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

PRINTED: 03/29/2017
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 03/15/2017

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 Surveys on 3/15/17. Reviewed in the course of this survey was complaint intake WY000002364. The following common abbreviations are used throughout this document: DON: Director of Nursing LPN: Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 157 SS=E	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 157	Corrective Actions: No immediate corrective actions could be accomplished as the identified practice has already occurred. Res #103, #160, & #166 no longer reside at the facility. Resident #39 was assessed by the facility and Physician and the Guardian was notified of change of condition. Others Potentially Affected: Any resident with a change in condition has the potential to be affected by this practice.	4/26/17

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

NHA 4/6/2017

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
APR 06 2017
Healthcare Licensing and Surveys

4/24/17 - 4:58 PM - Spoke to Bess Litton DON. POC accepted with agreed upon changes.

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F 157	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to notify the resident's representative or physician for 4 of 13 sample residents (#39, #103, #160, #166) with a change in condition. The findings were: 1. Review of a nurse's note dated 3/3/17 and timed 8:44 PM showed resident #166 had "...dark brownish urine.." when the resident was assisted to the bathroom. The following concerns were identified: a. Review of the nurse's notes showed no	F 157	Systemic Changes: Licensed Nurses will be educated by the DON/designee, on the requirement to notify the resident's physician and resident representative, on any change of resident condition. Unit Managers will perform daily review of resident condition (Monday - Friday) and report any changes at the morning Quality Conference. Licensed Nurses will monitor the resident's change of condition, every shift x 72 hours, at a minimum or until resolved. Monitoring: Weekly audit by Unit Manager/designee of change of condition notification and monitoring. Audits will be reported to the QAPI Committee monthly for further analysis and recommendations; until such time that the QAPI determines compliance is sustained.	4/25/17

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F 157	Continued From page 2 evidence the resident's representative was notified of the change. b. Interview with the DON on 3/15/17 at 2:15 PM confirmed the representative should have been notified. 2. Review of a nurse's note dated 2/8/17 and timed 9:39 PM showed resident #39 had urine in his/her catheter bag that was "dark red" in color. Further, the note showed the resident's representative identified the urine discoloration and asked the facility to send the resident to the hospital. The following concerns were identified: a. Review of the medical record showed no evidence the facility had identified the urine characteristic change prior to 2/8/17. Further, there was no evidence the representative was notified of a change in the resident's condition. b. Interview with LPN #1 on 3/15/17 revealed the resident had a history of blood in his/her catheter bag and it had been going on for a "while" before the resident was hospitalized. Further, the LPN revealed the blood comes and goes. c. Interview with the DON on 3/15/17 at 3 PM revealed she was not aware of how long the resident had blood in his/her urine and confirmed the representative was not notified until the change was identified by the representative on 2/8/17. 3. Review of the medical record for resident #160 showed the resident had an established representative. The following concerns were identified: a. Review of a nurse's note dated 2/24/17 and timed 6:15 AM revealed "Resident left facility via emergent transfer accompanied by emergent staff." Further review of the medical record	F 157		

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F 157	Continued From page 3 showed no evidence the resident's representative was notified. b. Review of a nurse's note dated 3/13/17 and timed 5:10 PM showed "Phone call from [physician] stating that d/t (due to) resident's change of condition, we can dc (discontinue) all [his/her] meds (medications) and initiate comfort care measures. Was told to call [physician's] office in the am (morning) so [the physician] could write scripts for liquid morphine and ativan (sic)." Further review of the medical record showed no evidence the resident's representative was notified. c. Interview with the DON on 3/15/17 at 4:20 PM confirmed notification of the resident's representative was not documented in the medical record. Further, she confirmed it was her expectation that notification of significant changes be communicated to the resident's representative and documented in the medical record. 4. Review of the medical record for resident #103 revealed a nurse's note dated 1/31/17 and timed 2:51 PM which stated "Patient has displayed a decrease in cognition and decline in physical therapy performance. Patient has been having chills and cough does not seem to be improving." The following concerns were identified: a. Review of the medical record showed no documentation of physician notification or evidence that a nursing assessment was completed. b. Interview with the DON on 3/15/17 at 4:20 PM confirmed notification of the physician was not documented in the medical record. Further, it was her expectation that assessments be completed and documented when a change of condition occurred.	F 157		

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F 309	Continued From page 4	F 309		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 309	Corrective Actions: No immediate corrective actions could be accomplished as the identified practice has already occurred. Res #103, #166, and #167 no longer reside in the facility. Resident #3a was assessed by the facility and the physician and the Guardian was notified of change of condition. Others Potentially Affected: Residents with a change of condition have the potential to be affected by this practice. Systemic Changes: Licensed Nurses will be educated by the DON/designee on the requirement: "the facility must ensure that residents receive treatment & care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choice..." Monitoring: Weekly audit by Unit Manager/designee of change of condition notification and monitoring. Audits will be reported to the QAPI Committee monthly for further analysis and recommendations; until such time that the QAPI determines compliance is sustained.	4/26/17

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F 309	Continued From page 5 Based on staff interview, medical record review, and policy and procedure review, the facility failed to assess 4 of 13 sample residents (#39, #103, #166, #167) for change of condition. 1. Review of a nurse's note dated 2/8/17 and timed 9:39 PM showed resident #39 had urine in his/her catheter bag that was "dark red" in color. Further, the note showed the resident's representative identified the urine discoloration and asked the facility to send the resident to the hospital. The following concerns were identified: a. Interview with LPN #1 on 3/15/17 revealed the resident had a history of blood in his/her catheter bag and it had been going on for a "while" before the resident was hospitalized. b. Review of the medical record showed no evidence the facility had identified the urine characteristic change prior to 2/8/17. c. Interview with the DON on 3/15/17 at 3 PM revealed she was not aware of how long the resident had blood in his/her urine. She also confirmed there was no documentation about the blood in the resident's urine prior to 2/8/16. 2. Review of a nurse's note dated 2/15/17 and timed 10:37 PM showed resident #167 was "...choking and had copious amounts of clear white mucous..." that s/he was coughing up. At that time, the resident stated that it felt like there was more stuck in his/her esophagus. The note showed the resident then coughed up "meat and vegetables," speech therapy was notified, and an esophagram was requested. Further review showed the resident told the nurse s/he was "OK" because s/he had used a pencil to dislodge the meat from his/her throat. The following concerns were identified: a. Review of the nurse's notes showed no	F 309		

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F 309	Continued From page 6 evidence that an oral assessment was completed at the time of the incident to verify the resident did not have injuries related to using a pencil to remove the items s/he was choking on. b. Review of the nurse's notes showed no evidence the resident was monitored for signs and symptoms of injury following the incident. 3. Review of a nurse's note dated 3/3/17 and timed 8:44 PM showed resident #166 had "...dark brownish urine.." when the resident was assisted to the bathroom. The following concerns were identified: a. Review of the nurse's notes showed no evidence the resident was monitored related to the identified urine characteristic change. b. Interview with the DON on 3/15/17 at 2:15 PM revealed the resident should have been placed on change of condition monitoring for the urine characteristic change. 4. Review of the medical record for resident #103 revealed a nurse's note dated 1/31/17 and timed 2:51 PM which stated "Patient has displayed a decrease in cognition and decline in physical therapy performance. Patient has been having chills and cough does not seem to be improving." The following concerns were identified: a. Review of the medical record showed no documentation of physician notification or evidence that a nursing assessment was completed. b. Interview with the DON on 3/15/17 at 4:20 PM confirmed notification of the physician was not documented in the medical record. Further, it was her expectation that assessments be completed and documented when a change of condition occurred.	F 309		

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F 309	Continued From page 7 5. Review of the policy titled "Change in Condition Clinical Monitoring Guidelines" last revised May 2015 showed "...Residents with any noted significant change in condition will have, at a minimum, the following monitoring guidelines implemented based on the nature and extent of the change. The following guidelines only serve as a general guide and monitoring frequency may have to be increased based on the presenting symptoms. Monitor the resident: Every 15 minutes x [times] 4 Every 30 minutes x 2 Every 1 hour x 4 Every 4 hours x 2 Every shift. These guidelines are to remain in effect until the MD/NP has been notified and additional monitoring guidelines are established or the resident's clinical condition has improved. If the resident's condition fails to improve continue monitoring every 15 minutes and update the MD/NP for continued monitoring or transfer to an acute care facility."	F 309		