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 03/30/2018

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SHEPHERD OF THE VALLEY HEALTHCARE CENTER	60 MAGNOLIA CASPER, WY 82604

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 3/29/18 to 3/3/18. The survey was prompted by compliant intakes WY000002528, WY000002539, WY000002584, and WY000002586. The following common abbreviations are used throughout this document: ADL: Activities of Daily Living. MDS: Minimum Data Set RN: Registered Nurse LPN: Licensed Practical Nurse CNA: Certified Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585		5/14/18

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

Electronically Signed | 04/18/2018

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.

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F 585	Continued From page 1 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as	F 585		

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F 585	Continued From page 2 necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to make prompt efforts to resolve grievances for	F 585	F585 Grievances Immediate corrective action: Resident #170 no longer resides at this	

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F 585	Continued From page 3 1 of 4 sample residents (#170) with care concerns. The findings were: 1. Review of the 3/1/18 quarterly MDS assessment showed resident #170 had a brief interview for mental status (BIMS) score of 15 (indicating s/he was cognitively intact), and required extensive assistance of 2 people for bed mobility, transfers, and toilet use. Further, the MDS showed no evidence behavior symptoms were present. The following concerns were identified: a. Review of a psychological services progress note dated 3/15/18 and timed 12:40 PM showed "...Resident is adamant throughout the session about staff not treating [him/her] right, not caring for [him/her] right, and neglecting [his/her] needs...Resident continues to assert feelings of powerlessness and persecution. Discussed incident recently where staff had to put a catheter in and it triggered memories from child sexual abuse. Discussed ways to remind [him/herself] without accusing staff of being inappropriate..." b. Review of a psychological services progress note dated 3/8/18 and timed 10:40 AM showed "...Resident continues to complain about staff and the food, insisting that staff will not help [him/her] when [s/he] needs it..." c. Review of a psychological services progress note dated 2/22/18 and timed 10:10 AM showed "...Resident continues to complain that the food is cold, there is no fresh fruit, and there are too many spices. Resident reports that if [s/he] complains too much, the nurses make things worse for [him/her]..." d. Review of a "nurses notes" entry dated 2/15/18 and timed 10:22 AM showed "...When the son reported overhearing someone interact with [the resident] re: [regarding] what medication	F 585	facility. Action as it applies to others: 1) All outstanding grievances have been addressed. A Resident Council meeting will be held to review grievances/concerns and to see if any other issues are noted. The Grievance/ Concern Policy remains current. DON/ADM and Grievance Officer were educated on the Policy and follow/up. Interdisciplinary Team (IDT) were educated on the policy requirements to ensure timely and satisfactory investigations and resolutions. All staff will be educated on the Grievance/ Concern policy to ensure prompt reporting of grievances/ Concerns All grievances will be reviewed at morning Quality Conference to ensure completion is timely and resolution satisfactory. Date of Completion: May 14, 2018 Recurrence will be prevented by: Three resident interview/audits regarding any grievances will be completed weekly on various units. Will also audit any current grievances/concerns each week to ensure response is timely and the resolutions is to the resident□s satisfaction. Audits will occur for the next 90 days. The results of these audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease or discontinue the audits based on the findings. The Correction will be monitored by the Administrator/Designee.	

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F 585	Continued From page 4 [s/he] was taking, that they stated to "just take it" [sic] This nurse assured him that this has not been the interactions witnessed by this nurse, and that if any patient (dementia or not) asks that the med aide or the nurse ought to tell the patient, and often they tell the patient generally what the medication is for rather than the technical name to help simplify the answers..." e. Review of the facility grievance log between 2/1/18 and 4/1/18 showed no evidence any grievances were filed for the resident during that time period. f. Interview with the unit manager on 3/30/18 at 2:15 PM revealed the facility required two staff members to provide care to the resident because the resident made accusations towards staff; however, the facility did not investigate the concerns that were brought up on 2/15/18, 2/22/18, 3/8/18, or 3/15/18. g. Review of the policy and procedure titled "Grievance/Concern" last revised 11/2016 showed "...Policy: 1. Any issue which involves a human being will be reported on a Grievance/Concern Report Form AND an incident report if there is potential for abuse, neglect, exploitation or misappropriation of funds. This will allow prompt investigation and reporting to appropriate agency or entity...Procedure: 1. Grievances/Concerns will be submitted orally or in writing, using the Grievance/Concern Report form and signed by the person filing the report..."	F 585		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		5/14/18

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F 677	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interview, and review of bathing documentation, the facility failed to ensure 3 of 12 sample residents (#68, #158, #170) who required assistance with bathing were provided assistance as required. The findings were: 1. Review of the 3/1/18 quarterly MDS assessment showed resident #170 had a brief interview for mental status (BIMS) score of 15 (indicating s/he was cognitively intact), and required extensive assistance of 2 people for bed mobility, transfers, toilet use and bathing. The following concerns were identified: a. Review of the bathing record between 3/1/18 and 3/27/18 for resident #170 showed the resident received showers on 3/4/18, 3/18/18, and 3/19/18. b. Review of the "Bathing hygiene Self-care deficit" care plan created on 12/6/17 showed the resident preferred "a shower or tub bath any time at least 2 times per week." 2. Review of the 2/20/18 annual MDS assessment showed resident #158 had diagnoses that included cancer, dementia, and depression. Further review showed the resident required extensive assistance of 1 staff member for bathing. The following concerns were identified: a. Review of the care plan for bathing and hygiene, updated 3/8/18, showed the resident's goal was "to be clean and odor free daily," and preferred to shower in the morning "at least 2 times a week." b. Review of the bathing documentation for January, February, and March 2018 showed 8	F 677	Immediate corrective action: Resident #170 no longer resides at this facility Resident #68, #158 had their individualized bathing care plans reviewed and remain current. These residents are being bathed per their individual preferences. Action as it applies to others: All residents will be reviewed to assure their bathing preferences are current. Future residents□ Plan of Care will address their bathing preferences Nursing staff will be educated on providing resident bathing per their preferences/per their individual plan of care. Staffing levels are reviewed each day and adjustments made as indicated based on census and acuity. Bathing preferences will also be considered when reviewing staffing and adjustments made in order to fulfill resident wishes for bathing. Bathing schedule sheets will be reviewed each day at Quality Wrap-up to assure all occurred as scheduled. Date of Completion: May 14, 2018 Recurrence will be prevented by: The Unit Managers/Designee will audit bathing preferences and ensure bathing completed per the individual resident□s preference. Audits will occur weekly on all units for the next 90 days. The results of these audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease or discontinue the audits based on the findings. The Correction will be monitored by the	

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F 677	Continued From page 6 weeks in which the resident only received 1 shower. 3. Review of the care plan for resident #68 with a review date of 1/25/18 showed the resident preferred to take a shower two times a week. The following concerns were identified: a. Review of the bathing documentation for January, February, and March 2018 showed the resident received showers on 1/25/18, 2/5/18, 2/15/18, 3/4/18, 3/20/18, and 3/29/18. b. Interview with resident #68 on 3/29/18 at 5:35 PM revealed the facility provided him/her with a shower 1 time per week. The resident stated if residents would like more frequent showers or baths, they can not have them because there is not nough staff. 4. Interview on 3/29/18 at 6:05 PM with LPN #1 revealed there was not enough staff at the facility. She stated the staff "backed each other up" to ensure cares were provided, but the shower aide was often pulled to the floor to fill empty CNA positions. 5. Interview on 3/30/18 at 10:55 AM with shower aide #1 revealed she had been staying past her scheduled shift to ensure residents on her unit received their scheduled baths. She stated she made sure every resident received 1 shower during the week before she started providing residents with a second shower. Additionally, she stated she had completed the first shower for all the residents on her unit, and had started to provide residents with their second showers of the week that morning. She added that if a shower aide was scheduled for the next day, Saturday, then more residents would receive a second shower. Review of her shower schedule	F 677	Director of Nursing/Designee.	

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F 677	Continued From page 7 for the day showed 8 residents were on the list to receive their second shower of the week. 6. Interview on 3/30/18 at 11:15 AM with CNA #2 and CNA #3 revealed when the facility was properly staffed, they made sure residents received their scheduled showers. They stated the facility was often not staffed fully, and "then we struggle" with providing showers. They added they were "steady with 1 bath a week" due to staff shortages. 7. Interview with the unit manager on 3/30/18 2:15 PM revealed residents should receive showers based on their preferences and should be encouraged to shower at least once per week. All refusals should be documented in the resident's record. Further, the facility has been monitoring showers in QAPI (Quality Assurance and Performance Improvement) as a result of the annual survey.	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on family and staff interview, medical record review, and review of emergency medical services records, the facility failed to promptly	F 684	Immediate corrective action: Resident #170 no longer resides at this facility.	5/14/18

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F 684	Continued From page 8 assess 1 of 3 sample residents (#170) who had a change in condition. This failure resulted in a delay in assessment and transport for resident #170, who had an emergency medical condition. The findings were: 1. Review of the 3/1/18 quarterly MDS assessment showed resident #170 had a brief interview for mental status (BIMS) score of 15 (indicating s/he was cognitively intact), and required extensive assistance of 2 people for bed mobility, transfers, and toilet use. The following concerns were identified: a. Review of a "Nurses notes" entry dated 3/27/18 and timed 8:56 AM showed "Resident reported to CNA that [s/he] was having chest pains. This nurse and other RN immediately responded to resident and found that [s/he] was on the phone with [his/her] son explaining to him that she was unable to get help. Resident expressed [s/he] was very scared and feeling extremely anxious, and expressed wanting to go to the hospital. 911 was called immediately and UM notified. Resident sent to [hospital] following c/o [complaints of] chest pain radiating down right arm and up right side of neck into [his/her] jaw. Resident left facility via gurney and ambulance at 0855." b. Interview with the resident's son on 3/30/18 at 10:32 AM revealed the resident contacted him at 7:20 AM on 3/27/18 and told him s/he was having chest pain and the call light had been on for 10 minutes. During the call, a staff member entered the resident's room, and the resident reported the chest pain. The staff member turned off the call light and left the room. The son reported that he told the resident to turn the call light on again. Further interview revealed that the staff member continued to come in and answer	F 684	RN# 1 and #2 received individual re-education on change in condition and need for immediate response for any resident complaining of chest pain. CNA #1 was educated to alert a different nurse should primary nurse be unavailable for immediate response if a resident is complaining of chest pain. Action as it applies to others: House audit of all residents with change of conditions with in the last 30 days will be completed to ensure that prompt response, assessment, and follow up was completed. All staff will be educated on change of condition to ensure prompt response, assessment and follow up completed. Date of Completion: May 14, 2018 Recurrence will be prevented by: The Unit Managers/Designee will audit to ensure all change of conditions are assessed and proper f/u completed. Audits will occur on all units weekly for the next 90 days. The results of these audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease or discontinue the audits based on the findings. The Correction will be monitored by the Director of Nursing/Designee.	

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F 684	Continued From page 9 the call light until around 8 AM at which time the nurse entered the room. The resident's son stated he knew the time the phone call with the resident began because he had checked his cell phone history. c. Interview with CNA #1 on 3/30/18 at 1:54 PM revealed she answered the resident's call light the morning of 3/27/18. She stated the resident requested a nurse because of chest pain and she reported it to the nurse at that time. Further interview revealed the CNA answered the call light two more times and reported the chest pain to the nurse again after answering the call light the subsequent times. The nurse went in "about 30 minutes" after being notified of the chest pain. d. Interview with RN #1 on 3/30/18 at 3:16 PM revealed CNA #1 reported the resident was having chest pain "during morning med pass." e. Interview with RN #2 on 3/30/18 at 4:27 PM revealed CNA #1 reported the resident was having "pain." The nurse revealed she gathered pain medication, entered the resident's room, and learned s/he was having chest pain. She further revealed the facility always sends residents with chest pain to the hospital, and the resident reported being "scared." f. Review of the 3/27/18 emergency medical services (EMS) patient care report showed the call to transport the resident to the emergency room was received at 8:35 AM. EMS arrived at the facility at 8:44 AM, and departed with the resident at 8:57 AM. g. Interview with the unit manager on 3/30/18 at 2:15 PM revealed the facility expectation was for a nurse to complete an assessment as soon as possible when chest pain is reported. The unit manager further revealed the resident was admitted to the hospital with a pulmonary	F 684		

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F 684	Continued From page 10 embolism.	F 684		