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 10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 10/8/18 to 10/9/18. The survey was prompted by complaint intakes WY00002695, WY00002696, and WY00002699. The following common abbreviations are used through this document: CNA; Certified Nurse Aide MDS : Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff and resident interview, and review of policies and procedures and employee files, the facility failed to ensure 4 of 10 sample residents (#36,	F 600	Past noncompliance: no plan of correction required.	10/25/18

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

Electronically Signed | 10/25/2018

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#41, #123, #148) identified in reported allegations of abuse and/or neglect, were free from abuse and/or neglect. This failure resulted in past non-compliance at actual harm to residents #34 and #41 who were physically injured by another resident (#137), and resident #123 who was spanked as a reminder to not go to the bathroom without assistance. In addition, this failure resulted in past non-compliance for neglect of resident #148 who was injured when staff failed to apply the required safety straps appropriately in the transport van. Corrective measures were implemented by the facility prior to the survey and compliance was determined to be met on 10/8/18. The findings were:

1. Review of the 8/30/18 nursing notes for resident #36 showed s/he told staff resident #137 hit him/her. Further review showed the nursing assessment of the resident's injuries included red areas on the right cheek, deltoid, and back areas. Review of the 8/30/18 nursing notes for resident #137 showed the resident reported s/he hit resident #36 because the resident came into his/her room. Interview on 10/8/18 at 2 PM with the staff development coordinator revealed both residents had dementia and resided in the closed care unit. She further stated resident #137 became angry when resident #36 entered resident #137's room on 8/30/18. Review of the facility's investigation of the incident and interview with the director of nursing (DON) on 10/9/18 at 9:30 AM revealed the facility reported the incident to the state survey agency on 8/30/18, and implemented corrective actions to prevent re-occurrence. The actions taken by the facility included:

a. At the time of the incident, staff responded promptly and separated the residents.

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One-to-one monitoring and every fifteen minute checks were implemented for resident #137 until s/he was admitted to a behavior management facility on 8/31/18. The resident received inpatient care and returned to the facility on 9/13/18.

b. The physician who provided care for the resident at the behavior management facility continued to provide guidance for staff and follow-up care for the resident after 9/13/18.

c. Staff reviewed this incident and past incidents to identify patterns, trends, and precipitating factors, including environment, medications and staffing. None were identified

d. Concerns regarding resident behaviors and incidents of abuse were being addressed by the Quality Assurance and Performance Improvement Committee.

e. Abuse education was provided for staff on 4/13/18 and 8/17/18.

2. Interview on 10/8/18 at 2 PM with the staff development coordinator revealed resident #137 and resident #41 had dementia and resided in the closed care unit. During the interview she stated resident #137 entered resident #41's empty room by mistake on 9/30/18. She further stated resident #41 found resident #137 in the room and asked resident #137 to leave. Interview on 10/9/18 at 3:10 PM with CNA #1 revealed she witnessed resident #137 "punching" resident #41 in the face multiple times on 9/30/18 when resident #41 asked resident #137 to leave resident #41's room. The CNA further stated staff responded promptly and intervened. Review of the 9/30/18 nursing notes for resident #41 showed resident #41 had redness on the left side of his/her face; and resident #137 did not have injuries. Observation of resident #41 on 10/9/18 at 10:05 AM showed s/he had a purple colored

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bruised area under his/her left eye and peri-orbital redness. Review of the facility's investigation of the incident and interview with the staff development coordinator on 10/8/18 at 2 PM, revealed the facility reported the incident to the state survey agency on 9/30/18 and implemented corrective actions to prevent re-occurrence. The actions taken by the facility included:

a. At the time of the incident, staff responded promptly and separated the residents.
One-to-one monitoring and every fifteen minute checks were implemented for resident #137 until s/he was admitted to a behavior management facility on 10/1/18. As of 10/9/18 the resident had not returned to the facility.

b. Staff determined when the resident returned to the facility the physician at the behavior management facility would continue to monitor the resident's medications and assist the staff in developing effective interventions to prevent re-occurring aggressive incidents.

c. Staff reviewed this incident and past incidents to identify patterns, trends, and precipitating factors, including environment, medications and staffing. None were identified

d. Concerns regarding resident behaviors and incidents of abuse were being addressed by Quality Assurance and Performance Improvement Committee.

e. Staff efforts to find alternate placement for resident #137 have been unsuccessful.

f. Abuse education was provided for staff on 4/13/18 and 8/17/18.

3. Review of the 8/17/18 quarterly MDS assessment showed resident #123 had severe cognitive impairment and ambulated with assistance. Review of the 8/27/18 care plan showed the resident required limited assistance

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of 1 with bed mobility, transfers and ambulation. Interview with the staff development coordinator on 10/8/18 at 2 PM revealed care assistant #1 witnessed CNA #2 spank resident #123 on 9/16/18 because the resident went to the bathroom without staff assistance. The staff coordinator further stated CNA #2 described her actions as a "love pat" to remind the resident not to go to the bathroom without assistance. Review of the nursing post-incident assessment revealed the resident did not have any visible signs of injury. Review of the employee file for CNA #2 showed no evidence of past similar incidents or record of abuse/neglect findings. Further review showed the CNA had received abuse/neglect training every 6 to 12 months and her certification was current. Review of the facility investigative report showed the incident was reported to the state survey agency on 9/16/18 and the corrective action to prevent re-occurrence was to terminate the employment of CNA #2 on 9/19/18.

4. Review of the 8/27/18 annual MDS assessment showed resident #148 had a brief interview for mental status (BIMS) score of 15 and was dependent on a wheelchair for mobility. Review of the corresponding care plan showed the resident required extensive assistance with transfers, toilet use, dressing, and personal care due to limited functional abilities and left leg amputation. Review of the 9/20/18 nursing notes showed the resident was injured in the van during transport to an appointment. Review of the facility's investigation of the incident showed the van driver did not apply the security straps appropriately. Interview with the staff development coordinator on 10/8/18 at 2 PM, revealed the van driver stopped at the stop light, then went forward when the light turned green

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and the resident fell backwards in his/her wheelchair. Review of the emergency department report, dated 9/20/18, showed the resident had a hematoma on the back of his/her head,and no fractures. Interview on 10/9/18 at 1:10 PM with the resident revealed when s/he "flipped over backwards, it scared the hell out of me." The resident also stated the hematoma was painful. Review of the van driver's employee file showed she received appropriate training prior to transporting residents and periodically thereafter. This review also showed she had not been involved in similar incidents during past years transporting residents in the van. Review of the investigative report showed the incident was reported to the state survey agency on 9/20/18; and staff implemented the following corrective actions to prevent re-occurrence.

a. Staff education was provided for all the van drivers.

b. A safety check of the van was completed to ensure the safety straps were functioning properly.

c. The van driver's employment was terminated.

5. Review of the 10 sample selected facility investigations, and facility policies and procedures showed the investigations were implemented and completed as directed by their abuse/neglect policies and procedures. Further review showed the policies and procedures were developed according to regulatory requirements.