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

PRINTED: 11/03/2016
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535042 | A. BUILDING _____ B. WING _____ | C 10/20/2016 |

| 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<br><br>A complaint survey was conducted in conjuction with the recertification survey by Healthcare Licensing and Surveys on 10/17/16 through 10/20/16. The survey was prompted by complaint intakes WY00002287 and WY00002302.<br><br>The following common abbreviations are used throughout this document:<br><br>CNA- Certified Nurse Aide<br>DON- Director of Nursing<br>MDS- Minimum Data Set<br>mg- milligrams<br>RN- Registered Nurse<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F 000 | | |
| F 244 SS=E | 483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION<br><br>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interview, review of resident council meeting minutes, and review of the facility grievance log, the facility failed to ensure grievances from the resident council were acted upon and followed through to resolution for 3 of 4 months (July, August, and September 2016) reviewed. The findings were: | F 244 | F244<br><br>**Corrective Actions**<br><br>The facility will resolve the Resident Council Grievances for the time period of July, August, and September 2016 to the best of their ability; given the time frame from the original concern and the date the concern was communicated to the Administrative Team. The Resident Council will be informed of their shared concern resolutions.<br><br>**Others Potentially Affected**<br><br>All residents have the potential to be affected by this practice. | 12/02/16 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

[signature] — DNHA — 11/11/2016

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.

Changes per Bess Litton, DON on 11/21/16 @ 1:52pm. POC accepted. Janice Cole

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 244 | Continued From page 1<br><br>1. Review of resident council meeting minutes for July, August, and September 2016 showed concerns were discussed related to staff not providing clean linens, making resident beds, and answering call lights. The following concerns were noted:<br>a. Interview with 13 residents on 10/18/16 at 1:30 PM revealed there had been no improvement with the issues brought up in previous resident council meetings, and that staff did not seem to try and fix the issues. The council president stated "They say they'll take care of it, but come the next meeting it's not taken care of and we have to do it over again."<br>b. Interview with the DON on 10/18/16 at 3:33 PM revealed the process for resolving grievances brought up during resident councils was for a grievance form to be filled out by the staff member in charge of documenting the minutes (usually the activities director) and brought to the daily interdisciplinary team meeting. At that point the concern was to be written in the grievance log and given to the appropriate department head for action, then taken back to the daily meeting before the next resident council where resolution was to be discussed with the residents.<br>c. Interview with social worker #1 on 10/18/16 at 4:30 PM revealed she kept a log of all resident grievances, both individual grievances and grievances from the resident council meetings. Review of the grievance log at that time revealed no evidence of grievances from the resident council for the months of July, August, or September 2016. Continued interview confirmed the log did not show grievances from the resident council.<br>d. Interview with the administrator and DON on 10/18/16 at 4:50 PM confirmed the activities | F 244 | **Systemic Changes** 12/02/16<br>The staff of the Activities Department and the Department Head Team will be educated on the process of receiving concerns at resident council; communicating those shared concerns with the Department Head Team; and the process of resolving shared concerns and notifying Resident Council of concern resolution.<br><br>**Monitoring**<br>The Administrator/designee will perform monthly audits of Resident Council concerns and concern communication to the facility's Department Head Team and resolution of those concerns. The Administrator will report audit findings monthly to the facility's QA Committee for further analysis and recommendations. Audits will continue until such time as the QA Committee determines compliance has been sustained. | |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 244 | Continued From page 2<br>director did not know the process for communicating resident council grievances to the administration staff for follow up. | F 244 | F253 | 12/02/16 |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure necessary maintenance services were provided to maintain a sanitary and comfortable environment. Maintenance issues were identified in 5 of 5 resident units (West, East, South, Rapid Recovery, Elbogen). The findings were:<br><br>1. Observation during the survey from 10/17/16 to 10/20/16 showed the carpet was in poor condition. The carpet appeared to be worn and dingy with years of use. In addition, the carpet was frayed in front of the doors leading into the West unit, near the television in the small common room in the South unit and at the entrance of resident room #64 and room #68. Additionally, on the Rapid Recovery unit in resident room #216 the carpet was rippled in multiple areas from the door into the room. Interview with the housekeeping director on 10/20/16 at 10:07 AM revealed the carpet was cleaned regularly, but due to the age of the carpet and overall use, it was not able to be effectively cleaned in areas. | F 253 | **Corrective Actions**<br>1. The carpet in all common areas and hallways are to be professionally cleaned. The frayed carpet in front of the doors leading into the West Unit, as well as the entrance of resident rooms #64 and #68 is to be repaired. The carpet in resident room #216 is to be replaced.<br>2. The ceiling tiles in the West Unit Living Room West Unit Dining Room, South Unit Hallway, South Unit Dining Room will be repaired/replaced.<br>3. The floor in the South Dining Room, near the food service window will be repaired/replaced.<br>4. The flooring on the threshold of the entrance onto the South Unit gift shop/store will be repaired/replaced.<br>5. The crack in the floor of the Elbogen common area will be repaired.<br>6. The sink faucet in resident room #23 will be repaired/replaced.<br><br>**Others Potentially Affected**<br><br>All residents have the potential to be affected by this practice.<br>1. The Maintenance Director/designee will complete an audit of all facility carpet in | 12/02/16 |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 253 | Continued From page 3<br>2. Observation on 10/20/16 at 8:30 AM showed there were ceiling tiles which were damaged. These included:<br>a. Two tiles in the West unit living room, 2 tiles in the West unit back dining room, and 1 tile in the West unit first dining room. The tiles were damaged with rings of discolored dried liquid.<br>b. Three Ceiling tiles in the hallway near the South unit linen closet had corners which were discolored and damaged.<br>c. Five ceiling tiles in the South dining room with dried discolored rings.<br><br>3. Observation on 10/20/16 at 9:07 AM showed the floor in the South unit dining room had an area measuring 7 feet by 4 feet near the food service window which was pitted, cracked and had spots of the flooring missing.<br><br>4. Observation on 10/20/16 at 9:07 AM showed the threshold of the entrance into the South unit gift shop/store from the South dining room had damaged flooring and a build up of dirt and debris around the damaged areas.<br><br>5. Observation on 10/20/16 at 8:47 AM showed the floor leading into the Elbogen common area had a crack in the flooring which measured 52 inches across. The seam of the crack had a build up of darkened dirt and debris.<br><br>6. Observation on 10/20/16 at 9:12 AM showed the wall inside resident room #122, located to the right of the entrance, had damage which included peeling paint. The area was on the bottom part of the wall and measured 3 feet across and 6 inches wide.<br><br>7. Observation on 10/20/16 at 8:54 AM showed | F 253 | common areas to ensure that it is clean and in good repair. Any identified areas will be repaired.<br>2. The Maintenance Director or designee will complete a facility wide audit of ceiling tiles to ensure that they are in good repair and free of stains. Any tiles found not to be in good repair, will be repaired/replaced.<br>3. The maintenance director or designee will complete a facility wide audit on the flooring of the dining rooms to identify any tiles that need to be replaced/repaired.<br>4. The maintenance director or designee will complete a facility wide audit on the flooring in the common areas to identify any tiles that need to be replaced/repaired.<br>5. The maintenance director or designee will complete a facility wide audit on the faucets of the resident bathrooms. Any faucets found with holes will be repaired/replaced.<br><br>**Systemic Changes**<br><br>The Maintenance Department will be educated on physical plant expectations regarding carpet, ceiling tiles, floors and faucets. | |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 253 | Continued From page 4<br>the sink faucet in resident room #23 had holes where the metal had corroded away.<br><br>8. Interview with the director of maintenance on 10/20/16 at 10:21 AM revealed he was aware of the carpet needing to be replaced in some resident rooms, and the supplies were available, but the work needed to be scheduled. He further verified other flooring in the building was in poor condition and there was no schedule in place for addressing the work at that time. He was not aware of the damaged ceiling tiles. | F 253 | **Monitoring**<br><br>The Maintenance Director or designee will complete a random weekly audit of five facility areas with the emphasis on carpet, ceiling tiles, flooring, and faucets x 30 days, and then monthly x 90 days.<br><br>Audit findings will be reported to the QA Committee monthly, for further analysis and recommendations, until such time as the QA Committee has determined that compliance has been sustained. | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced | F 280 | | |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 280 | Continued From page 5<br>by:<br>Based on observation, medical record review, and staff interview, the facility failed to revise the care plan for 3 of 23 sample residents (#15, #81, #86). The findings were:<br><br>1. Review of the 9/28/16 significant change MDS assessment revealed resident #86 had a deep tissue injury. Review of the weekly wound documentation form dated 9/21/16 revealed the resident had a deep tissue injury to the left heel. Review of the 10/3/16 physician order showed a foam dressing was ordered for the posterior left lower extremity, above the foot, where the knee brace had rubbed and caused a blister. Observation on 10/19/16 at 1:50 PM revealed the resident had a deep tissue injury to the left heel and there was a red area to the posterior left lower extremity above the foot. Review of the current care plan provided by the facility (last revised 9/29/16) showed the resident's wounds were not addressed. During an interview on 10/19/16 at 5 PM the MDS coordinator confirmed the resident's wounds were not addressed on the care plan.<br><br>2. Review of the 9/14/16 annual MDS assessment showed resident #81 was always incontinent of bladder and bowel. Review of the care area assessment (CAA) for urinary incontinence dated 9/16/16 revealed staff would toilet the resident on a schedule. According to the 9/16/16 bowel and bladder assessment, the resident needed to be toileted upon rising, before and after meals, at bedtime, and as needed. Review of the current care plan provided by the facility (last revised 8/3/16) showed a toileting schedule to manage the resident's incontinence was not included. During an interview on 10/19/16 | F 280 | F280 12/02/16<br>**Corrective Actions**<br><br>Resident #86 care plan has been updated to reflect the resident's individualized current plan of care and physician's orders.<br><br>Resident #81's care plan has been updated to reflect the resident's individualized current plan of care and physician's orders.<br><br>Resident #15's care plan has been updated to reflect the resident's individualized current plan of care and physician's orders.<br><br>**Other's Potentially Affected**<br><br>Residents with wounds and/or toileting needs have the potential to be affectec by this practice.<br><br>**Systemic Changes**<br>The Nursing Administration Team will be educated by the DON, regarding updating resident care plans to reflect current individualized resident needs and physician's orders.<br><br>**Monitoring**<br>The DON/designee will complete weekly audits on resident care plans to validate that individualized resident needs and physician's orders are reflected in the plan of care. | 12/02/16 |

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

PRINTED: 11/03/2016
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535042 | A. BUILDING _____ B. WING _____ | C 10/20/2016 |

| 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 280 | Continued From page 6<br>at 5 PM the MDS coordinator confirmed the resident's care plan did not include a toileting schedule to address the resident's incontinence.<br><br>3. Review of the 9/1/16 revised care plan for skin issues showed resident #15 had an "arterial pressure wound" to the right lateral calf and had a history of skin breakdown to the buttocks, groin, and pannus. Interventions included being "followed weekly by the wound nurse" and "treatment as ordered." The following concerns were identified:<br>a. Observation of the resident's skin on 10/19/16 at 5:53 PM with the wound nurse showed an open area to the right upper buttock, with pink edges and no drainage. The wound nurse measured the area, which was 0.9 cm by 0.7 cm. The area was treated with calazime ointment.<br>b. Review of the weekly wound documentation showed the most current note was dated 9/28/16. This note showed a "Rt [right] buttock St [stage] II was resolved. It also showed the "staff nurse notified MD of new L [left] buttock stage II PU [pressure ulcer]."<br>c. Interview with the DON on 10/20/16 at 11:47 AM verified the care plan was not updated to reflect the buttock wounds. | F 280 | Audit findings will be reported to the monthly QA Committee for further analysis and recommendations. Audits will continue until such time as the QA Committee has determined that compliance has been sustained.<br><br>**F283 12/02/16**<br><br>**Corrective Actions**<br>Resident #169 no longer resides in the facility.<br><br>**Others Potentially Affected**<br>Residents being discharged from the facility have the potential to be affected by this practice.<br><br>**Systemic Changes**<br>The Licensed Nurses will be educated by the DON/designee on the process of completing a discharge summary & recapitulation of the resident's stay. Medical Records will be responsible for auditing discharge records for a Discharge Summary and Recapitulation of Stay on all residents discharged from the facility; reporting findings to the DON. | 12/02/16 |
| F 283 SS=D | 483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS<br><br>When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the | F 283 | **Monitoring**<br>Medical Records will audit discharge records for a Discharge Summary and Recapitulation of Stay, and report findings to the DON.<br><br>The DON will report findings to the monthly QA Committee for further analysis and recommendations; until such time as the QA Committee has determined that compliance has been sustained. | |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 283 | Continued From page 7<br>consent of the resident or legal representative.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and medical record review, the facility failed to ensure a discharge summary and recapitulation of the resident's stay was completed for 1 of 3 closed records reviewed (#169). The findings were:<br><br>Review of the nurse's note dated 9/2/16 showed resident #169 was discharged to an inpatient hospice. Review of the medical record showed no evidence a discharge summary or recapitulation of the resident's stay was completed for the resident.<br><br>Interview with the DON on 10/19/16 at 4:43 PM confirmed there was no discharge summary completed for the resident at the time of discharge, and that her expectation was for a discharge summary to be completed for the resident when discharged to hospice. | F 283 | | |
| F 284 SS=D | 483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN<br><br>When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and medical record | F 284 | | |

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

PRINTED: 11/03/2016
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535042 | A. BUILDING _____ B. WING _____ | C 10/20/2016 |

| 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 284 | Continued From page 8<br>review, the facility failed to ensure a post-discharge plan of care was developed for 1 of 2 sample residents (#168) whose discharge was anticipated. The findings were:<br><br>Review of the 9/7/16 discharge summary for resident #168 showed the resident was initially admitted on 3/7/16 for treatment of wounds and infection, and received "therapies for strengthening." Further review showed the resident had MRSA (methicillin-resistant Staphylococcus aureus) in his/her wounds, and would "need follow up care with infectious disease." Review of a nurse's note dated 9/7/16 showed the resident left the facility with family, with medications provided, including insulin and insulin supplies. Review of the medical record showed no evidence a post-discharge plan of care was completed or sent with the resident.<br><br>Interview with the DON on 10/19/16 at 5:21 PM confirmed there was no evidence a post-discharge plan of care was developed for the resident prior to discharge. She further revealed a post-discharge plan of care should have been completed for the resident, including a list of medications and instructions. | F 284 | F284 12/02/16<br><br>**Corrective Actions**<br><br>Resident #168 no longer resides in the facility.<br><br>**Others Potentially Affected**<br><br>Residents being discharged from the facility have the potential to be affected by this practice.<br><br>**Systemic Changes**<br><br>The Licensed Nurses will be educated by the DON/designee, regarding the post-discharge plan of care process and the associated forms that need to be completed and provided to the discharging resident/responsible party.<br><br>**Monitoring**<br><br>Medical Records will audit all discharge records to validate that a post-discharge plan of care has been completed, and report to the DON. Audits will be completed weekly on all discharged resident records. The DON will report audit findings monthly to the QA Committee for further analysis and recommendations, until such time as the QA Committee has determined that compliance has been sustained. | 12/02/16 |
| F 314 SS=E | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and | F 314 | | |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 314 | Continued From page 9<br>prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, staff interview, and review of policies and procedures, the facility failed to ensure monitoring and treatment of pressure ulcers for 6 of 6 sample residents (#15, #86, #131, #137, #152, #162) with pressure ulcers. The findings were:<br><br>1. Review of the 9/28/16 significant change MDS assessment revealed resident #86 was at risk for pressure ulcers and had a deep tissue injury. Review of the weekly wound documentation form dated 9/21/16 showed the resident had a deep tissue injury to the left heel which measured 4 by 5 centimeters (cm). Review of the 10/3/16 physician order showed a foam dressing was ordered for the posterior left lower extremity, above the foot, where a knee brace was rubbing and caused a blister. The dressing was ordered to be changed every three days. Observation on 10/19/16 at 1:50 PM revealed the resident had a deep tissue injury to the left heel and there was a red area to the posterior left lower extremity above the foot. The following concerns were noted:<br>a. Review of the medical record on 10/18/16 revealed the last documentation, including a description with measurements, for the left heel wound was the weekly wound documentation form dated 9/29/16 (19 days previous). During an interview on 10/18/16 at 5:15 PM the DON confirmed the lack of documentation regarding the pressure ulcer.<br>b. During the observation on 10/19/16 at 1:50 PM the red area on the posterior left lower | F 314 | F314 12/02/16<br><br>**Corrective Actions**<br><br>Resident #86:<br>• Receives weekly wound assessment and documentation by the Wound Nurse/designee, since 10/19/16;<br>• Is receiving wound care per physician's orders;<br>• Has an individualized wound care plan;<br>• Has a TAR that reflects the current wound care being provided as ordered by the physician.<br><br>Resident #15:<br>• Receives weekly wound assessment and documentation by the Wound Nurse/designee, since 10/19/16;<br>• Wounds are being accurately identified in the resident's medical record.<br><br>Resident #152:<br>• Receives weekly wound assessment and documentation by the Wound Nurse/designee, since 10/16/16;<br>• TAR reflects the current wound care orders and wound care administered to the resident per physician's orders. | 12/02/16 |

PRINTED: 11/03/2016
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 10/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHEPHERD OF THE VALLEY HEALTHCARE CENTER | 50 MAGNOLIA CASPER, WY 82604 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 314 | Continued From page 10<br>extremity did not have a foam dressing in place in accordance with physician orders. An interview with RN #1 on 10/20/16 at 10:10 AM confirmed there should have been a foam dressing in place.<br>c. Review of the October 2016 treatment administration record (TAR) revealed "Foam dressing to left lower leg posterior above foot. Brace rubbing on skin forming a blister. Change q [every] 3 days. Every day shift." Further review showed nursing staff signed off on that item every day. It was unclear when the foam dressing was actually changed. During an interview on 10/20/16 at 11:46 AM the DON confirmed the documentation on the TAR did not accurately reflect the physician's order to change the dressing every 3 days. She stated she was unable to determine when the dressing was actually changed.<br>d. Review of the current care plan provided by the facility (last revised 9/29/16) showed the resident's wounds were not addressed. During an interview on 10/19/16 at 5 PM the MDS coordinator confirmed the resident's wounds were not addressed on the care plan.<br><br>2. Review of the 9/1/16 revised care plan for skin issues showed resident #15 had an "arterial pressure wound" to the right lateral calf and had a history of skin breakdown to the buttocks, groin, and pannus. Interventions included being "followed weekly by the wound nurse" and "treatment as ordered." Review of the weekly wound documentation showed the most current note was dated 9/28/16. This note showed a "Rt [right] buttock St [stage] II was resolved. It also showed the "staff nurse notified MD of new L [left] buttock stage II PU [pressure ulcer]." The following concerns were identified:<br>a. Review of the medical record showed after | F 314 | Resident #162:<br>• Receives weekly wound assessment and documentation by the Wound Nurse/designee, since 10/18/16;<br>• Is receiving wound care, per physician's orders since 10/20/16.<br><br>Resident #137 receives weekly wound monitoring and documentation by the Wound Nurse/designee, since 10/19/16.<br>• Resident #131 is receiving weekly wound monitoring and documentation by the Wound Nurse/designee, since 10/19/16.<br><br>**Others Potentially Affected**<br><br>Residents with wounds have the potential to be affected by this practice.<br><br>**Systemic Changes**<br><br>The facility hired a Wound Nurse, who began treating resident wounds on 10/14/16.<br><br>The facility has designated an RN to serve as a back up to the Wound Nurse in such circumstances as the Wound Nurse is unavailable.<br><br>The Wound Nurse/back up Wound Nurse and Nursing Administration Team will be educated by the DON on the | 12/02/16 |

| 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 10/20/2016 |

| 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 314 | Continued From page 11<br>9/28/16 there were no further notes related to the buttock wound. In addition, there were no treatment orders in the record related to the buttock wound which was resolved, or the newly identified wound documented on 9/28/16.<br>b. Observation of the resident's skin on 10/19/16 at 5:53 PM with the wound nurse showed an open area to the right upper buttock, with pink edges and no drainage. The wound nurse measured the area, which was 0.9 cm by 0.7 cm. The area was treated with calazime ointment.<br>c. Interview with the DON on 10/20/16 at 11:47 AM verified wound documentation and orders were lacking related to this resident's wounds.<br><br>3. Review of the initial MDS assessment dated 9/29/16 showed resident #152 had diagnoses that included multi-drug resistant organisms (MDRO), diabetes, rheumatoid arthritis, and bacteremia. Continued review showed the resident had 2 diabetic ulcers, 3 gouty (arthritic nodule) ruptures, a stage IV pressure ulcer to the right buttock, required total assistance with 2 or more persons for transfers, and was at risk for skin breakdown. Review of the care plan for skin, revised 10/4/16 showed the resident had skin issues and wanted his/her skin to heal. Interventions included staff to provide treatments as ordered, to be turned/repositioned frequently, and to have skin observed at least weekly during the bathing process. The following concerns were identified:<br>a. Review of wound documentation notes showed a weekly wound documentation form was completed on the resident on 9/24/16. Further review showed 3 weeks of documentation was lacking, with the next completed wound | F 314 | requirement for weekly wound monitoring and documentation.<br><br>**Monitoring**<br><br>The DON/designee will perform weekly audits on Wound Care Monitoring and Documentation. Findings from the audits will be reported monthly to the QA Committee for further analysis and recommendations; until such time as the QA Committee determines that compliance has been sustained. | 12/02/16 |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 314 | Continued From page 12<br>documentation dated 10/16/16.<br>b. Review of the TAR for September/ October 2016 showed a treatment was ordered for the wound on the right buttock to be completed every day shift beginning 9/23/16. However, the TAR failed to show documentation the treatment was completed on 9/26, 10/1, 10/10, 10/11, and 10/17.<br><br>4. Review of the initial MDS assessment dated 9/29/16 showed resident #162 had diagnoses that included left femur fracture, pressure ulcers to the sacrum/coccyx and right heel, and diabetes. Continued review showed the resident had 2 stage II pressure ulcers (sacrum, right heel), required some assistance of 2 or more persons for transfers, and was at risk for skin breakdown. Review of the care plan for skin, dated 9/26/16 showed the resident had skin issues and wanted his/her skin to heal. Interventions included staff to provide treatment as ordered, and for the resident to use a boot on right foot, and to have skin observed at least weekly during the bathing process. The following concerns were identified:<br>a. Review of wound documentation notes showed a weekly wound documentation form was completed on the resident on 9/27/16. Further review showed no evidence of weekly wound documentation for 2 weeks, with the next completed wound documentation on 10/18/16.<br>b. Review of the October 2016 TAR showed a treatment was ordered for the coccyx wound to be completed every day shift beginning 9/28/16. Further review showed the treatment was not documented as being completed on 10/2, 10/4, 10/10, 10/11, and 10/12.<br>c. Review of nursing progress notes dated 10/10/16 showed the resident voiced concern regarding his heel wound to the nurse. | F 314 | | |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 314 | Continued From page 13<br><br>5. Review of the annual MDS assessment dated 5/9/16 showed resident #137 had diagnoses that included morbid obesity, muscle weakness, dehydration, and pressure ulcers. Continued review showed the resident required extensive assistance of 2 or more persons for transfer and was at risk of skin breakdown. In addition it showed an unhealed pressure ulcer of stage 1 or higher. Review of the care plan for skin showed the resident had a long history of vascular wounds. Interventions dated 6/1/16 showed "My skin will be observed with daily cares and at least weekly by the wound nurse." However, review of wound care documentation showed the resident was last seen by the wound care nurse on 10/19/16 and prior to that was seen on 9/27/16, with no documentation/monitoring of wound care for 21 days.<br><br>6. Review of the admission MDS assessment dated 1/14/16 showed resident #131 showed diagnoses including diabetes mellitus type 2, coronary artery disease, and chronic kidney disease. Continued review showed the resident required assistance of 1 or more persons for transfers and was at risk of skin breakdown. Review of the resident care plan for skin showed s/he had skin issues: "Stage 3 pressure ulcer dated 5/20/16 to be treated weekly by the wound nurse." However, review of wound care documentation showed the resident was last seen by the wound care nurse on 10/19/16 and prior to that was seen on 9/27/16, without documentation/monitoring of wound care for 21 days.<br><br>7. On 10/20/16 at 11:35 AM the DON provided a document entitled "Skin Program Cheat Sheet." | F 314 | | |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 314 | Continued From page 14<br>She stated nursing staff were expected to follow this document regarding pressure ulcers. Review of the document showed "...Weekly Wound Documentation Form (one wound per form) in PCC [Point Click Care] until wound/PU is healed. Should be completed with team on wound rounds." During a previous interview on 10/18/16 at 5:15 PM the DON confirmed the lack of documentation regarding pressure ulcers. | F 314 | F371 12/02/16<br><br>**Corrective Actions**<br><br>The facility discarded the Healthshakes that were identified thawing; without dates.<br><br>The facility has begun dating Healthshakes that are placed for thawing; with a 14-day cycle.<br><br>Dietary Staff were educated on proper hand hygiene during the survey process.<br><br>**Others Potentially Affected**<br><br>Residents who receive Healthshakes have the potential to be affected by this practice.<br><br>**Systemic Changes**<br><br>The Dietary staff were educated on the spot when Healthshakes were identified as not being dated.<br><br>The Dietary Manager will be educated the Dietary Staff again on 11/23/16 regarding dating Healthshakes and performing hand hygiene before and after glove use, after handing non-food | 12/02/16 |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure safe food handling practices in 2 of 5 kitchens (the south kitchen, the west kitchen). The findings were:<br><br>1. Observation on 10/17/16 at 3:35 PM in the South kitchen showed 14 cartons of thawed health shakes located in a refrigerator unit. There was no label to show when they were to be used by or discarded. According to the instructions printed on the cartons, the "Mighty Shakes" were good for 14 days after thawing. | F 371 | | |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 371 | Continued From page 15<br>2. Observation of the West kitchen on 10/20/16 at 11:03 AM showed 3 trays of thawed "Mighty Shakes" stored in the refrigerator unit. The trays contained 25-30 cartons each and none were labeled with a use by or discard date.<br><br>3. Observation of meal service in the South kitchen on 10/19/16 at 11:48 AM showed dietary aide #1 handled the door to the refrigerator unit to get a food item. Without performing hand hygiene she returned to the steamtable and continued serving resident meals.<br><br>According to Food Code 2013, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands."<br><br>4. Interview with the Certified Dietary Manager on 10/19/16 at 2:30 PM verified a system for dating the health shakes for expiration was needed, and further verified hand hygiene was needed after hands became contaminated. | F 371 | surfaces, and before serving resident food.<br><br>**Monitoring**<br><br>The Dietary Manager will perform weekly audits, at random day and times, regarding hand hygiene during the meal service process and on appropriate dating of Healthshakes.<br><br>The Dietary Manager will report findings monthly to the QA Committee for further analysis and recommendations, until such time as the QA Committee determines that compliance has been sustained. | 12/02/16 |
| F 425 SS=E | 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general | F 425 | | |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 425 | Continued From page 16<br>supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and policy and procedure review, the facility failed to ensure medications available for resident use were not past the manufacturer's recommended expiration dates in 4 of 8 medication carts (West, South, East 1, and East 2) and 1 of 2 (East) medication rooms. The findings were:<br><br>1. Observation on 10/20/16 at 9:15 AM of the South medication cart #1 showed 1 blister pack of Tizanidine HCl 4 mg tablets had expired on 9/30/16, and 27 of 30 tablets remained in the pack. Interview at that time with medication aide #1 verified the medications were available for resident use and past the expiration date.<br><br>2. Observation on 10/20/16 at 9:59 AM of the East medication cart #2 showed 4 blister packs of resident medications had expired. The following concerns were identified:<br>a. Tramadol HCL 50 mg tablets expired on | F 425 | **F425** **12/02/16**<br><br>**Corrective Actions**<br><br>All expired medications were discarded at the time of the survey, in the appropriate destruction method, in the following areas:<br>• South Med Cart #1<br>• East Med Cart #2<br>• East Med Cart #1<br>• East Med Room Refrigerator<br>• West Med Cart.<br><br>**Others Potentially Affected**<br><br>All residents have the potential to be affected by this practice.<br><br>**Systemic Changes**<br><br>The DON/designee will educate Licensed Nurses, CMA's, and the Nursing Administration Team on the process of regularly checking all medication storage areas for expired or medications.<br><br>The facility will develop a schedule to regularly check for expired medications on each Nursing Unit. | 12/02/16 |

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 10/20/2016 |

| 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 425 | Continued From page 17<br>10/12/16; 2 of 30 tablets remained in the pack.<br>b. Tramadol HCl 50 mg tablets expired on 7/31/16; 5 of 30 tablets remained in the pack.<br>c. Oxycodone HCl 5 mg tablets expired on 10/8/16; 9 of 30 tablets remained in the pack.<br>d. Hydrocodone - APAP 5-325 mg tablets expired on 9/25/16; 13 of 31 remained in the pack.<br>e. Interview on 10/20/16 at 9:59 AM with medication aide #2 verified the medications were available for resident use and past the expiration date. Further she stated that the "nurses had just checked the carts" on the East wing the day before.<br><br>3. Observation on 10/20/16 at 10:18 AM on the East medication cart #1 showed 1 blister pack of Furosemide 20 mg tablets had expired on 8/31/16; 8 of 30 tablets remained in the pack.<br><br>4. Observation on 10/20/16 at 10:35 AM of the East medication room refrigerator showed 1 box of Bisacodyl Suppository 10 mg had expired on 5/16; 18 remained in the box.<br><br>5. Observation of the West unit medication cart at 9:35 AM on 10/20/16 showed a Glucagon Emergency kit (treatment for low blood sugar) had an expiration date of 8/2016. Interview at that time with RN #1 confirmed the kit was available for resident use.<br><br>6. Review of the policy titled, "Medications: Storage of," dated June 2016, showed "...3. No discontinued, outdate, or deteriorated medications/solutions are available for use in this facility. All such medications/solutions are destroyed". | F 425 | **Monitoring**<br><br>The DON/designee will audit medication storage areas weekly for expired medications.<br><br>Audit findings will be reported monthly to the QA Committee for further analysis and recommendations, until such time as the QA Committee determines compliance has been sustained. | 12/02/16 |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 431<br>F 431<br>SS=D | Continued From page 18<br>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by: | F 431<br>F 431 | F431 12/02/16<br><br>**Corrective Actions**<br><br>The South Unit Med Cart #2 is locked when the nurse steps away from the cart; and is being monitored by the Unit Manager.<br><br>**Others Potentially Affected**<br><br>Residents who reside on the South Unit have the potential to be affected by this practice.<br><br>**Systemic Changes**<br><br>The Licensed Nurses and CMA's will be re-educated, on or before 12/02/16 by the DON/designee, regarding the requirement of keeping medication carts locked whenever the cart is not being actively used; and/or the nurse needs to step away from the medication cart.<br><br>**Monitoring**<br><br>The DON/designee will audit all medication and treatment carts daily, at random times, on all units to ensure that carts are appropriately locked. Audit findings will be reported monthly to the QA Committee for further analysis and recommendations; until such time as the QA Committee has determined that compliance has been sustained. | 12/02/16 |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 431 | Continued From page 19<br>Based on observation, staff interview, and policy and procedure review, the facility failed to ensure safe and secure storage of medications in 1 of 8 medications carts (South unit medication cart #2) during 3 random observations. The findings were:<br><br>1. Observation on 10/17/16 at 4:18 PM showed medication cart #2 was placed in front of the South unit nurse's station. Further observation showed the cart was unlocked as RN #2 and a student were obtaining medications. The RN left the student and unlocked cart unattended and walked down the hallway. Continued observation at 4:25 PM showed RN #2 had returned to the cart, obtained medications, and again left the unlocked cart and student unattended.<br><br>2. Observation on 10/18/16 at 11:13 AM showed medication cart #2 was placed in front of the South unit nurse's station. The cart was unlocked and unattended. Continued observation showed multiple nursing and maintenance staff walked past the cart. The cart remained unlocked and unattended until 11:25 AM, when an unidentified staff member pushed in the locking mechanism, locking the cart.<br><br>3. Observation on 10/18/16 at 1:20 PM showed medication cart #2 was placed in front of the South unit nurse's station. The cart was unlocked and unattended, with no staff members in the vicinity. Continued observation showed 2 residents and one family member of a resident passed the cart. At 1:24 PM, licensed practical nurse (LPN) #1 locked the cart.<br><br>4. Interview with the DON at 10:50 AM on 10/20/16 confirmed the medication carts need to | F 431 | | |

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

PRINTED: 11/03/2016
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535042 | A. BUILDING _____ B. WING _____ | C 10/20/2016 |

| 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 431 | Continued From page 20<br>be locked, further she stated "It's not ok to leave [the cart] open when delivering medications to residents."<br><br>5. Review of the policy titled "Medications: Storage of", dated June 2016, showed "...5. Compartments containing medications are locked when not in use. Trays or carts used to transport such items are not left unattended. (Compartments include, but are not limited to, drawers, ...carts and boxes". | F 431 | **F441** **12/02/16**<br><br>**Corrective Actions**<br><br>Resident #152 is receiving wound care, utilizing appropriate Infection Prevention and Control techniques since 10/20/2016.<br><br>Resident #123's Foley catheter drainage bag and tubing is being maintained up off of the floor, and is not being rolled over due to tubing positioning.<br><br>CNA staff was re-educated by SDC on proper hand hygiene techniques in the dining room and during meal service with residents. Resident #126 is receiving proper assistance from staff during meal service; staff are performing appropriate hand hygiene at meal service time.<br><br>**Others Potentially Affected**<br><br>All residents have the potential to be affected by this practice.<br><br>**Systemic Changes**<br><br>Certified Nursing Assistants will be re-educated on proper hand hygiene techniques during meal service, on or before 12/02/2016 by the SDC.<br><br>Licensed Nurses will be re-educated on hand hygiene and proper Infection Prevention techniques to use during | 12/02/16 |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if | F 441 | | |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 441 | Continued From page 21<br>direct contact will transmit the disease.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure infection prevention practices were followed by staff during 4 random observations. These practices affected residents #123, #126, and #152. The findings were.<br><br>1. Review of the medical record for resident #152 showed the resident had multiple wounds on his/her heel, wrist, finger, and buttocks requiring wound care and dressing changes. During observation of wound care on 10/18/16 at 2:25 PM, the following concerns were identified:<br>a. While preparing for the wound care, a bottle of wound care cleanser fell into a trash can containing discarded wound dressings and cotton tipped applicators. RN #3 reached into the trash with an ungloved hand, retrieved the contaminated bottle, and placed it on the resident's nightstand. Further observation showed she used the same bottle to cleanse 3 separate wounds.<br>b. While dressing the buttock wound RN #3 obtained a pair of scissors out of a plastic caddy | F 441 | wound care, on or before 12/02/16, by the DON/designee.<br><br>**Monitoring**<br><br>Weekly Infection Control Audits will be completed by the DON/designee, regarding hand hygiene, wound care infection prevention techniques, and hand hygiene during meal service. Audit findings will be reported monthly to the QA Committee for further analysis and recommendations, until such time that the QA Committee has determined that compliance has been sustained. | 12/02/16 |

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

PRINTED: 11/03/2016
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535042 | A. BUILDING _____ B. WING _____ | C 10/20/2016 |

| 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 22<br>full of wound care supplies and placed them directly on the resident's bed sheets. Further, the nurse used the scissors to cut the sterile packing strip that was placed in the resident's buttock wound.<br>c. Interview at that time with RN #3 verified that a barrier should have been placed on the resident's bed before placing the scissors on the sheets. Further, she stated "I didn't realize I grabbed the bottle out of the trash, I shouldn't have done that."<br><br>2. Observation on 10/17/16 at 5:55 PM showed resident #123 was sitting in a wheelchair with his/her Foley catheter tubing lying on the floor below him/her. Continued observation showed the resident rolled over the catheter tubing, and then back over it again. CNA #1 assisted the resident out of the dining area and rolled the wheelchair over the Foley catheter tubing.<br><br>3. Observation on 10/20/16 at 9:13 AM showed resident #123 sitting in a wheelchair in the dining area with Foley tubing lying on the floor.<br><br>4. Observation on 10/19/16 at 11:54 AM showed CNA #2 delivered a meal tray to resident #126. After placing the tray on the table the aide walked across the room, picked up a chair using both hands, and took it to where the resident was seated. Without performing hand hygiene the CNA handled the resident's beverage glasses and utensils as he assisted the resident with dining.<br><br>5. Interview with the DON at 10:45 AM on 10/20/16 confirmed hand hygiene should be completed prior to feeding residents, and running over the catheter tubing was an infection control | F 441 | | |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 441 | Continued From page 23<br>risk and not good practice. Further, she confirmed scissors used in wound care and dressing changes needed to be placed on a barrier in the room and not directly on bed sheets. Additionally she stated "The wound cleanser should have been left in the trash and not used."<br><br>6. Review of the policy titled, "Handwashing/Hygiene", dated August 2014, showed "...5. Employees must wash their hands for at least twenty (20) seconds ...g. before and after assisting a resident with meals..."<br><br>7. Review of the policy titled, "Infection Prevention Program Overview", dated May 2014, showed "...A. INFECTION PREVENTION NURSE...Responsibilities may include:...Implementing evidence-based infection control practices, including those mandated by regulatory and licensing agencies, and guidelines from the CDC..." | F 441 | | |
| F 465 SS=E | 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure the environment was maintained in a safe and sanitary manner for staff in 5 of 5 kitchens (Main, South, East, Rapid recovery, West kitchens) and other random locations (the dishroom, the laundry room, and | F 465 | | |

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

PRINTED: 11/03/2016
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535042 | A. BUILDING _____ B. WING _____ | C 10/20/2016 |

| 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 465 | Continued From page 24<br>the South unit clean utility room). The findings were:<br><br>1. Observation on 10/20/16 at 8:54 AM showed the clean utility room on the South unit had a damaged wall. The wall was crumbling in an area that measured 5 feet by 5.5 inches. Also, the countertop and backboard around the sink in the room were coming apart with areas of loose material. This damage created a surface that could not be effectively cleaned.<br><br>2. Observation on 10/17/16 at 3:20 PM showed the floor in the main dishroom had been removed and the grout/base of the floor was visible and was not finished. Interview with the certified dietary manager at that time revealed work had begun on the drain in approximately February 2016. She was uncertain of the completion time for the additional work which was required to cover the floor.<br><br>3. Observation in the main kitchen on 10/17/16 at 3:20 PM showed the wall underneath the garbage disposal sink was damaged and falling apart.<br><br>4. Observation of the East unit kitchen on 10/19/16 at 10:50 AM showed an area measuring 6 feet by 1 foot of the flooring near the steamtable was stained and discolored. There was also an area 3 feet by 2 feet with damage to the wall inside of the entrance with peeling paint and gouged areas.<br><br>5. Observation of the West unit kitchen on 10/19/16 at 11:03 AM showed 11 floor tiles near the steam table which were cracked/chipped. The wall behind the steam table had damage covering an area 5 feet by 1 foot. In addition, the door | F 465 | F465 12/02/16<br><br>**Corrective Actions**<br><br>The damaged wall, countertop and backboard on the clean utility room on the South Unit is to be repaired or replaced.<br><br>The main dish room floor will be repaired or replaced.<br><br>The wall underneath the garbage disposal sink will be repaired.<br><br>The floor tiles, wall damage and door frame on the West Unit Kitchen will be repaired or replaced.<br><br>The East Unit kitchen floor in front of the steam table, wall damages and peeling paint will be repaired or replaced.<br><br>The floor tiles, countertop edging and wall damage on both sides of the refrigerator will be repaired or replaced.<br><br>The ceiling tiles, cabinets, peeling paint and missing hardware on the South Uni Kitchen will be repaired or replaced. The Laundry room floor will be painted. The ceiling in the clean linen folding area will be repaired. The hole in the wall next to the new dryer will be repaired. | 12/02/16 |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 466 | Continued From page 25<br>frame between the steamtable area and the beverage area had chipped paint and gouged wood.<br><br>6. Observation of the Rapid Recovery kitchen on 10/19/16 at 11:17 AM showed 13 broken/chipped floor tiles, missing countertop edging, and damage to the walls on both sides of the refrigerator.<br><br>7. Observation of the South unit kitchen on 10/17/16 at 3:35 PM showed 2 damaged ceiling tiles. The tiles had discoloration and a flaking surface. The cabinets in the kitchen had missing or damaged hardware and peeling paint.<br><br>8. Observation of the laundry room on 10/20/16 at 10:05 AM showed the floor had once been painted a gray color and the paint was now worn away in various areas. In addition, there was a section of the ceiling in the clean linen folding area that was damaged and coming away. There was a hole in the wall near a new dryer unit that exposed the sheet rock and covered an area 13 inches by 2.5 inches.<br><br>9. Interview with the administrator on 10/20/16 at 8:55 AM revealed he was aware of issues in the building and they were in the process of getting bids to have projects done. There were no projects scheduled at that time. | F 465 | **Others Potentially Affected**<br><br>All residents have the potential to be affected by this practice.<br><br>1. The Maintenance Director or designee will conduct a facility wide audit of all food service areas to ensure that the floors, ceilings, paint and walls are in good repair. Any issues noted in the audit will be resolved.<br>2. The Maintenance Director or designee will conduct a facility wide audit on all laundry service areas and utility rooms to ensure that the floors, ceilings, and walls are in good repair. Any issue noted will be resolved.<br><br>**Systemic Changes**<br><br>The Maintenance Department will be educated on the regulatory expectations regarding the maintenance of floors, ceilings and walls in food service areas, laundry service areas, and utility rooms. | |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; | F 514 | **Monitoring**<br><br>The Maintenance Director or designee will complete a random weekly audit of five facility service areas with the emphasis on floors, ceilings, walls, and countertops; x 30 days and then monthly x 90 days. Audit results will be reported to the QA Committee for further analysis and trending, until such time as substantial compliance has been achieved. | |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 514 | Continued From page 26<br>accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and medical record review, the facility failed to ensure medical records were complete and accurate for 2 of 26 sample residents (#40, #125). The findings were:<br><br>1. Review of the 9/12/16 quarterly MDS assessment showed resident #125 was admitted on 4/25/16, had diagnoses that included urinary incontinence and urinary retention, and had an indwelling urinary catheter. Review of a 4/26/16 physician order showed staff were to track the resident's intake and output each shift. The following concerns were identified:<br>a. Review of the "Resident Consumption Flow Record" from 10/1/16 through 10/18/16 showed no intake was recorded on 22 shifts.<br>b. Review of the resident's output records from 10/1/16 through 10/18/16 showed the resident's output was not recorded on 23 shifts.<br>c. Interview with RN #2 on 10/20/16 at 8:50 AM confirmed the documentation was not complete for the resident's intake and output.<br><br>2. Review of the 9/15/16 quarterly MDS assessment showed resident #40 was admitted on 6/10/16, and had diagnoses that included | F 514 | F514 12/02/16<br><br>**Corrective Actions**<br>Per #40 and #125 no longer have orders for I&O. meal intakes are documented with each meal.<br><br>**Others Potentially Affected**<br>Resident's residing on the East Unit have the potential to be affected by this practice.<br><br>**Systemic Changes**<br>The Licensed Nurses and CNA's will be re-educated on the process of determining food/fluid intake and recording intake and output, by the SDC on or before 12/02/16.<br><br>**Monitoring**<br>The Unit Managers will monitor intake and output daily on their respective units, and report monthly to the QA Committee any trends, for further analysis and recommendations; until such time as the QA Committee has determined that compliance has been sustained. | 12/02/16 |

PRINTED: 11/03/2016
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 10/20/2016 |

| 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 514 | Continued From page 27<br>hypertension, depression and a history of falls. Review of a 8/20/16 physician order showed staff were to track the resident's intake and output of fluids each shift. The following concerns were identified:<br>a. Review of the intake records from 10/1/16 through 10/18/16 showed the food and fluid intake was to be recorded for each meal, and there were 31 meals with no information recorded.<br>b. Review of the resident's output records from 10/1/16 through 10/18/16 showed the resident's output was not recorded on 5 shifts.<br>c. Interview with the DON on 10/20/16 at 11:15 AM verified the intake and output records were not complete. | F 514 | | |