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Healthcare Licensing

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FORM APPROVED
OMB NO. 0938-0391

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 _____	R-C 10/22/2015

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 The following common abbreviations are used throughout this document: BIMS- Brief interview for mental status CNA- Certified nurse aide DON- Director of nursing services MDS- Minimum Data Set RN- Registered nurse Less commonly used abbreviations will be annotated in each deficiency.	(F 000)	F323 1. Residents #24, #51, #77, #150, ~~#100, #137, #75, #89, #95~~ have all been assessed for fall interventions. #100, #137, #75, #89, #95 assessed for injuries of unknown origin. 2. All residents have been reviewed and assessed for fall interventions. and for injuries of unknown origin. 3. All nursing staff has been educated on the need to assess and reassess residents' fall interventions as needed. and that all injuries of unknown origin are to be reported to NHA immediately. 4. Residents experiencing falls or at high risks for falls will be reviewed and assessed for proper interventions. These residents will be reviewed weekly for 4 weeks to ensure intervention relevance. Injuries of unknown origin will be reviewed daily for interventions & reported to QAPI 5. The DON/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	11/24/15
(F 323) SS=E	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, review of fall logs, staff interview, and medical record review, the facility failed to ensure interventions were implemented/developed to prevent and minimize falls for 4 non-sample residents (#24, #51, #77, #150). In addition, the facility failed to identify/investigate causes for injuries of unknown origin for 2 sample residents (#100, #137) and 3 non-sample residents (#75, #89, #95). The findings were: 1. Review of the mobility/fall prevention care plan			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/16/15

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. Changes made per phone conf with Carly Applegate WHA on 11/19/15 CA 52 am. POC - 11/17/15. POC accepted.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: JM1512 Facility ID: WY00027 If continuation sheet Page 1 of 12

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{F 323}	Continued From page 1 for resident #51 showed the resident was high risk for falls due to requiring assistance with transferring from sitting to standing, an unsteady balance while standing, and a history of multiple falls. Review of the interventions showed on 3/14/15 an intervention was added to not leave the resident alone while on the toilet. The following concerns were identified: a. Review of the 9/29/15 incident/fall progress note timed at 7:56 PM showed the resident had an unwitnessed fall in the bathroom while attempting to self transfer. The resident did not have any signs of injury and skin was intact. The note further showed the CNA who left the resident alone was educated regarding the resident's safety needs. b. Interview with the DON on 10/22/15 at 1:07 PM verified the interventions to prevent falls were expected to be followed. 2. Review of the 9/12/14 care plan/interventions for mobility/fall prevention showed resident #24 the resident had falls in the past and required assistance to ambulate. The staff were to provide 1 to 1 supervision with the resident when using the bathroom to ensure s/he doesn't attempt to transfer with out assistance. The interventions further showed on "3/23/15 staff will be educated to take the resident to the bathroom when [s/he] requests." This was the latest date for the fall interventions on the care plan. The following concerns were identified: a. Review of the 10/19/15 incident/fall progress note timed at 12:35 PM showed the resident had an unwitnessed fall in the bathroom while attempting to self transfer. The resident did not have any signs of injury and skin was intact and there was no redness. The note further showed the employee was new and left the	{F 323}		

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{F 323}	Continued From page 2 resident alone to answer another call light. The CNA was educated regarding the resident's safety needs. b. Interview with the DON on 10/22/15 at 1:07 PM verified the care plan interventions to prevent falls were expected to be followed. 3. Review of the facility "Fall Scene Investigation Report" for a fall dated 10/20/15 and timed 4:30 AM for resident #150 showed the resident was found on the floor in his/her room. It was determined that the resident lost his/her balance while attempting to self-transfer while alone and unattended. Review of the progress note dated 10/20/15 and timed 5:14 AM showed an "SBAR (Situation Background Assessment Recommendation) Incident/Fall Long version" note that described the fall, however, there was no recommendations for development of interventions related to fall prevention. Review of the fall prevention care plan created on 9/24/15 showed the facility had not yet reviewed or revised the care plan following the 10/20/15 fall. 4. Observation on 10/20/15 at 10:45 AM showed resident #77 in a recliner with the foot rest elevated. The wheelchair was located next to the recliner located in the common area of the East unit. The resident attempted to sit up in the chair and crawl over the foot rest. Continued observation showed again the resident attempted to get out of the recliner. The resident placed his/her right leg on the arm of the chair, and the left leg in a gap between the body of the chair and the elevated footrest. An unidentified staff member approached and encouraged the resident to sit back in the chair and rest, saying "You need to rest. You need to keep you feet up, it's good for your circulation." The staff member	{F 323}		

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(F 323)	Continued From page 3 then left the resident sitting back in the chair. At 11 AM, the resident turned 90 degrees in the chair dangling his/her feet over the arm of the chair rocking back and forth attempting to get out of the recliner. A CNA then assisted the resident from the recliner using a gait belt and 1-person stand pivot to the wheelchair. Review of the MDS assessment dated 10/14/15 showed the resident had a BIMS score of 10/15 indicating moderate cognitive impairment. Further it showed the resident required extensive assistance with transfers and ambulation. The resident was independent with locomotion. Mobility devices included wheelchair and walker. Review of the care plan for falls, last revised on 9/28/15, showed the resident had a history of falls. The goal related to falls showed the resident "...would like to continue to safely ambulate to all destinations..." Review of the falls investigation reports showed the resident fell on 9/28/15, 10/1/15, and 10/19/15. The 10/1/15 fall showed the resident was attempting to transfer from the wheelchair and had not locked the brakes. The resident was alone and unattended. The 10/19/15 fall report showed the resident lost his/her balance while ambulating. 5. Review of the September 2015 fall log showed there were 73 falls throughout the facility for the month. The log included information which would assist in identifying trends; however, failed to identify if there were injuries sustained from the falls. Review of the October 2015 fall log showed when reviewed on 10/22/15 there were 34 falls recorded and 16 (47%) of these falls were unwitnessed. There was no information on this log as to injuries. Interview with the administrator on 10/22/15 at 12 PM revealed the system for tracking resident falls continued to be a work in	(F 323)		

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(F 323)	Continued From page 4 progress. 6. Review of the nurses' notes for September revealed the following injuries for resident #137: a. Review of the nurse's note dated 9/27/15 showed the nurse documented, "received pt [resident] this am with a telfa [wound dressing] on her right middle finger." Review of previous notes did not indicate the cause of the injury. Further, there was no further documentation made available by the facility to show an investigation was conducted to determine the cause of the injury in order to prevent further injuries. b. Review of the nurse's note dated 10/11/15 showed the resident had a "large dark blue bruise involving all of [his/her] left thumb and part of [his/her] left wrist. Unknown cause." Review of the "Internal Investigation Form" dated 10/11/15 showed for description of the incident, it was reported the resident had a bruise on the left thumb and part of the left wrist. Further review of the investigation showed the resident was interviewed on 10/12/15. The resident denied s/he had been abused. The resident further indicated the cause of the injury was unknown. There were no additional interviews conducted with staff to determine the cause of injury to prevent recurrence. Review of the quarterly MDS assessment dated 9/2/15 showed the resident had a BIMS score of 6/15 indicating severe cognitive impairment. 7. Review of the "Resident Bath List" for August through October 2015 showed the following injuries were identified by staff: a. On 8/4/15 the report showed resident #75 had a bruise on the left forearm. There was no documentation made available to show the cause of the injury had been investigated in order to	(F 323)		

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{F 323}	Continued From page 5 prevent further injuries. b. On 9/9/15 the report showed resident #89 had a skin issue on the right big toe, the skin issue was not described. Review of the documents provided related to the resident's toe showed on 9/22/15 the resident was seen by the physician. Review of the physician visit note showed the resident had a "black lesion on [his/her] right big toe for several weeks." Further, it showed the resident had decreased sensation from below the knee on the right side relate to a stroke. Further review of the provided documents did not show an investigation was conducted related to the original cause of the injury in order to prevent further injuries. c. On 10/8/15 the report showed resident #95 had a bruise on the right thumb. There was no documentation made available to show the cause of the injury had been investigated in order to prevent further injuries. d. On 10/9/15 the report showed resident #100 had a bruise on the left hand and also a skin tear. Review of the MDS assessment dated 10/15/15 showed the resident had diagnoses that included non-Alzheimer's dementia and was severely impaired with daily decision making. Review of the skin impairment care plan showed the resident had fragile skin and lacked safety awareness. the following concerns were identified: i. Review of a progress note dated 10/11/15 and timed 10:25 AM showed the resident had a skin tear noted to the back of the left hand. ii. Review of the facility internal investigation dated 10/11/15 and reported time of 10:27 AM showed the skin tear was identified; however, the interview summary with the nurse stated "she doesn't know or have suspicions as to	{F 323}		

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(F 323)	Continued From page 6 how the wound happened." Further review showed the facility did not feel the skin tear was a result of abuse or neglect; however, the facility failed to identify reasons for the determination in order to prevent further injuries.	(F 323)		
(F 353) SS=F	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, resident and family interview, review of staffing schedules, review of bathing documentation, medical record review, and review of resident council meeting minutes, the facility failed to ensure adequate staff were	(F 353)	F353 1. Resident #31, was assisted. The process of filling in the schedule when staff stays and fill in shifts that are open was completed as soon as identified. The facility continues to advertise and recruit staff. 2. A review of all open positions was completed to assure needed positions are accurate. 3. All staff was educated on attendance guidelines, policy and procedures. 4. Daily audits of the schedule will occur and any open shifts will be reported to the DON for guidance and assistance in covering the shifts. This will be an ongoing practice with results shared monthly with the facility QAPI Committee.	11/27/15

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{F 353}	Continued From page 7 assigned to provide for the physical, psychological, and quality of life needs for residents on 5 of 5 resident units (East, West, Elbogen, South, Rapid Recovery). The census was 158. The findings were: 1. During a group interview on 10/20/15 at 9:30 AM 6 of 18 residents in attendance revealed the main concerns were the lack of CNAs, lack of baths/showers, and the length of time to get call lights answered. Review of the resident council meeting minutes for August, September and October 2015 showed several concerns which were not resolved as they carried over month to month. The following concerns were identified: a. The concerns for the 8/5/15 meeting showed "need more CNAs." b. The 9/2/15 meeting minutes showed "...call lights take up to an hour or more for them to be answered...wheelchairs are not being cleaned...CNAs making residents go to bed without their teeth being brushed...residents are not receiving fresh linens in the room." c. Review of the 10/7/15 minutes showed "call lights are still not being answered in a timely manner...wheelchairs need to be cleaned more often...towels and washcloths are not getting changed out or cleaned...residents want the facility to keep the shower aides the same and make sure residents get scheduled showers..." 2. Observation on 10/21/15 beginning at 7:14 AM showed the call light in resident room 120 illuminated. A CNA entered the room at 7:22 AM, turned off the call light, and exited the room in less than a minute. Interview with the resident (#31) in the room at that time revealed s/he rang the call light because s/he wanted to get out of bed. The resident further revealed the CNA stated	{F 353}		

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(F 353)	Continued From page 6 she would be back in a few minutes to assist the resident out of bed. Continuous observation from 7:22 AM to 7:55 AM (33 minutes) showed the resident continued to wait for help. 3. Observation in the West unit on 10/21/15 beginning at 4:44 AM showed CNA #9 in the West unit, CNA #10 in the Elbogen unit, and RN #3 on both the Elbogen and West units. Interview at that time with CNA #9 revealed she was the only CNA on duty all night. She further revealed the CNA from the Elbogen unit "helped a lot" when needed. Observation at 5 AM showed a call light illuminated and sounded in the Elbogen unit. RN #3 was also on the Elbogen unit passing medications. CNA #10 entered the room, and CNA #9 left the West unit to assist. At that time there were no staff present in the West unit, and 4 residents were observed awake and in the common area or hallway. CNA #9 returned to the West unit at 5:01 AM. 4. The following confidential interviews were provided during the survey from 10/19/15 to 10/22/15: a. Interview with family member A on 10/21/15 at 12:38 PM revealed concerns related to staffing. S/he felt there were not enough CNAs to provide care, and it took too long for his family member to be assisted to the bathroom. b. Interview with a family member B on 10/19/15 at 5:50 PM revealed concerns related to staffing. S/he stated her family member had recently gone 5 days with no bath, and s/he felt there were not enough staff to care for everyone at the facility. c. Interview with family member C on 10/22/15 at 9:45 AM revealed s/he was concerned there were not adequate numbers of	(F 353)		

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(F 353)	Continued From page 9 staff to care for his/her family member and others in the facility. The family member revealed residents were not getting showers/baths. d. Confidential interview with a resident on 10/19/15 at 3:17 PM revealed concerns related to staffing. The resident stated there were not enough aides to provide care to residents, including giving showers and changing linens. e. Confidential interview with a resident on 10/19/15 at 3:55 PM revealed the facility was "short-staffed" and it had created a problem with residents receiving showers. f. Confidential interview with a resident on 10/20/15 at 12:05 PM during a meal, revealed the dining room was not usually that well-staffed during meals, and they must have brought in additional help because there was a survey in progress. g. Confidential interview with a resident on 10/19/15 at 5:35 PM revealed concerns with staffing. The resident stated resident care was "very much affected" by the low staff numbers. The resident revealed s/he waited over a week for a shower, and is not allowed some nights to brush his/her teeth or wash up before bed because the CNAs did not have enough time to assist. h. Confidential interview with a resident on 10/21/15 at 1:17 PM revealed: "I haven't had a shower in 3 days." The resident stated it bothered him/her and that s/he would like to receive more frequent showers. The resident reported s/he had asked staff several times to receive a shower. S/he stated that the staff kept saying, "We're short-staffed right now." Review of the Resident Bath List documentation provided by the facility for October 2015 showed that the last documented bath for the resident was 10/14/15. i. Interview with CNA #1 on 10/21/15 at 6:14	(F 353)		

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(F 353)	Continued From page 10 AM revealed there was "not enough time to provide proper care" to residents due to staffing issues. The staff member further stated there was "not enough time to get [the residents] up, face washed, teeth brushed, dressed, and out" of their rooms to get to the meal on time. Additionally, the staff member confirmed it had become more challenging now that CNAs assigned to the floor became responsible for providing baths to residents also. The CNA added, "Now that we have to give baths too, it's too much. It would be doable if we had fewer residents to take care of, but it's really hard when I have twenty residents." j. Interview with CNA #3 on 10/20/15 at 10 AM revealed the use of bath aides was discontinued and the CNAs working on the floor now had to also give the residents their showers, taking them away from resident care on the floor. The aide also indicated she was not familiar with the residents' shower routines. k. Interview with CNA #14 on 1/21/15 at 6:45 AM, revealed the facility was short staffed and the CNAs had to rush through the residents' care. She further revealed the main care area that was not getting done was resident showers. l. Interview with CNAs #2 and #13 on 10/20/15 at 8:15 PM revealed there were not "usually" as many CNAs scheduled as there were this week. The aides stated during this time of evening they would normally have 3 aides instead of 4. 5. Interview with the human resources (HR) director and administrator on 10/21/15 at 4:30 PM revealed the facility was staffed based on hours per patient day (PPD) which was calculated by taking the number of staff members for the day, times 8 (Hours), divided by the resident census.	(F 353)		

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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 _____	R-C 10/22/2015

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 11 Further interview revealed the facility staffed with a CNA PPD of 2.14 and a Certified Medication Aide (CMA), LPN, and RN combined PPD of 1.08. The following concerns were identified with the staffing: a. Review of the daily staff assignment sheets and the daily staff posting for 10/9/15 to 10/20/15, provided by the facility, showed the facility was staffed below PPD for 9 out of 12 days. The PPD for nurses and certified medication aides was less than 1.08 on 10/20/15, 10/18/15, and 10/13/15. Further review showed the PPD for CNAs was below 2.14 on 10/19/15, 10/18/15, 10/17/15, 10/16/15, 10/12/15, 10/11/15, and 10/10/15. b. Interview with corporate RN #1 on 10/22/15 at 2:30 PM revealed the CMAs were included with the certified nursing aides on the daily staff posting; however, they were not assigned to provide resident care tasks except to pass medications. c. Interview with the HR director on 10/21/15 at 4:30 PM revealed the facility currently had 18 open CNA positions and 15 open nurse positions.	(F 353)		