PRINTED: 06/28/2005
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 06/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY	60 MAGNOLIA CASPER, WY 82604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 203 SS=D	483.12(a)(4)-(6) TRANSFER AND DISCHARGE REQUIREMENTS	F 203		

Scope & severity level was changed as a result of the Informal Dispute Resolution conducted July 27, 05 per Jean McLean, RD, Acting Manager, Office of Healthcare Licensing & Surveys.

Before a facility transfers or discharges a resident, the facility must:

Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

Record the reasons in the resident's clinical record; and

Include in the notice the items described in paragraph (a)(6) of this section.

Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

Notice may be made as soon as practicable before transfer or discharge when:

The health of individuals in the facility would be endangered, under (a)(2)(iv) of this section;

The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section;

An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or

A resident has not resided in the facility for 30 days.

F203 The facility shall ensure that resident transfer and discharge requirements are met. This will be accomplished by:

1. The development and implementation of a written discharge and transfer policy. — 7-11-05

2. Resident number 163 will receive a 30 day written notice of discharge articulating the reason for discharge as well as appeal and advocacy contacts. + all Residents who have a [illegible] — 6-14-05

3. The facility administrator will monitor the discharge process to assure that the above policies and procedures are properly administered. + report trends to the QA regarding — 7-11-05

Submitted for Jean McLean 7/12/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Keith Kristovich — TITLE: Administrator — (X6) DATE: 7-12-05

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.

The POC was accepted with corrections made on 7/15/05 @ 1355 by Keith Kristovich, administrator and Karen Womack, RN, Health Surveyor.

PRINTED: 06/28/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUM 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 06/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY	60 MAGNOLIA CASPER, WY 82604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 203	Continued From page 1 Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: The reason for transfer or discharge; The effective date of transfer or discharge; The location to which the resident is transferred or discharged; A statement that the resident has the right to appeal the action to the State; The name, address and telephone number of the State long term care ombudsman; For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, and review of facility records and medical records, the facility failed to notify one of one sample resident (#163) of discharge, the reason for discharge,	F 203		

PRINTED: 06/28/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HU N 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 06/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY	60 MAGNOLIA CASPER, WY 82604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 203	Continued From page 2 and failed to give advance notice of that discharge. In addition, the facility failed to ensure the resident had information related to the right to appeal and advocacy contacts. The findings were: Review of the facility's admission, transfer and discharge log revealed resident #163 left the facility on 4/29/05 at 2 PM for a hospital admission. The log then documented on 5/3/05 (no time) "Gave up Bed." Interview with the director of nursing (DON) on 6/14/05 at 1:27 PM revealed the resident's medical care was too complicated, the facility could not meet his medical needs, it took too much time and staff, and therefore, the resident had not been re-admitted. The DON could not state what care the resident now required, or how the resident's care was different than before. Interview with the assistant administrator on 6/14/05 at 1:26 PM revealed when facility residents required hospitalization, the bed was just held for the resident as long as the facility had space available. Interview with the assistant administrator and DON on 6/14/05 at 1:27 PM revealed the facility did not have a transfer or discharge policy. The following concerns were noted related to the resident's discharge from the facility: a. Medical record review revealed a notification of resident's rights, signed by the resident on admission, and dated 3/25/05. The document stated the resident had the right to be notified of discharge and the right not to be discharged unless: Services were no longer needed; Other residents were in danger; Or, lack of payment for services. Social service notes dated 5/3/05 (no time) revealed the resident was at the hospital and the facility administrator	F 203		

PRINTED: 06/28/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUM[illegible] 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 06/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY	60 MAGNOLIA CASPER, WY 82604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 203	Continued From page 3 decided not to accept the resident back. The notes revealed the decision was based on the resident's behavior, refusal for treatment, and the resident was "too medically complex." b. Review of the physician's discharge summary dated 5/9/05 documented the resident's condition on discharge was "stable" and the facility "refused readmission after acute hospital stay." Interview with the physician on 6/15/05 at 2:41 PM revealed the resident had "No fundamental change in medical status." The physician state the resident had been admitted to the hospital for stabilization of a respiratory problem and the facility refused to take the resident back. The physician stated there was no medical reason for why the resident had not returned. c. Interview with the social service director on 6/15/05 at 9:43 AM revealed the disclssion to discharge was made by the facility because the resident was "too medically complex." The director stated that when the resident left for the hospital, the facility and the resident anticipated the resident would return to the facility. The decision not to let the resident return was made "the following week." The director stated the resident was not told of the facility's decision; the hospital social worker and the resident's parents were told. The director stated the resident and the resident's parents were never notified in writing of the discharge or the right to appeal. d. Interview with the resident on 6/16/05 at 9:45 AM revealed he/she was never informed by the facility of their intent to discharge and he/she had never received any verbal or written information. The resident stated it was the hospital and his/her parents who had informed the resident. The resident further stated that he/she had been in and out of the hospital several	F 203		

PRINTED: 06/28/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUI J 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 06/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY	60 MAGNOLIA CASPER, WY 82604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 203	Continued From page 4 times and each time had anticipated he/she would return to the facility and had returned. This time was no different for the others. The resident stated feelings of being "let down" and stated, "I'm without a home."	F 203		