STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	C 08/18/2016

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 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Survey from 8/17/16 to 8/18/16. The survey was prompted by complaints WY00002222, WY00002232, WY00002247 and WY00002274. The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide. DON: Director of Nursing RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews the facility failed to ensure 1 of 2 submitted resident grievances reviewed, which involved 2 residents (#12, #13), was reasonably responded to and/or resolved. The following concerns were identified: Interview with resident #13 on 8/17/16 at 1:40 PM stated that s/he had submitted a signed grievance jointly with resident #12 approximately two weeks previous. The grievance pertained to the care a CNA (unnamed) had given to the residents. The	F 166	**F166 Right to Prompt Efforts to Resolve Grievance** **Corrective Actions:** Resident #12 no longer resides in the facility. Resident #13 remains at the facility and Rapid Recovery Unit Manager instituted a new grievance at the time of discovery. **Others Potentially Affected:** All residents in the facility have the potential to be affected by this practice. **Systemic Changes:** Department Managers have been educated on the facility Abuse Policy and Procedure and the Grievance Policy and Procedure.	9/29/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 9/12/2016

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.

OVER

9/20/16

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F 166	Continued From page 1 resident stated that the grievance was filed directly with the Rapid Recovery Unit Manager. The following concerns were identified: a. Resident #13 stated during the 8/17/16 interview that no one had followed up with him/her to address the concerns. b. Interview with resident #12 on 8/17/16 at 2 PM confirmed a grievance form was jointly signed with resident #13 and submitted to the Rapid Recovery Unit Manager. Further, the resident stated no one had followed up with him/her to address the concerns. c. Interview with the Rapid Recovery Unit Manager on 8/18/16 at 5 PM acknowledged the grievance filed by residents #12 and #13 had been received. However, he revealed it could not be found. A new grievance was instigated at that time.	F 166	**Monitoring:** Audits will be completed by DON/designee 2x weekly for 4 weeks ensuring proper investigation and follow up of reported allegations. **QA:** The DON or designee will report audit results to the Quality Assurance Committee on a monthly basis for further analysis and recommendations. The Quality Assurance committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	9/29/2016 9/29/2016
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported	F 225	This issue will be monitored in QA monthly resolution. - A **F225 Investigate/Report Allegations/Individuals.** **Corrective Actions:** Resident #162 no longer resides at the facility. Family member #1 no longer resides at the facility. Residents #19, #11, and #12 continue to reside in the facility. No immediate actions could be taken for the residents affected. ~~This issue will be monitored~~ error - A	

9/28/16 This POC accepted with agreed to changes between Michael Spidel, Administrator and Tony Madden, State Health Surveyor.

9/28/16

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F 225	Continued From page 2 immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on incident review, staff interview, review of State survey agency logs, and policy review, the facility failed to report 3 of 3 allegations of abuse reviewed to the state survey agency in a timely manner. In addition, the facility failed to complete a thorough investigation for 1 of those 3 allegations (#12). The findings were: 1. Interview with the interim DON, social services director (SSD), and administrator on 8/17/16 at 4:30 PM confirmed that 2 family members of resident #11 had been living at the facility since the resident was admitted on 3/7/16, and the family members had been utilizing the resident shower room on the Rapid Recovery Unit. During the interview it was revealed that family member #1 was verbally abusive with staff. Review of a	F 225	**Others Potentially Affected:** All residents in the facility have the potential to be affected by practice. **Systemic Changes:** Department Managers have been educated on the facility Abuse Policy & Procedure and the Grievance Policy & Procedure as well as education on the regulations regarding the reporting of suspected abuse/neglect. **Monitoring:** Audits will be completed by DON/designee 2x weekly for 4 weeks ensuring proper reporting, investigation and follow up of reported allegations. **QA:** The DON or designee will report audit results to the Quality Assurance Committee on a monthly basis for further analysis and recommendations. The Quality Assurance committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful. This issue will be monitored in QA until resolution.	9/29/2016 9/29/2016 9/29/2016

9/20/16

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F 225	Continued From page 3 7/9/16 incident, timed at 12:30 PM, report showed resident #12 was involved in a verbal altercation with family member #1 over the use of the shower room. The following concerns were identified: a. Further review of the 7/9/16 incident showed the facility failed to document any interview with resident #12 to determine if the incident involved verbal abuse. Additionally, the incident documentation failed to show any additional interviews with other residents to determine if family member #1 was abusive toward them, since it had already been determined that family member #1 was verbally abusive to staff. The only follow-up information documented was a nursing note dated 7/9/16 at 1:16 PM (46 minutes after the incident) that showed, "[Resident # 11's family members] are using our patients' shower facilities for personal use. Our patient, [resident #12], had already made arrangements with the CNAs for the last two days to shower right after lunch. Both days our resident had gone to take [his/her] shower and found one of the [family members] using the shower during [his/her] scheduled time...." b. Review of the State survey agency incident log showed the facility failed to report this incident, and this was confirmed with the administrator, SSD, and interim DON during the interview on 8/17/16 at 4:30 PM. 2. Review of a grievance form dated 5/25/16 showed an allegation of verbal abuse was filed by RN #1 on behalf of resident #19. The following concerns were identified: a. Review of the "additional documentation" section of the grievance form stated an in depth investigation was completed on 6/9/16 (15 days after the initial grievance form was completed). b. Review of the State survey agency incident	F 225		

9/28/16

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F 225	Continued From page 4 log showed the incident was reported on 6/5/16 (11 days after the grievance was submitted to the facility). In addition, there lacked evidence the agency was notified of the results of the investigation. c. Interview with the interim DON on 8/18/16 at 5:30 PM revealed the investigation could not be found. 3. Record review revealed an allegation of verbal abuse was received by the facility on 5/27/16 which regarded resident #162. Review of 2 employee files indicated a substantial amount of documented investigation occurred surrounding this allegation, which was determined to be unsubstantiated. The following concerns were identified: a. Review of the facility incident log showed no references to this incident. b. Interview on 8/18/16 at 6 PM with the facility interim DON confirmed that a thorough investigation had taken place. However, the facility failed to initially notify the State survey agency within 24 hours of the allegation as required. c. Review of the state survey agency incident log confirmed the facility failed to report this allegation. Review of the facility policy titled, "Abuse Prevention Plan (WY, NE)" revised November 2015 showed:"...G. Reporting/Response: 1. Report all alleged violations and substantiated incidents to the State Agency as required and take all necessary corrective actions depending on the results of the investigation. All incidents of maltreatment or suspected maltreatment will be reported immediately for the initial report and 5 business days for the final investigative report."	F 225		

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