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 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITION AND WELLNESS	**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 10/29/18 to 10/30/18. The survey was prompted by complaint intakes WY00002705, WY00002709, and WY00002714. The following common abbreviations are used through this document: CNA: Certified Nurse Aide DON: Director of Nursing Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 600 SS=D	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 review of incident reports, and staff interview, the facility failed to ensure 1 of 17 sample residents (#17) identified in reported allegations of abuse and/or neglect, were free	F 600	1. No immediate corrective action taken for resident 17. At the time of the incident, resident was assessed and found to be without injury. The staff	12/14/18

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

Electronically Signed | 11/21/2018

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F 600	Continued From page 1 from abuse and/or neglect. The findings were: 1. Review of an incident report dated 10/11/18 showed CNA #1 was alleged to have been verbally and physically abusive towards resident #17. Review of a statement provided by CNA #2 on 10/11/18 at 4:35 PM showed CNA #1 was alleged to have told the resident if s/he didn't stop pinching the CNA, the CNA was going to pinch his/her genitalia. Further, it was alleged CNA #1 grabbed the resident's clothed groin area, pushed his/her hand arm down, and stated she was stronger than the resident was. The following concerns were identified: a. Interview with CNA #2 on 10/30/18 at 10:15 AM revealed CNA #1 asked her to assist with care for the resident. During care, the resident pinched CNA #1 on the arm and the CNA stated "If you don't stop pinching me, I am going to pinch your [genitalia]." CNA #1 grabbed the resident's clothed "groin." CNA #2 demonstrated the strength of CNA #1's grip by placing her hand on her upper arm and squeezing. Further interview revealed CNA #1 "pushed" the resident's arms down, told him/her she was "stronger" than the resident, and laughed. CNA #2 revealed CNA #1 "held a sling on [the resident's face] and laughed, saying it was Halloween." CNA #2 revealed she had not received any training on abuse and neglect except what was "briefly" covered in orientation. CNA #2 described the resident as "sweet" and stated s/he doesn't pinch intentionally. The CNA revealed the resident did not understand what s/he was doing and pinched staff related to contractures and an inability to open his/her hand fully. b. Interview with CNA #1 on 10/30/18 at 10:25 AM revealed she did tell the resident "stop pinching me or I am going to pinch you back."	F 600	member was suspended pending investigation and was subsequently terminated. 2. All residents have the potential to be affected. All staff will be educated on the types of abuse and neglect and examples of each will be given. Staff will be educated on how to identify signs of staff burnout. 3. The Interim Administrator, Director of Nursing (DON), Unit Managers and Staff Development Coordinator will be educated no later than Dec 7th, 2018 by the Director of Clinical Services on ensuring the investigations of staff to resident abuse allegations are inclusive of evaluating staff relationships if another staff member has made the accusation, assessing for staff burnout, and ensuring there are interventions put into place to prevent further occurrence. Additionally, the Staff Development Director will educate all staff on the types of abuse and neglect, as well as, signs of staff burn out. Education will be completed no later than Dec 12th, 2018 and those staff members not present at education sessions due to illness, vacation or casual work status will be educated upon their return prior to their first shift worked. 4. The DON and Interim Administrator together will review all investigations involving staff to resident allegations to ensure the investigation is complete, includes assessing staff relationships if applicable, assesses staff burnout, and includes an intervention to prevent further occurrence. All investigations will be reviewed weekly for four weeks and then	

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F 600	Continued From page 2 The CNA denied threatening to pinch the resident's genitalia, pushing the resident's arms down, and telling the resident she was stronger than him/her. The CNA revealed she did place a sling in front of the resident's face, not over it, and said "boo." c. Interview with the DON on 10/30/18 at 11:48 AM revealed no new interventions were implemented following the 10/11/18 allegation. d. Interview with the staff development coordinator on 10/30/18 at 12 PM revealed the facility does not review for possible staff burnout, does not evaluate staff relationships, and did not implement anything extra to prevent future occurrences. Further, she revealed the CNA #1 did not say she was upset or angry; however, it was revealed a fire alarm had sounded during the shift and the CNA said it caused her to fall "behind" on her work. The SDC revealed the facility might "need to do more on examples of what could be abusive above a normal interaction."	F 600	monthly for two months. Results of audits will be reported at the monthly Quality Assurance Process Improvement Meeting for further review and discussion to continue or discontinue audits based on the findings.	