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell and Martin,	F 281		

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

PRINTED: 01/30/2015
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
	536042	A. BUILDING _____ B. WING _____	C 01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY HEALTHCARE CENTER	50 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 281	Continued From page 2 2008, page 568, "The nurse who prepares the medication must also give it to the client."	F 281	F314 The facility will ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident that has a pressure sore receives necessary services to promote healing, prevent infection and prevent new sores from forming. This will be accomplished by:	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to prevent the development of avoidable pressure ulcers for 1 of 3 sample residents (#28) at risk for developing pressure ulcer. The findings were: Medical record review showed a care plan for resident #28 which was revised on 6/23/14. The care plan showed the resident was at risk for skin breakdown due to immobility, shearing, and incontinence. Further review of the 6/23/14 care plan showed the resident required extensive assistance with bowel and bladder function and used a sit-to-stand mechanical lift. Interview with the resident on 1/14/15 at 3:00 PM revealed s/he had skin breakdown because "they don't change me." The resident stated s/he had been incontinent for several years prior to coming to the facility and only recently "got sores." Observation on 1/15/15 at 3:35 PM showed the	F 314	1.Resident # 28 has been assessed by nursing as well as by resident's physician. 2. The DON will in-service nursing staff on turning and repositioning and incontinence care. 3. The DON or designee will audit 3 random at risk resident's per week X 4 weeks to ensure that the resident receives timely incontinence care and repositioning as outlined in the resident's individualized plan of care. Auditor will make immediate corrective action if warranted.	

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

PRINTED: 01/30/2015
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 01/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY HEALTHCARE CENTER	50 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 314	Continued From page 3 resident had an open area to his/her coccyx where the edges of the wound presented with white edges, that appeared to be wet, and the center of the wound was bright red in color. Interview with Unit Manager #1 on 1/15/15 at 3:35 PM confirmed there was an open area. Interview and observation at that time, with the Director of Nursing on 1/15/16 at 4:06 PM confirmed that the resident had an open area to the coccyx, located on a "high risk area for pressure." Review of wound documentation obtained on 1/15/15 at 6:12 PM from Unit Manager #2 revealed it was a late entry note for 1/14/15 at 4:08 PM that was written on 1/16/15 and untimed. The note documented "noted shallow ulceration along Rt. [right] Gluteal cleft." The documentation further revealed staff certified nursing assitants were educated about the resident's skin and "the need for pressure offloading."	F 314	4. Results of the weekly audits will be reported to the monthly QA Team X 3 months for their review/recommendations. At the end of 3 months, the QA team will make recommendations if indicated, and/or continue/discontinue audits.	2/23/15