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 12/13/2019

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 12/11/19 to 12/13/19. The survey was prompted by complaint intake WY00002981. The following common abbreviations are used through this document: DON: Director of Nursing RN: Registered Nurse CNA: Certified Nursing Assistant 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 review of facility incident reports, emergency room (ER) admission report review,	F 600	Past noncompliance: no plan of correction required.	1/3/20

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

Electronically Signed | 01/03/2020

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 12/13/2019

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 600	Continued From page 1	F 600		

disciplinary action form review, "Plan of Correction" review, training record review, medical record review, staff interview, and policy and procedure review, the facility failed to ensure residents were free from neglect for 1 of 7 sample residents (#8) reviewed for incidents and accidents. This failure resulted in actual harm to resident #8, who required treatment at the hospital after falling during transport while not properly secured. The failure was determined to be past non-compliance. Corrective measures were implemented by the facility and compliance was determined to be met on 12/11/19. The findings were:

1. Review of a facility incident report dated 12/11/19 and timed 7:34 PM showed resident #8 was on the facility transportation van and tipped over. The resident was transported to the ER for evaluation. The following concerns were identified:

a. Review of a statement dated 12/11/19 showed van driver #1 reported she picked up the resident at a doctor's office and loaded the resident in the van. The van driver attached the 2 rear straps to the resident's wheelchair; however she "was in a hurry" and did not secure the 2 front straps. During transportation, the resident "tipped backward" and the van driver pulled into a parking lot where she checked on the resident and contacted the facility.

b. Review of an "ER Admission Report" dated 12/11/19 and timed 5:30 PM showed the resident was transferred to the hospital after leaving a doctor's appointment. Further review showed the resident reported "...The Driver did not secure [his/her] wheelchair; and when they started to drive, [s/he] flew backwards out of [his/her] wheelchair hitting [his/her]head. [S/he] said [s/he]

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 12/13/2019

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 600	Continued From page 2	F 600		

saw stars, did not pass out, and has neck pain..." The hospital placed a "collar" for treatment of the neck pain and admitted the resident for observation.

c. Review of a "disciplinary action form" dated 12/11/19 showed "...Employees comments: I am so sorry for my negligence. I can assure you this will never happen again..."

d. Interview with van driver #1 on 12/12/19 at 4:21 PM revealed when the resident was picked up, the van driver was "running far behind" and the resident had been waiting for "over an hour." The van driver revealed she secured the 2 rear straps, but failed to secure the 2 front straps, which resulted in the resident's wheelchair tipping backwards during transport. The van driver revealed there was disciplinary action for running late; however, the van was "over-scheduled" and she felt "burnt out" due to the heavy work load.

e. Interview with the DON on 12/12/19 at 3 PM revealed all van drivers were trained to strap in wheelchairs, correctly use van lifts, van and lift weight limits, oxygen tank securement, and safety checks prior to driving the van.

2. Review of the "Plan of Correction related to van incident on 12/11/19" showed the facility planned to provide immediate education to van drivers with return demonstration on securing residents, suspended the van driver, and instituted audits for return demonstration of van securement. Results of the audits were to be reviewed monthly at the quality assurance and performance improvement (QAPI) meeting for 3 months.

3. Review of the "Coach Driver Training Record" showed the facility performed training with 4 of 6 van drivers (including van driver #1) on 12/11/19,

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 12/13/2019

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 600	Continued From page 3 and 2 of 6 van drivers had a training date of "12-19." Return demonstrations and a written exam were performed by 6 of 6 van drivers on 12/11/19. 4. Review of the policy titled "Abuse, Corporal Punishment, Involuntary Seclusion, Mistreatment, Neglect, Misappropriation of Resident Property, and Exploitation" updated September 2017 showed "...Neglect: Failure of the Center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress..."	F 600		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, review of facility incident reports, and policy and procedure review, the facility failed to ensure resident safety for 1 of 6 sample residents (#2) reviewed for falls. This failure resulted in actual harm for resident #2, who fell and sustained a fracture shortly after admission to the facility. The findings were: 1. Review of the admission MDS assessment dated 11/12/19 showed resident #2 had an	F 689	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Shepherd of the Valley Rehabilitation and Wellness Center does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative	1/9/20

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 12/13/2019

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 689	Continued From page 4 admission date of 11/7/19 and diagnoses which included cancer, fusion of the spine, anxiety disorder, schizophrenia, and muscle weakness. The resident had a BIMS score of 9, indicating moderately impaired cognition. Further review showed the resident required the extensive assistance of 1 person for bed mobility, transfers, locomotion on the unit, and toilet use, extensive assistance of 2 or more people for dressing, and total assistance of 1 person for bathing. The following concerns were identified: a. Review of the facility policy titled "Fall Evaluation (Morse Scale) and Management" updated March 2008 showed "Policy Statement: The Center implements a fall management plan based on medical history review and resident evaluation...Admission: 1. The licensed nurse (LN) completes the Morse Scale on admission to the Center. a. All residents have the potential of falling. Certain factors that may require implementation of specific care plan measures are: i. if the total Morse Scale score is greater than 45, the resident is considered as having High Potential for falls. Implement appropriate care plan interventions for fall management..." b. Review of an incident report dated 11/7/19 and timed 8:05 PM showed staff walked past the resident's room and saw him/her lying on the floor next to the bed. The resident's right wrist was swollen and painful. The resident told staff s/he went to the bathroom and fell twice, once after toileting him/herself and once while trying to clean the toilet. Review of the "other info" section showed "Resident was educated on use of call light which was within reach clipped to [his/her] bed spread. Educated on no self transferring as well. Per sister resident had been self transferring and unsafe at the hospital." Review of the "notes" section showed "soft touch call light, education to	F 689	proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency The facility will ensure the resident environment remains as free of accident hazards as is possible. This will be accomplished by: Resident #2 is no longer residing in the care center. Any new admission who is at risk for falls is identified to be at risk for falls. 100% audit will be completed by facility on all new admissions in the last 30 days to ensure pro-active fall prevention interventions were identified and put into place if patient at mod-high risk. All licensed nursing staff will be educated by SDC or designee to the above deficiency and expectations for evaluation and pro-active interventions to be implemented for those residents identified to be a moderate to high fall risk, including timely care planning. The Director of Nursing or designee will audit all new admissions for MORSE fall scale, for identified moderate to high risk residents and appropriate pro-active interventions in place and documented. Results of audits will be reviewed at monthly QAPI meetings X 3 months to address findings and determine continuation.	

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 12/13/2019

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 689	Continued From page 5	F 689		

use call light before getting up."

c. Review of a progress note dated 11/7/19 and timed 9:30 PM showed the resident was transported to the hospital after falling twice. Review of a progress note dated 11/8/19 and timed 1:47 AM showed the resident returned from the hospital with a diagnoses which included "radial distal fracture and ulnar styloid fracture" which were "splinted." The resident was to follow up with orthopedics in "2-3 days."

d. Review of a physician progress note dated 11/19/19 showed the resident was scheduled for surgical intervention related to the right wrist fracture on "Thursday."

e. Review of the care plan last revised on 11/18/19 showed the resident's care plan for falls was not initiated until 11/8/19, after the resident had already fallen in the facility. The plan showed the resident had "an actual fall with [sic] r/t [related to] poor balance". Interventions initiated on 11/8/19 included "I need reminders to use my call light before getting up until I am stronger", "I prefer a soft touch call light", "neuro-checks per protocol", "provide me activities that promote exercise and strength building where possible", and "PT [physical therapy] consult for strength and mobility".

f. Interview with the DON on 12/12/19 at 3 PM revealed the resident admitted to the facility following a spinal fracture and the facility did not implement a fall care plan until after the resident's fall on 11/7/19 because staff were "still getting to know [him/her]."