PRINTED: 05/19/2017
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 05/05/2017

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 from 5/4/17 through 5/5/17. Complaints reviewed in the course of this survey were complaint intake WY000002393, WY000002395, WY000002400, WY000002403, and WY000002405 The following common abbreviations are used throughout this document: DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse LPN: Licensed Practical Nurse CNA: Certified Nursing Assistant ADL: Activities of Daily Living Less commonly used abbreviations will be annotated in each deficiency	F 000		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide care in accordance to the resident's written plan of care for 1 of 13 sample residents (resident #26). The findings were:	F 282	Corrective Actions: Resident #26had a perimeter mattress and a floor mat added on 5/4/17 to care plan and the equipment was put into service on 5/4/17. Others Potentially Affected: Any resident has the potential to be affected by this practice.	6/9/17

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

NHA 5/24/2017

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
MAY 24 2017
Healthcare Licensing and Surveys

6/1/17 - 9:49Am - Spoke c Mike Speidel administrator
Plan of correction accepted.
Tim

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F 282	Continued From page 1 Observation on 5/4/17 at 3:40 PM showed resident #26 was on his/her knees by the side of the bed in his/her room. There was no fall mat on the floor, and the bed had a flat mattress with no bolsters in place. Review of care plan, last revised 5/4/17, for resident #26 showed the resident had a brief interview of mental status (BIMS) score which indicated "severe cognitive impairment related to recent seizure activity." An intervention, initiated 4/11/17, was "staff will insure [sic] that bolsters are added to my bed for safety." Further review of the "resident room care plan," dated 4/10/17, showed areas marked for positioning and safety included "bed bolsters-seizure pads," "mattress on floor beside bed" and "resident is a high risk for falls." Interview on 5/5/17 at 9:30 AM with the administrator revealed the expectation was for CNAs and staff to look at the care plan and follow the goals and interventions in place.	F 282	Systemic Changes: The Nursing Department staff will be educated on the timely intervention initiation of safety measures for residents at risk of falling. Education will be provided by the DON/designee on or before 6/9/17. Monitoring: A weekly audit will be completed by the Unit Managers to determine safety interventions are in place. The DON will report audit findings to the QAPI Committee monthly until such time as the QAPI Committee determines that compliance has been sustained.	
F 323 SS=E	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	F 323	Corrective Actions: Res #152, #199, and #200 have their call lights placed within their reach since 5/5/17. Call lights are functioning properly.	6/9/17

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F 323	Continued From page 2 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. (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, and resident and staff interview, the facility failed to ensure call lights were provided in an appropriate manner to allow residents to call for assistance, creating a potential for hazard or harm during 3 of 3 random observations of residents in their rooms (residents #152, #199, #200). The findings were: Observation on 5/4/17 at 1:05 PM showed resident #199 was sitting in a geri-chair type wheelchair positioned at the end of his/her bed. The resident's call light was placed at the head of the bed, near the pillows and out of reach of the resident. Review of the resident's care plan showed the ADL for mobility intervention was "I use a gerichair for mobility and require one staff assist to mobilize me to all destinations." Observation on 5/4/17 at 2:25 PM showed resident #200 lying in bed in his/her room with his/her eyes closed. The call light for the resident was lying on the floor, below the side table	F 323	Others Potentially Affected: All residents have the potential to be affected by this practice. Systemic Changes: All staff will be re-eduated on the need to place call lights within the resident's reach, and to observe for call light placement whenever in a resident's room. Education will be provided by the DON/designee on or before 6/9/17. Monitoring: Daily call light audits will be completed by all Nursing Administration and Department Head Members. Audits will be reported to the QAPI Committee for further analysis and recommendations; until such time that the QAPI Committee determines that compliance has been sustained.	

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F 323	Continued From page 3 positioned alongside the right side of the bed. At 2:28 PM a staff member entered the room and spoke to the resident's roommate about a medical form. The staff member left the room at 2:32 PM without noticing the call light for resident #200 was on the floor. At 2:44 PM a certified occupational therapy assistant (COTA #1) entered the room, spoke with the roommate, and exited the room at 2:50 PM without noticing the call light on the floor. At 3:06 PM a CNA #3 entered the room and left at 3:08 PM without noticing the call light on the floor. Observation on 5/4/17 at 3:15 PM showed resident #152 was in bed with his/her eyes open and left leg hanging over the edge of the bed. A bedside table was alongside the left side of the bed at a distance of twelve inches from the mattress and positioned higher than the mattress, and the call light was draped over the table and hanging down several inches below the table top. Interview with the resident at 3:32 PM showed the resident was only to respond to questions with one syllable words, and s/he kept repeating the word "Why?". When asked if s/he could reach the call light, the resident did not verbally respond, but tried to move toward the call light and was unable to reach it. Interview on 5/5/17 at 11:38 AM with the DON revealed the call lights should be in reach of the residents, and she confirmed that resident #152 had weakness to one side of his/her body and it would have been appropriate to have the call light secured to the bed so s/he could easily reach it with his/her unaffected side. She further confirmed resident #199 was unable to propel him/herself in the wheelchair.	F 323		