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

PRINTED: 12/14/2016
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 11/29/2016

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 the Office of Healthcare Licensing and Surveys on 11/29/16. The survey was prompted by complaint intakes WY00002307 and WY00002321. The following common abbreviations are used throughout this document: BIMS- Brief Interview for Mental Status DON- Director of Nursing Services MDS- Minimum Data Set MAR- Medication Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 323		

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

NHA 12/23/2016

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.

Received
DEC 23 2016
Healthcare Licensing and Surveys

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F 323	Continued From page 1 (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, incident investigation review, resident and staff interview, review of employee education files, and review of quality assurance performance improvement (QAPI) meeting minutes, the facility failed to ensure safety for 1 of 1 residents (#1) who was injured during motor vehicle transport. Based on the failure of the facility to provide effective training to all drivers and ensure safety belt checks were completed, this deficient practice was cited as past noncompliance at actual harm as the resident sustained a fractured leg. At the time of survey on 11/29/16 the facility had implemented a QAPI plan to provide increased resident safety during motor vehicle transportation. A complete van driver re-certification process was completed on 11/18/16. The findings were: Review of the 11/17/16 incident investigation summary showed on 11/12/16 while being transported on a facility van to an activity, resident #1 was not secured in his/her wheelchair and was injured when the van came to an abrupt stop. The resident's wheelchair had been secured; however, a check to ensure the resident was belted in was not completed. The resident sustained a fractured leg. Interview with the resident on 11/29/16 at 12:37 PM regarding the 11/12/16 accident verified the	F 323	Past noncompliance: no plan of correction required.	

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F 323	Continued From page 2	F 323		

seatbelt was not secured and s/he fell out of the wheelchair and fractured his/her leg. The resident stated s/he didn't realize the seatbelt was undone until the fall occurred. Observation at that time showed the resident had a brace on the left leg. The resident revealed s/he continued to be non-weight bearing and hoped the physician would clear him/her that week to begin therapy. The resident stated medication was administered for pain, the leg was stiff and had "spasms."

Review of the 9/21/16 Quarterly MDS assessment showed the resident was cognitively intact with a BIMS score of 15/15.

Further review of the facility investigation showed it was thorough and the van driver was suspended pending the investigation. Review of the 11/15/16 QAPI meeting minutes showed the root cause of the accident was a "knowledge deficit" of the driver (#1). The driver was taken off driving duty permanently after the incident. Review of the education file related to driving/transportation for driver #1 showed there was a 26-question test completed. There was no date on the test and the driver had failed to answer correctly on 6 of the 26 questions. The other 4 drivers employed at the facility were provided re-education/certification on 11/18/16. Review of the employee files for these drivers showed completion of this certification. In addition, the safety committee was assigned to continue monitoring by completing audits to ensure system compliance.

Observation on 11/29/16 at 2:58 PM of van #1 and at 4:20 PM of van #2 showed the 2 facility transportation vans were equipped with safety straps to secure the wheelchairs as well as

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F 323	Continued From page 3 shoulder/lap belts to secure the residents. Interview with driver #2 at 4:20 PM verified she was provided the re-certification and that safety monitoring and checks were being completed. Interview with the DON on 11/29/16 at 4:31 PM verified the education driver #1 received prior to being allowed to drive "was not the best." She verified the safety plan was implemented on 11/18/16 when the re-certification of the drivers was completed and the problem was corrected as of that date with continuing QAPI audits.	F 323		