CENTERS FOR MEDICARE & MEDICAID SERVICES

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 08/27/2015

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 complaint survey was conducted by Healthcare Licensing and Surveys on 8/26/15 through 8/27/15. The survey was prompted by complaint intakes WY00002051 and WY00002093. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CAA- Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set RN- Registered Nurse NHA- Nursing Home Administrator Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interview, and review of medical records and facility staffing, the facility failed to ensure resident supervision and safety for 1 of 5 resident care units (West). At	F 323		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Admin | (X6) DATE Resubmit 10/1/15

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: JMI511 Facility ID: WY0027 If continuation sheet Page 1 of 8

OCT 01 2015
Healthcare Licensing and Surveys

Plan of correction accepted on 10/5/15. spoke E Carley Applegate at 9:10am

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

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 08/27/2015

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 323	Continued From page 1 the time of the survey there were 22 residents on the West unit that required staff supervision and oversight. The findings were: 1. Observation of the West hallway on 8/26/15 from 7:55 PM - 7:55 PM showed 9 residents were in the dining area and 8 of the residents were sitting at tables with meals in front of them. No nursing staff members were observed in the dining area at that time. Continued observation showed resident #71 picked up food that had been spilled on the table and began to eat it. 2. Observation of resident #133 on 8/26/15 at 7:55 PM showed the resident was on his/her hands and knees in the resident's room. The resident grabbed the bed to get off the floor and no staff members were available to observe and assess the resident on the floor. Continued observation at that time showed CNA #1 was pushing a resident's wheelchair down the hall and was attempting to redirect other residents from going to the dining room area while resident #133 was on the floor. 3. Observation on 8/26/15 at 8:08 PM showed CNA #1 was providing 1-to-1 assistance with a resident near the nurses' station who was attempting to get out of his/her wheelchair. CNA #2 hollered down the hall that she needed assistance. CNA #1 replied that she was assisting the other resident at that time. CNA #2 replied "There are 2 nurses down there." CNA #1 then informed CNA #1 that the nurses were helping resident #133. CNA #2 stated she would "focus on people who aren't hoyers" and took another resident in a room to provide care. 4. Observation on 8/26/15 at 8:15 PM revealed a	F 323	<u>F323 Plan of Correction:</u> 1. The residents who reside on the West Unit are receiving staff supervision and oversight. All residents on the West Unit have received updated safety assessments. 2. All residents on the West Unit have the potential to be affected by this practice. All residents have received updated safety assessments. 3. Staff has received training on safety awareness and management for residents on West Unit, including monitoring resident while in common areas. 4. Staffing will be reviewed daily by Director of Nursing or designees to ensure appropriate supervision to minimize accidents and hazards; while supporting the resident's independence and functioning status, while in common areas. Regular rounding will be performed to monitor and redirect residents in common areas not being used; i.e. dinning room, outside of meal service, activity room during meal service Weekly audits will be performed on the West Unit for safety and supervision needs. 5. Director of Nursing will report to QAPI the findings of the audits, for a minimum of three months. QAPI will monitor for trends and make recommendations thereafter.	10/09/2015

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

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 08/27/2015

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 323	Continued From page 2 CNA from another unit was asked by RN #2 to obtain vital signs for resident #133 because the other staff was "busy." 5. Interview with a resident's family member on 8/16/15 at 8 PM revealed the family had to routinely assist residents during the evening meal because there was not enough staff to help. Continued interview at that time revealed there have been resident-to-resident altercations due to staff not being available. 6. Interview with RN #1 on 8/26/15 at 8:40 PM revealed the nurses were changing schedules because of lack of staff. RN #1 further stated there were "not enough staff." 7. Review of medical records for May 2015 showed there were 6 falls during the month (residents #134, #133, #117, #21, #49). Review of facility staffing showed 6 of the 6 falls occurred when there was either no activities staff on the unit and/or the nursing staff was less than what the facility had determined to be necessary for the West hallway. 8. Review of medical records for June 2015 showed there were 6 falls during the month (residents #19, #65, #117, #78, #93, #49). Review of facility staffing showed 5 of the 6 falls occurred when there was either no activities staff on the unit and/or the nursing staff was less than what the facility had determined to be necessary for the West hallway. 9. Review of medical records for July 2015 showed there were 13 falls during the month (residents #133, #117, #21, #5, #78, #71, #49, #147). Review of the facility staffing showed 9 of	F 323		

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

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 08/27/2015

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 323	Continued From page 3 the 13 falls occurred when there was either no activities staff on the unit and/or the nursing staff was less than what the facility had determined to be necessary for the West hallway. 10. Review of medical records for 8/1/15 - 8/26/15 showed there were 11 falls during the month (residents #42, #65, #117, #71, #49, #147). Review of facility staffing showed 5 of the 11 falls occurred when there was no activities staff on the unit and/or the nursing staff was less than what the facility had determined to be necessary for the West hallway. 11. Interview with RN #2 on 8/26/15 at 7:45 PM revealed normal staffing for the West hall was 1 nurse for each shift and 3 CNA's for day shift, 2 CNA's for evening shift, and 2 CNA's for night shift. 12. Review of facility staffing for May 2015 showed the nursing staff was less than what the facility had determined to be necessary for the West hallway 17 out of 31 days. Review of the facility staffing for June 2015 showed the nursing staff was less than what the facility had determined to be necessary for the West hallway 14 out of 30 days. Review of the facility staffing for July 2015 showed the nursing staff was less than what the facility had determined to be necessary for the West hallway 13 out of 31 days. Review of the facility staffing for 8/1/15 - 8/26/15 showed the nursing staff was less than what the facility had determined to be necessary for the West hallway 11 out of 26 days. 13. Interview with the NHA on 8/27/15 at 2 PM revealed the facility had not identified an increase in resident falls on the West hallway and had not	F 323		

CJC

CENTERS FOR MEDICARE & MEDICAID SERVICES

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 08/27/2015

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 323	Continued From page 4 Implemented specific interventions to attempt to decrease the falls.	F 323	F353 Plan of Correction: 1. Residents on the West Unit are receiving staff supervision to provide for their physical, psychosocial, and quality of life needs. • Staff members are present in the West Unit dining room meal time when residents are seated at the tables. Supervision is provided to discourage residents picking up spilled food off of the table. • Resident #133 is receiving staff supervision in order to provide for physical needs, psychosocial needs, and quality of life needs. • Residents identified have received updated safety assessments. 2. All residents on the West Unit have the potential to be affected by this practice. All residents have received updated safety assessments. 3. Staff members have received training on safety awareness and management for residents on West hallway, including monitoring resident while in common areas. 4. Staffing will be reviewed daily by Director of Nursing or designees for appropriate supervision to minimize accidents and hazards; while supporting the resident's independence and functioning status. Weekly audits will be performed on the West Unit for safety and supervision needs, while supporting the resident's independence and functioning status, while in common areas. Regular rounding will be performed to monitor and redirect residents in common areas not being used; i.e. dinning room, outside of meal service, activity room during meal service 5. Director of Nursing will report the audit findings to QAPI for a minimum of three months. QAPI will monitor for trends and make recommendations thereafter.	10/09/2015
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interview, and review of medical records and facility staffing, the facility failed to ensure adequate number of staff were assigned to provide for the physical, psychosocial, and quality of life needs for 1 of 5 resident care units (West). At the time of the survey there were 22 residents on the West unit. The findings were:	F 353		

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

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 08/27/2015

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 353	Continued From page 5	F 353		

1. Observation of the West hallway on 8/26/15 from 7:45 PM - 7:55 PM showed 9 residents were in the dining area and 8 of the residents were sitting at tables with meals in front of them. No nursing staff members were observed in the dining area at that time. Continued observation showed resident #71 picked up food that had been spilled on the table and began to eat it.

2. Observation of resident #133 on 8/26/15 at 7:55 PM showed the resident was on his/her hands and knees in the resident's room. The resident grabbed the bed to get off the floor and no staff members were available to observe and assess the resident on the floor. Continued observation at that time showed CNA #1 was pushing a resident's wheelchair down the hall and was attempting to redirect other residents from going to the dining room area while resident #133 was on the floor.

3. Observation on 8/26/15 at 8:08 PM showed CNA #1 was providing 1-to-1 assistance with a resident near the nurses' station who was attempting to get out of his/her wheelchair. CNA #2 hollered down the hall that she needed assistance. CNA #1 replied that she was assisting the other resident at that time. CNA #2 replied "There are 2 nurses down there." CNA #1 then informed CNA #1 that the nurses were helping resident #133. CNA #2 stated she would "focus on people who aren't hoyers" and took another resident in a room to provide care.

4. Observation on 8/26/15 at 8:15 PM revealed a CNA from another unit was asked by RN #2 to obtain vital signs for resident #133 because the other staff was "busy."

CENTERS FOR MEDICARE & MEDICAID SERVICES

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 08/27/2015

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 353	Continued From page 6	F 353		

5. Interview with a resident's family member on 8/16/15 at 8 PM revealed the family had to routinely assist residents during the evening meal because there was not enough staff to help. Continued interview at that time revealed there have been resident to resident altercations due to staff not being available.

6. Interview with RN #1 on 8/26/15 at 8:40 PM revealed the nurses were changing schedules because of lack of staff. RN #1 further stated there were "not enough staff."

7. Review of medical records for May 2015 showed there were 6 falls during the month (residents #134, #133, #117, #21, #49). Review of facility staffing showed 3 of the 6 falls occurred when the nursing staff was less than what the facility had determined to be necessary for the West hallway.

8. Review of medical records for June 2015 showed there were 6 falls during the month (residents #19, #65, #117, #78, #93, #49).

9. Review of medical records for July 2015 showed there were 13 falls during the month (residents #133, #117, #21, #5, #78, #71, #49, #147).

10. Review of medical records for 8/1/15 - 8/26/15 showed there were 11 falls during the month (residents #42, #65, #117, #71, #49, #147).

11. Interview with RN #2 on 8/26/15 at 7:45 PM revealed normal staffing for the West hall was 1 nurse for each shift and 3 CNA's for day shift, 2

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

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 08/27/2015

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 353	Continued From page 7 CNA's for evening shift, and 2 CNA's for night shift. 12. Review of facility staffing for May 2015 showed the nursing staff was less than what the facility had determined to be necessary for the West hallway 17 out of 31 days. Review of the facility staffing for June 2015 showed the nursing staff was less than what the facility had determined to be necessary for the West hallway 14 out of 30 days. Review of the facility staffing for July 2015 showed the nursing staff was less than what the facility had determined to be necessary for the West hallway 13 out of 31 days. Review of the facility staffing for 8/1/15 - 8/26/15 showed the nursing staff was less than what the facility had determined to be necessary for the West hallway 11 out of 26 days. 13. Interview with the NHA on 8/27/15 at 2 PM revealed the facility had not identified an increase in resident falls on the West hallway and had not implemented specific interventions to attempt to decrease the falls	F 353		