Part 2

This was split into two parts because of size

PRINTED: 11/06/2015
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 _____	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 314	Continued From page 32	F 314		

care plan for skin revised on 8/8/12 showed the resident was at risk for skin breakdown due to incontinence of bowel and bladder and interventions included staff to provide cares as ordered. The following concerns were identified:

a. Continuous observation on 10/20/15 from 9:06 AM to 1:15 PM, 4 hours and 9 minutes showed the resident was in his/her wheelchair, with lap belt applied, and was not repositioned, offered to toilet, or checked for incontinence.

b. Observation of care on 10/20/15 at 1:15 PM showed 2 staff members assisted the resident to transfer to bed and checked the resident for incontinence. CNAs #4 and #5 confirmed the resident was incontinent of bowel and bladder at that time.

c. Interview with the DON on 10/22/15 at 10:45 AM revealed the facility wanted residents to be repositioned at least every 2 hours to maintain skin integrity.

2. Observation on 10/20/15 at 10:30 AM showed resident #137 was sitting in the common area in a wheelchair watching television and looking at the newspaper. The resident self-propelled to the dining room. Continued observation showed the resident ate the noon meal. Following the meal, the resident left the dining room at 12:45 PM and returned to the common area to watch television. At 1:15 PM the resident was assisted to the activities area to play cards until 2:50 PM. The resident was then taken to his/her room and assisted to the toilet. The resident had not been repositioned during the 4 hour and 20 minute observation. Review of the 9/4/15 quarterly MDS assessment showed the resident was at risk for developing pressure ulcers. Further, it showed the resident needed extensive assistance with bed mobility and transfers.

PRINTED: 11/06/2015
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 _____	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 314 Continued From page 33

3. Review of the policy titled "Repositioning" revised in April 2014 showed "...repositioning the resident in the chair 1. Encourage the chair-bound resident, who is able to move, to change positions or shift weight every fifteen minutes, or as often as possible...4. Assist the resident to change his or her position in the chair, Monitor the need for toileting or incontinence care when changing position."

F 315 SS=E 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review, resident and staff interview, and policy and procedure review, the facility failed to ensure appropriate measures to prevent urinary tract infections and to restore as much normal bladder function as possible in 5 of 9 sample residents (#31, #54, #68, #137, #151) who required assistance with catheters/incontinence care. The findings were:

1. Review of the 9/3/15 quarterly MDS

F 314

F315

1. Residents #31, #54, #68, #137, #151 have been reassessed for indwelling catheters and care plans updated as appropriate. OR incontinence

F 315

2. All residents with indwelling catheters have been reassessed and care plans updated as appropriate. All residents with incontinence have been reassessed and care plans updated as appropriate

3. All direct care staff have been educated on policy and procedure for indwelling catheters and assisting incontinent residents with toileting.

4. The Leadership team will complete audits 3 x weekly on various units at various times x 90 days to assure resident with incontinence or utilizing an indwelling catheter care plans are being followed. Finding will be reported to the DON/Designee. 11/27/15

5. The DON/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance.

PRINTED: 11/05/2015
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 _____	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 315	Continued From page 34	F 315		

assessment showed resident #54 had diagnoses that included manic depression and signs and symptoms of involuntary nerve involving the musculoskeletal system. Further review showed the resident required total assistance of 1 person for personal hygiene and total assistance of 2 or more persons for toileting, bed mobility, and transfers. The following concerns were identified:

a. Observation on 10/20/15 at 9:10 AM showed LPN #3 and CNAs #8 and #11 lifted the resident manually to position the sling under the resident and then attached it to the mechanical lift. CNA #8 then detached the urinary drainage bag from the chair and lifted it and held it above the resident's bladder level. Continued observation showed there was urine in the tubing of the drainage bag causing urine to flow backwards toward the resident's bladder.

b. Interview with the DON on 10/22/15 at 10:45 AM revealed the catheter should not be lifted above the level of the resident's bladder because it increases the risk of infection.

c. Review of the policy titled "Urinary Catheter Care" revised November 2014 showed "...3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder..."

2. Review of the 9/3/15 MDS assessment for resident #68 showed diagnoses that included Alzheimer's disease, muscular atrophy, and non-Alzheimer's dementia. Continued review showed the resident required extensive assistance of 2 or more persons for transfers and is at risk for skin breakdown. Review of the care plan for skin revised on 8/8/12 showed the resident was at risk for skin breakdown due to incontinence of bowel and bladder and

PRINTED: 11/06/2015
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 _____	C 10/22/2015

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 315	Continued From page 35	F 315		

interventions included staff to provide cares as ordered. The following concerns were identified:

a. Continuous observation on 10/20/15 from 9:05 AM to 1:15 PM, 4 hours and 9 minutes, showed the resident was in his/her wheelchair, with lap belt applied, and was not repositioned, offered to toilet, or checked for incontinence.

b. Observation of care on 10/20/15 at 1:15 PM showed 2 staff members assisted the resident to transfer to bed and checked the resident for incontinence. CNAs #4 and #5 confirmed the resident was incontinent of bowel and bladder at that time.

3. Review of the 10/4/15 quarterly MDS assessment showed resident #151 had diagnoses that included muscle weakness and hypertonicity of the bladder. Further review showed the resident had a BIMS score of 3/15 (severe cognitive impairment) and required extensive assistance for transfers and toileting. Review of the care plan addressing incontinence, created on 9/5/12, showed the resident was incontinent and required 1-2 person assist with toileting, including before and after meals. The following concerns were identified:

a. Continued observation on 10/20/15 beginning at 10:25 AM showed the resident sitting in the wheelchair in the common area. At 11:17 AM, CNA #6 wheeled the resident into the dining room, without offering to toilet the resident or checking for incontinence.

b. At 12:04 PM the resident was assisted out of the dining room by a dietary aide into the hallway. At 12:20 PM, CNAs #2 and #3 assisted the resident into his/her room and into bed under a blanket, without offering to toilet the resident or checking for incontinence. At that time the surveyor requested they check for incontinence.

PRINTED: 11/06/2015
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 _____	C 10/22/2015

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 315	Continued From page 36	F 315		

The CNAs checked and changed the resident's brief and confirmed the resident had been incontinent of bowel and bladder.

4. Observation on 10/20/15 at 10:30 AM showed resident #137 was sitting in the common area in a wheelchair watching television and looking at the newspaper. The resident self-propelled to the dining room. Continued observation showed the resident ate the noon meal. Following the meal, the resident left the dining room at 12:45 PM and returned to the common area to watch television. At 1:15 PM the resident was assisted to the activities area to play cards until 2:50 PM. The resident was taken to his/her room to be placed on oxygen while the portable tank was filled. At that time the resident was toileted. The CNA asked the resident when s/he had been toileted and the resident responded it was around noon and did not feel the need to go to the bathroom. During the continuous observation, the resident had not been to the bathroom since 10:30 AM. CNA #3 assisted the resident to the toilet and the resident was found to be incontinent of urine and also voided at that time. Review of the care plan for bowel and bladder function, last revised on 4/7/15, showed the resident was to be offered/toileted every morning, before and after meals and at night and as needed.

5. Observation on 10/20/15 at 1:10 PM showed resident #31 was sitting in a wheelchair located in the hallway outside his/her room. Interview with the resident at that time, revealed s/he had requested assistance to change the incontinence pad at 10 AM, approximately 3 hours earlier. Further observation showed the resident's outer clothing was wet. The resident had a Foley catheter (tube extending into the bladder for urine

PRINTED: 11/06/2015
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 _____	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 315	Continued From page 37	F 315		

drainage) hanging from the bottom of the chair. CNAs #1 and #2 then transferred the resident from the wheelchair with a Hoyer lift to the bed. The incontinence pad was soaked with urine and back of the resident's clothing was wet. The urine drainage bag only had a scant amount of urine. The resident indicated the catheter had been irrigated the night before. The CNAs changed the resident and notified the nurse. During an interview with the resident the following day on 10/21/15 at 2:30 PM s/he stated the nurse did not attend to the catheter until 1:30 AM that morning. Review of the nurse's note date 10/21/15 and timed 4:47 AM showed the indwelling urinary catheter had been changed.

Review of the annual MDS assessment dated 9/16/15 showed diagnoses to include paraplegia, multiple sclerosis, and neurogenic bladder. In addition, the resident was cognitively intact with a BIMS score of 15/15. Further it showed the resident required total assistance with transfers and toilet use.

During an interview with the DON on 10/22/15 at 3:30 PM, she acknowledged the catheter needed to be attended to earlier.

6. Interview with the DON on 10/22/15 at 10:45 AM revealed residents should be toileted when gotten up, before meals, after meals, at bed time, and as needed. Further interview revealed the facility wanted residents to be repositioned at least every 2 hours to maintain skin integrity.

F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
SS=E

F 323

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives

PRINTED: 11/06/2015
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 _____	C 10/22/2015

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 323	Continued From page 38 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 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.	F 323	1. Residents #24, #51, #77, #150, have all been assessed for fall intervention. Residents #100, #137, #75, #89, #95, have all been 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 administration 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 by administration for interventions and reporting criteria. 5. The DON/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	

PRINTED: 11/06/2015
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 _____	C 10/22/2015

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 323	Continued From page 39	F 323		

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 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

PRINTED: 11/05/2015
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 _____	C 10/22/2015

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 323	Continued From page 40	F 323		

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 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

PRINTED: 11/06/2015
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 _____	C 10/22/2016

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 41	F 323		

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 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

PRINTED: 11/06/2015
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 _____	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 323	Continued From page 42	F 323		

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 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

PRINTED: 11/06/2015
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 _____	C 10/22/2015

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 323	Continued From page 43 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 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 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		

PRINTED: 11/06/2015
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 _____	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 329	Continued From page 44 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents were free of unnecessary medications for 1 of 24 sample residents (#141). The findings were: Review of the 5/27/15 significant change MDS assessment for resident #141 showed diagnoses to include anxiety disorder. Further, it showed the resident was cognitively intact. The section for medications received included an anxiolytic. Review of the Care Area Assessment showed the resident triggered for psychotropic drug use and it was to be care planned. Review of the medication administration record showed the resident was prescribed the antianxiety medication alprazolam to be given as needed. Further review showed the resident received 18 doses from 10/2/15 through 10/21/15 and 23 doses from 9/1/15 through 9/30/15. The following concerns were identified: a. Review of the care plan failed to show a	F 329	F329 1. Resident #141 was reassessed for PRN usage of alprazolam. PRN parameters and non-pharmacological interventions were updated in the residents care plan. 2. All residents receiving Anxiolytic Medications PRN were reassessed and PRN assessment parameters and non-pharmacological interventions were updated in the residents care plan. 3. Education was provided to all nursing staff on resident specific Non-Pharmacological approaches and PRN assessment parameters for residents receiving Anxiolytic medications PRN. 4. the Don/Designee will complete : Audits of residents who have ordered PRN anxiolytic medication will be audited weekly x 90 days to assure non-pharmacological interventions have been attempted prior to administration and a progress note with results and reason for administering completed. 5. The DON/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	11/27/15

PRINTED: 11/08/2015
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 _____	C 10/22/2015

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 329	Continued From page 45 plan was developed for psychotropic medication use. b. Review of the nurses' notes showed when the medication was given and indicated it was effective. There were no documentation to show an assessment was completed indicating the use of the medication to include any behavior the resident displayed. Further, there was no documentation to show non-pharmacological interventions were attempted. c. During an interview with the corporate nurse on 10/22/15 at 2:15 PM, she acknowledged the resident needed to be assessed prior to administration of the psychotropic medication, behaviors monitored and non-pharmacological interventions attempted.	F 329	F332 1. Residents #74, #106, #135, #17 have been assessed and physician notified of noted medication orders. Medication orders have been obtained and clarified. 2. All residents' medication regimens have been reviewed for medication errors. 3. Education and retraining has been provided to nursing staff and medication aide in regards to patient medication administration rights, verification of medication orders, and medication error reporting. 4. Medication pass audits of at least 10 opportunities will be conducted on all licensed nurses and trained medication aides by DON/Designee. Additional training and audits will be conducted as determined by the results of the first audit. 5. The DON/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	11/27/15 JC
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and staff interview, the facility failed to maintain a medication error rate under 5 percent (%). Four medication errors were observed out of 29 opportunities for error, which resulted in an error rate of 13.7%. The findings were: 1. Observation on 10/20/15 at 8:37 PM showed LPN #1 did not administer resident #74 latanoprost solution eye drops .005% to both eyes because the medication was "not available." Further review showed the medication had not	F 332		

PRINTED: 11/06/2015
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 _____	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 332	Continued From page 46	F 332		

been administered on 10/15/15, 10/17/15, 10/18/15, and 10/19/15. The medication was to be given at bedtime.

2. Observation on 10/21/15 at 5:20 AM showed LPN #2 applied a 5% Lidoderm patch 700 mg (milligrams) (50 mg/gram) on resident #106. During reconciliation of the medications on 10/22/15 at 10 AM, review of the "Order Summary Report" and signed by the physician on 4/21/15 showed there was no dose accompanied with the order, it only showed where the medication patch was to be placed. During an interview at that time, the South unit manager verified the order did not include a dose, and acknowledged a dose was needed, and that the physician needed to be notified.

3. Observation on 10/21/15 at 5:35 AM showed LPN #2 gave resident #135 Tylenol 500 mg 2 tablets. Reconciliation of the medications on 10/22/15 at 10 AM failed to show an order for the medication was available in the medical record. The nurse verified the order was not in the medical record. She suggested at that time that the order may be located in the thinned medical record. Review of the thinned medical record showed there was a list of medications that included the medication Tylenol. It did not indicate the list was a part of physician orders. The list was signed, it did not show the signatory was a physician.

4. Observation on 10/21/15 at 7:05 AM showed RN #2 administered resident #17 the medication "hypothyroid" 88 mcg (micrograms) 1 tablet and levothyroxine 75 mcg one tablet. Both medications are thyroid replacement hormones. During reconciliation of the medications on

PRINTED: 11/06/2015
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 _____	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 332	Continued From page 47 10/22/15 at 9:40 AM, review of the "Order Summary Report" and signed by the physician on 4/14/15 showed an order for levothyroxine 88 mcg. There was no written order for the 75 mcg dose. An interview with the East unit manager at that time confirmed levothyroxine 75 mcg was not included on the orders and further review of the physician orders failed to show an order for the medication. Review of the medication administration record for October 2015 only showed levothyroxine 88 mcg. Observation of the medications for the resident located in the medication cart with the unit manager at the time of the interview showed both doses of the thyroid medication were available. The unit manager confirmed the 75 mcg dose should not have been administered.	F 332	F333 1. Residents #17 have been assessed and physician notified of noted medication orders. Medication orders have been obtained and clarified. 2. All residents' medication regimens have been reviewed for medication errors.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to ensure resident #17 was free of a significant medication error identified during 1 of 2 medication passes. The findings were: Observation on 10/21/15 at 7:05 AM showed RN #2 administered resident #17 the medication "hypothyroid" 88 mcg 1 tablet and levothyroxine 75 mcg one tablet. Both medications are thyroid replacement hormones. During reconciliation of the medications on 10/22/15 at 9:40 AM, review	F 333	3. Education and retraining has been provided to nursing staff and medication aide in regards to patient medication administration rights, verification of medication orders, and medication error reporting. 4. Medication pass audits of at least 10 opportunities will be conducted on all licensed nurses and trained medication aides by DON/Designee. Additional training and audits will be conducted as determined by the results of the first audit. 5. The DON/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance. 11/27/15	

PRINTED: 11/06/2015
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
	536042	A. BUILDING _____ B. WING _____	C 10/22/2015

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 333	Continued From page 48 of the "Order Summary Report" and signed by the physician on 4/14/15 showed an order for levothyroxine 88 mcg. There was no written order for the 75 mcg dose. An interview with the East unit manager at that time confirmed levothyroxine 75 mcg was not included on the orders and further review of the physician orders failed to show an order for the medication. Review of the medication administration record for October 2015 only showed levothyroxine 88 mcg. Observation of the medications for the resident located in the medication cart with the unit manager at the time of the interview showed both doses of the thyroid medication were available. The 75 mcg bubble pack showed 7 doses had been administered. The East unit manager contacted the pharmacy and found the physician had ordered to decrease the dose of thyroid medication to 75 mcg on 9/3/15 due to "thyroid overtreated." The physician had not notified the facility of the change in dose. The unit manager acknowledged both medications should not have been given. Further, the dose of levothyroxine 75 mcg located in the cart needed to be clarified. The unit manager ordered a TSH (thyroid stimulating hormone) level to be drawn.	F 333		
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	F 353		

PRINTED: 11/06/2015
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 _____	C 10/22/2015

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 353	Continued From page 49 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 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 16 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	F 353	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. 11/7/15 JC	

PRINTED: 11/06/2015
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 _____	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 50	F 353		

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 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

PRINTED: 11/06/2015
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 _____	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 51	F 353		

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 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.

PRINTED: 11/06/2015
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 _____	C 10/22/2015

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 353	Continued From page 52	F 353		

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 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

PRINTED: 11/06/2015
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 _____	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 53	F 353		

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. 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

PRINTED: 11/06/2015
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 _____	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 54 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	F356 1. The Nursing hours posting was corrected as soon as the discrepancy was identified. 2. Each charge nurse will be trained to review the daily Nursing hours posting and update the hours and census if needed at the end of each shift. 3. Education has been provided to Administration, Human Resources, Leadership Team and Staffing coordinator in regards to the regulatory requirements of Nursing hours posting and need for timely required corrections. 4. Daily audits by HR/Designee will be completed at random times x 90 days to assure the Nursing hours posting is accurate. These postings will be retained for 18 months. 5. The HR/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	11/27/15 jc
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		

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 _____	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 356	Continued From page 55	F 358		

This REQUIREMENT is not met as evidenced by:
Based on review of daily staff postings, and staff interview, the facility failed to accurately post the number of nursing staff and their actual hours worked for 4 of 4 days of survey (10/19/15 - 10/22/15). The findings were:

Review of the daily staff postings for 10/19/15 through 10/22/15 showed each day the facility identified RNs, LPNs, and CNAs. The facility included certified medication aides (CMAs) in the actual numbers for CNAs. Interview with Corporate RN #1 on 10/22/15 at 2:30 PM revealed the CMAs were included with the numbers of CNAs on the posting. She then verified the CMAs were not assigned to provide resident care tasks, their assignment was to pass medications.

F 386 SS=D — 483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS — F 386

The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff

PRINTED: 11/06/2015
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 _____	C 10/22/2015

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 386	Continued From page 56 interview, the facility failed to ensure physicians documented review of the resident's total care and medication regimen for 2 non-sample residents (#17, #106). The findings were: 1. Review of the "Order Summary Report" dated 4/14/15, for patient #17 showed the physician reviewed the resident's medications and treatments. Review of the "Physician Record of Visit" notes dated 6/30/15 and 8/28/15 showed the reason for the physician visit was "2 mo [month] routine visit." The physician only noted a partial list of the resident's diagnoses and ordered laboratory studies to be completed. There was no indication the physician examined/seen the resident or reviewed medications and treatments. 2. Review of the "Order Summary Report" dated 4/21/15, for patient #106 showed the physician reviewed the resident's medications and treatments. Review of the "Physician Record of Visit" notes dated 5/28/15 and 8/12/15 showed the reason for the physician visit was "2 month routine required visit." The physician only noted a partial list of the resident's diagnoses and orders were written. There was no indication the physician had examined/seen the resident or reviewed medications and treatments. 3. During an interview with the DON on 10/22/15 at 3:30 PM, she revealed the system for medication reconciliation reviews to be completed during the bi-monthly provider visits "fell apart." Further, she acknowledged the physician needed to document resident contact and that medication and treatments were reviewed.	F 386	F386 1. Residents #17 and #106, medication regimen and treatment orders have been reviewed for error and signed by the attending physician. 2. All residents' medication regimen and treatment orders have been reviewed for error and signed by the attending physician. and seen by a physician as Required. 3. Education has been provided education in regards to medication and treatment orders regulations and the requirements for physician medication regime reviews. 4. The DON/Designee will complete Audits of medication regime and treatment order reviews 3 x weekly on various units x 90 days to assure compliance. 5. The DON/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance. 11/27/15 JL	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

PRINTED: 11/06/2015
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 _____	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 431	Continued From page 57	F 431		

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, review of policies and procedures, and staff interview, the facility failed

F431

1. Residents #135, #95 and #64 were assessed. Noted expired medication was disposed of.

2. All medication carts were reviewed for expired or mislabeled medications.

3. All nursing staff and medication aides have been provided education inregards to medication storage, medication labeling and handling of biologicals.

4. The DON/Designee will complete medication cart audits 3x weekly for 90 days on various units, at varied times to ensure that all medications are labeled and stored within regulatory guidelines.

5. 5. The DON/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance.

11/27/15 JC

PRINTED: 11/06/2015
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 _____	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 431	Continued From page 58	F 431		

to ensure medications not labeled with an expiration date and expired medications were removed and not available for use in 2 of 2 units reviewed for expired medications (South, East). The findings were:

1. South Unit:
a. Observation during the medication pass on 10/21/15 at 5:35 AM showed LPN #2 removed the medication Tylenol 500 mg (milligrams) from the medication cart to administer to resident #135. Further review of the stock medication bottle showed it did not display the expiration date. The LPN acknowledged the medication needed to be labeled with the expiration date.
b. Observation on 10/21/15 at 12:45 PM of the medication cart with CMA #1 showed for resident #59 the medications valsartan/hydrochlorothiazide 160/25 mg (antihypertensive) and anastrozole 1 mg (antineoplastic) were not labeled with an expiration date. The medication aide verified the medications needed to be labeled with the date. In addition, the local pharmacy providing the medications was called at that time and they indicated they do not label medications with expiration dates.

2. East Unit:
a. Observation on 10/21/15 at 1:40 PM of the medication cart with the East unit manager showed for resident #95 a vial of Humalog insulin was opened and labeled with the manufactures date 4/14. It was unclear if the date was the expiration date. There were no additional dates found on the vial. The unit manager acknowledged the medication needed to be removed from the cart.
b. During the same observation, it showed

PRINTED: 11/06/2015
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 _____	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 431	Continued From page 59 the medication valacyclovir (antiviral) for resident #64 had an expiration date of 9/10/15. 3. Review of the policy and procedure entitled: "Storage and Expiration of Medications, Biologicals, Syringes, and Needles Application LTC [long term care] Facilities Receiving Pharmacy Products and Services from Pharmacy", last revised on 1/1/13 showed: "...Facility should ensure that medications and biologicals: 4.1 Have an Expiration Date on the label ..." Further it showed "16. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals ..."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must 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. (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	F 441	F441 1. Residents #19, #38, #54, #82, #140 have been assessed. 2. All residents have the potential to be effected. 3. Education has been provided to all staff in regards to hand hygiene during meals, appropriate placement of catheter bags during transfers, and shower cleaning procedures between residents. 4. The SDC/Designee will conduct visual audits of staff providing cares and infection control practices 3x weekly for 90 days, completing reeducation as needed. 5. The SDC /Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance. 11/27/15 JK	

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 _____	C 10/22/2015

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 441	Continued From page 60	F 441		

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:
Based on observation, staff interview medical record review, and policy and procedure review, the facility failed to ensure infection control practices were implemented during 4 random observations. These practices affected residents #19, #38, #54, #82, and #140. The findings were:

1. Observation of meal assistance on 10/20/15 at 12:44 PM for residents #82 and #19 showed CNA #8 was assisting both residents to eat. The CNA then touched resident #19 on the hands, rubbed the resident's shoulder, and then used the same hand to handle resident #82's drinking glass by the rim. The CNA then assisted resident #82 to eat. The CNA then used her right hand to hold resident's #82's hand, followed by grabbing resident #19 drinking glass with the same hand by the rim, and assisting the resident to eat.

2. Observation on 10/19/15 at 6:12 PM showed 4

PRINTED: 11/05/2015
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 _____	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 441	Continued From page 61	F 441		

residents sitting at a dining room table for the evening meal to include resident #140 and resident #38. CNA #12 sat between the 2 residents and assisted them with gloved hands. The CNA assisted resident #38 after food had fallen off the fork by placing the food back on the utensil. The CNA then assisted resident #140 picking up his/her sandwich and tearing it into smaller pieces. The CNA then cut resident #38's food with a knife the resident had first attempted to use. The CNA then returned to assist resident #140. The CNA did not change gloves or perform hand hygiene between the residents and after directly handling their food.

3. Interview with the DON on 10/22/15 at 10:45 AM revealed staff are to use one hand for 1 resident while assisting multiple residents to eat. Further, she verified touching the resident and then the glass and utensils of another resident would not be following infection control procedures and minimally staff should use hand sanitizer between residents.

4. Review of the quarterly MDS assessment dated 9/3/15 showed resident #54 had diagnoses that included manic depression and signs and symptoms of involuntary nerve involving the musculoskeletal system. Further review showed the resident required total assistance of 1 person for personal hygiene and total assistance of 2 or more persons for toileting, bed mobility, and transfers. The following concerns were identified:

a. Observation on 10/20/15 at 9:10 AM showed LPN #3, CNAs #8 and #11 lifted the resident manually to position the sling under the resident and then attached it to the mechanical lift. CNA #8 then detached the urinary drainage bag from the chair and lifted it and held it above

PRINTED: 11/06/2015
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 _____	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 441	Continued From page 62 the resident's bladder level. Continued observation showed there was urine in the tubing of the drainage bag causing urine to flow backwards toward the resident's bladder. b. Interview with the DON on 10/22/15 at 10:45 AM revealed the catheter should not be lifted above the level of the resident's bladder because it increases the risk of infection. c. Review of the policy titled "Urinary Catheter Care" revised November 2014 showed "...3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder..." 5. Observation on 10/20/15 at 10 AM showed resident #140 was taken to the shower in a wheelchair. CNAs #3 and #7 transferred the resident from the wheelchair to the shower chair. CNA #3 washed the resident's anterior perineum and lower extremities with gloved hands. The CNA then washed the resident's hair with the same gloved hands. Review of the 10/4/15 quarterly MDS assessment showed the resident total assistance with toileting and transfers. In addition, the resident needed extensive assistance with personal hygiene.	F 441		
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.	F 520		

PRINTED: 11/06/2015
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 _____	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 520	Continued From page 63 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, medical record review, observation, and review of policy and procedure, the facility failed to implement an effective quality assurance performance improvement (QAPI) program to identify and correct previously identified deficiencies in a variety of areas. The findings were: Review of the 8/27/14 previous recertification survey showed cited deficiencies included: F241, F253, F282, F312, F315, F323, F353, F356, F441, and F520. Although these citation were put back into compliance on on 10/7/14, these citations are being cited again during this 10/22/15 survey. In addition, review of the 8/27/15 complaint survey showed the facility was out of compliance and pending a revisit survey to determine compliance with citations F353 and F323. During the current survey dated 10/22/15	F 520	F520 1. No residents were specifically identified. Immediate review of deficiencies cited was conducted through an Ad Hoc QAPI meeting. 2. All residents have the potential to be effected by this practice. Plans of corrections have been developed with audit schedules to ensure that corrections for cited deficiencies are sustained. 3. All staff will be trained on plans of correction. 4. The QAPI committee will review all plans of correction, identifying trends, needs and sustainability. 5. The Administrator/Designee will report findings to the Regional QAPI monthly for a total of 3 months for recommendations, changes, and continuance. 11/27/15 JC	

PRINTED: 11/06/2015
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 _____	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 520	Continued From page 64 these areas remained out of compliance. Interview with the facility administrator on 10/22/15 at 5:20 PM revealed the QAPI program continued to work on these areas; however, the problems continued. The facility administrator verified she and the management team needed to further develop the QAPI program to ensure effective interventions to correct the re-cited areas.	F 520		