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 12/18/2018

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

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 12/7/18 through 12/18/18. The survey was prompted by complaint intake(s) WY00002745, WY00002746, and WY00002751. The extended survey was completed on 12/18/18. The following common abbreviations are used through this document: BIMS: Brief Interview for Mental Status CNA: Certified Nurse Aide DNA: Deoxyribonucleic Acid (molecule that contains a unique genetic code) DON: Director of Nursing MAR: Medication Administration Record RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 610 SS=K	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 610		1/16/19

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

Electronically Signed | 01/07/2019

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F 610	Continued From page 1 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility investigation review, and staff interview the facility failed to implement measures to maintain 24-hour resident safety during an investigation to identify a potential perpetrator of an alleged sexual assault. This failure resulted in an immediate jeopardy situation related to lack of increased supervision to protect at-risk adults during the night shift. The census was 157. The findings were: 1. Review of the medical record showed resident #2 was admitted on 8/4/18 with diagnoses which included non-Alzheimer's dementia and anxiety. The resident had a BIMS score of 1, which indicated severe cognitive impairment. Further review of the medical record showed the resident presented to the emergency room on 11/4/18 due to a significant change related to respiratory status, and an assessment at that time prompted the hospital to perform a sexual assault forensic exam, and notify local law enforcement. 2. Review of the facility's investigation showed on 12/5/18 the facility was notified by the local law enforcement agency the sexual assault forensic evidence kit indicated there was DNA other than the resident's present (P30 Antigen; pre-seminal fluid). Further review showed the police planned to collect a DNA sample from the only male CNA on shift during the time period an assault was suspected to have occurred.	F 610	1. Resident 2 is safe and free from abuse. She has been monitored since her return from the hospital and has not had abnormalities noted in her skin assessments or a change in her baseline behaviors. The police department has closed the case due to insufficient evidence that an assault occurred. 2. All residents are at risk. Skin assessments were conducted on all residents and no evidence of abuse noted. 3. A staff member has been assigned to round in the facility 24/7 to ensure the safety of the residents. Staff were educated on the following: Staff to have increased awareness of any strangers/visitors in the facility and their location; awareness of residents from other units who are not on their home unit; awareness of any resident to resident relationships; awareness of residents wandering into other resident rooms, recognizing abnormal behavior and reporting to management; reporting anything that is suspicious or out of the ordinary to a manager immediately and observation and reporting of any resident injuries. Any staff member on vacation, sick leave, or on casual status during education sessions will receive education	

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F 610	Continued From page 2 3. Interview with the administrator, the assistant administrator, and the DON on 12/7/18 at 2:30 PM confirmed DNA was collected from one CNA on 12/6/18, and the CNA was suspended pending the results of the DNA testing. They stated 40 interviews of cognitively intact residents were conducted about feeling safe, and all residents felt safe. They provided additional education to staff about residents being in areas of the facility they didn't usually frequent, and awareness of visitors. They stated the wound care nurse conducted skin checks starting with female residents and also planned to assess all male residents' skin. They also assigned management staff to round for increased presence and awareness on each unit during the day and "in the evening." However, they confirmed no extra management staff had been scheduled to round on the night shift. The administrator stated the latest management staff was in the building was "in the evening." 4. On 12/7/18 at 6:10 PM the administrator, assistant administrator, and DON were notified of the immediate jeopardy related to the lack of resident protection during the night shift while a potential perpetrator of an alleged sexual assault remained unidentified. 5. The facility's action plan included the following corrective actions: a. Education to all staff on duty beginning on 12/6/18 in the following areas: i. awareness of strangers/visitors in the building and their location, ii. awareness of residents from other units who are not on their home unit, iii. awareness of any resident to	F 610	upon their first shift worked. 4. Rounding logs are completed after each rounding tour and turned into the Administrator for review. Any suspicious activity is reported immediately. Rounding logs will be reviewed daily Monday through Friday and any adjustments to duties or rounding activities will be made as needed and discussed at monthly QAPI for any additional changes to the program.	

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F 610	Continued From page 3 resident relationship, iv. awareness of residents wandering into other resident rooms, recognizing abnormal behavior and reporting these to managers, v. report anything that is suspicious or out of the ordinary to a manager immediately, observation and reporting of any resident injuries. b. Immediate implementation of specific management rounding of the facility 24/7. The rounding personnel will be comprised of staff from all departments and assigned exclusively to the rounding task. c. Education and training of managers to the rounding expectations which included filling out rounding logs. 6. The facility action plan was accepted on 12/8/18 at 12:10 PM and the immediate jeopardy was removed at 12:58 PM. Deficient practice, however, remained at a scope and severity of E (pattern of no actual harm with potential for more than minimal harm).	F 610		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		1/16/19

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F 755	Continued From page 4 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and review of medical records, narcotic administration logs, facility medication error reports, and policies and procedures, the facility failed to utilize pharmacy services to develop an effective system for ensuring pain medications were available when needed, and identifying and addressing medication errors. This failure affected 3 of 4 sample residents (#7, #8, #9) whose medication regime included scheduled pain medications. The findings were: 1. On 12/18/18 at 2:15 PM, interview with resident #7 revealed his/her scheduled pain medications were administered 1 to 3 hours late. S/he stated at times, s/he did not receive the medication because it was not available. Review of the physician's orders dated 11/5/18 showed an order for scheduled doses of oxycodone (narcotic pain medication) 30 milligrams (mg) every 6 hours for	F 755	1. Resident 7, 8 and 9 are receiving their narcotic pain medications on time and per MD order. 2. All residents who take narcotic pain medications are at risk. At the time of survey, all residents who receive narcotic pain medications were reviewed to ensure the correct dose was on hand and supply on hand was adequate. 3. The contracted pharmacy was contacted and a request for additional medication was made for those residents who take scheduled and as needed doses of the same medication. Additional medication cards will prevent the need for repeated reorders of the same medication. The nurses will be educated by the Director of Education no later than January 11, 2019 on the following: Ensuring there is adequate supply of	

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F 755	Continued From page 5 pain. Review of the November 2018 and December 2018 MAR and narcotic administration logs showed the following concerns were identified: a. On 11/10/18 the resident did not receive the 11 AM dose because the medication was not available. b. On 11/15/18 the 11 AM dose was documented on the MAR, but there was no record of this medication administration on the narcotic log. c. On 12/12/18 the medication was administered at 10:03 AM and 6:27 PM (more than 8 hours between doses). d. On 12/16/18 the medication was administered at 10:10 PM, with the next dose on 12/17/18 at 6:10 PM (8 hours between doses). e. On 12/17/18 at 2:25 PM the resident received 20 mg instead of 30 mg. The next dose was 30 mg, and was administered at 11:55 PM (over 10 hours between doses). Interview on 12/18/18 at 2:40 PM with RN#1 revealed the resident received the 20 mg dose because the 30 mg dose was not available at that time. She further stated this was not an error because staff obtained a physician's order that day for the 20 mg dose. 2. Review of the physician's orders for resident #8 showed an order dated 11/23/18 for oxycodone 10 mg every morning and at bedtime. The following concerns were identified: a. Review of the November 2018 MAR showed the nurses documented 10 mg was administered every morning on 11/23/18, 11/24/18, 11/25/18/ and 11/29/18. Further review showed the bedtime dose on 11/30/18 was also 10 mg. However, according to the November 2018 narcotic administration logs, the resident	F 755	narcotic medications so that residents do not miss doses when waiting for the reorder to arrive and ensuring any omission of medication is reported to the MD and a medication error report is completed, Additional education to nurses and medication aides included information on the 5 Rights to medication administration, which includes timeliness of medication administration. Those on vacation, sick leave, or on casual status will be educated upon their return to work, prior to their first shift worked. 4. A medication pass competency will be completed on every nurse and medication aide no later than January 11, 2019. Any nurse or medication aide on vacation, sick leave, or casual status will have competency performed upon their first shift worked. The DON or designee will audit three medication passes per week at random times and random units to ensure the 5 Rights of medication administration is followed. This will include timeliness of medication administration and narcotic medication availability. Additional audits will include audit of narcotic supply each week to ensure medication is available for administration. Audits will be weekly for four weeks and then monthly for three months. Results of audits will be discussed at monthly QAPI meetings for recommendation for continuation or discontinuation of audits based on weekly/monthly audit results.	

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F 755	Continued From page 6	F 755		

received 30 mg at those times, instead of 10 mg.

b. Review of the 12/7/18 physician's orders showed the order for oxycodone was changed to 20 mg every morning and at bedtime. Review of the narcotics logs showed the resident received 10 mg two times on 12/7/18, 10 mg in the morning and 20 mg at bedtime on 12/8/18, and on 12/9/18 received none that morning and 10 mg at bedtime.

c. During an interview on 12/18/18 at 3:20 PM, the DON acknowledged the medication errors and stated he had not been aware of the errors.

3. Review of the November 2018 and December 2018 physician's order for resident #9 showed an order for Morphine (narcotic pain medication) 30 mg two times every day for pain. The following concerns were identified:

a. Review of the November 2018 and December 2018 narcotic administration logs showed the dates/times the resident received Morphine 30 mg were not the same as documented on the MAR for 11/10/18, 11/15/18, 11/29/18, and 12/12/18.

b. During an interview on 12/18/18 at 3:20 PM, the DON revealed this inconsistency was a "dating error."

4. Interview on 12/18/18 at 2:40 PM with RN #2 revealed the process for refilling narcotic medications was complex and time-consuming. She stated the reorder process for refills should be initiated before the last dose of the medications was administered. She stated sometimes the nurses waited until after the last dose was administered before initiating the reorder process. She further stated this made it difficult to have the next scheduled dose

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F 755	Continued From page 7 available. 5. Interview on 12/18/18 at 4:35 PM with the DON revealed he was working on developing a process for identifying variances, reconciling narcotic usage with physician orders, implementing staff competencies, and revising current procedures for medication errors. He further stated staff had talked with the pharmacist that week about sending a larger supply of pills for resident #7 to reduce the number of times staff had to implement the medication reorder/refill process. 6. Review of the policy and procedure titled, "Medication Error", revised December 2014, showed "Errors will be documented, investigated, reported and reviewed for need of interventions and to prevent recurrence." A review of the medication error report showed 3 medication errors occurred from 11/1/18 to 12/18/18; none of the errors identified on 12/18/18 were included in the report.	F 755		