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 12/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITATION 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 from 11/26/19 to 12/10/19. The survey was prompted by complaint intake WY0002976. The following common abbreviations are used through this document: DON: Director of Nursing RN: Registered Nurse LPN: Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of	F 660		1/17/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/03/2020

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F 660	Continued From page 1 developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and	F 660		

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F 660	Continued From page 2 data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on medical record review, and family, staff, and adult protective services interview, the facility failed to ensure adequate discharge planning to reduce factors leading to preventable readmission for 1 of 3 sample residents (#1) who discharged from the facility. The findings were: Review of the discharge MDS assessment dated 10/16/19 showed resident #1 had a brief interview for mental status (BIMS) score of 15, indicating the resident was cognitively intact, and had diagnoses included Parkinson's disease, cellulitis of right and left lower limb, unspecified dementia without behavioral disturbance, major depressive disorder, chronic pain, atherosclerotic heart disease of native coronary artery without angina pectoris, and cerebrovascular disease. Further review showed the resident required extensive assistance for bed mobility, transfers, locomotion, dressing, toilet use, and personal hygiene, and required total assistance for bathing. Review of the care plan titled "I have an ADL [activities of daily living] self-care performance deficit r/t [related to] dementia, limited mobility", initiated on	F 660	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 proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. The facility will ensure there is an effective discharge planning process. This will be accomplished by: Resident #1 is no longer residing in the care center. Residents who are not recommended for discharge but insist on leaving are	

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F 660	Continued From page 3 9/9/19 showed the resident required the extensive assistance of two staff members with toileting and incontinence care, was totally dependent on 2 staff members for transfers with the use of a mechanical lift, and required the extensive assistance of one staff member for bed mobility, personal hygiene, dressing, and grooming. Review of an "OT [occupational therapy]-Therapist Progress & Discharge Summary" note dated 10/15/19 and timed 10:51 AM showed "...caregivers report safety concern during ADLs and functional transfers...The pt. [patient] stated [s/he] and [his/her] son are getting on a bus and going to ND [North Dakota] where they plan to look for work and stay in a homeless shelter. The Pt. and [his/her] son were advised that this not a safe DC [discharge] plan. Review of a "PT [physical therapy]-Therapist Progress & Discharge Summary" note dated 10/15/19 and timed 2:40 PM showed "...Patient discharging with family to possible homeless shelter in North Dakota. Patient has no DME [durable medical equipment] so this will cause a problem with leaving the facility. Patient family educated [s/he] needs a wc [wheelchair]." Review of a "Discharge Summary" with an "effective date" of 10/14/19 showed the anticipated date of discharge was 10/16/19 and the reason for discharge was "Wanted to go to North Dakota with son and DIL [daughter-in-law]." The discharge address was "Bismarck North Dakota" and transportation arrangements showed "Family to transport to greyhound bus." The social services summary section showed "Resident wants to discharge with [his/her] son to North	F 660	identified to be at risk. The facility will complete 100% base line audit of any resident meeting this criteria within the last 30 days for any potential safety concerns. IDT including all Social Service staff will be educated to the above deficiency and expectations including discharge instructions on resident care needs risks and implications for a safe discharge. The Social Services Director or designee will audit all resident discharges of those who are to be determined unsafe for discharge by IDT for any discrepancies related to safe discharge and reasonable means for a safe discharge attempted by the facility. Results of audits will be reviewed at monthly QAPI meetings X 3 months to address findings and determine continuation.	

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F 660	Continued From page 4	F 660		

Dakota. [S/he] is cognitively alert to make that decision..." The discharge summary showed other special needs or comments were "Facility gave [him/her] wheelchair. No extra services due to going across state lines." Review of the discharge summary skin assessment showed the resident had a "pressure" wound to the "right lower leg (rear)" and "left lower leg (rear)." There were no measurements or wound stage indicated. Further review of the discharge summary showed "Other Referrals (Meals on wheels, lifeline, community resources): N/A [not applicable] due to crossing state lines" and "Future appointments: Family will make as soon as they get to ND", and the prognosis was "poor."

Review of a progress note dated 10/16/19 and timed 9:43 AM showed "Resident discharged from facility this morning at 0800 [8 AM]. Family present at discharge. Discharge instructions given and medication listed given. All currently scheduled medications sent with resident on discharge, including scheduled pain medication (Percocet). Resident's belongings packed in bag (per request) and taken to cab with resident. Resident's last bowel movement was 8 shifts ago with MOM [milk of magnesia] administered yesterday. Additional medication not provided today as resident and family were going to be boarding a Greyhound bus to travel to ND [North Dakota]." The following concerns were identified:

1. Review of the medical record showed no evidence the facility presented or discussed more suitable locations or contacted other agencies such as adult protective services (APS). Further, there was no evidence the facility provided detailed written instructions on the resident's care needs, or the risks and implications of discharge to a location which was not equipped to meet the

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F 660	Continued From page 5 resident's needs to the resident or the resident's family. 2. Interview with the administrator, social services director, DON, and physical therapy director on 12/4/19 at 2:32 PM revealed the facility had spoken to the resident and s/he was adamant s/he wanted to go. They confirmed the resident discharged from the facility on 10/16/19, and the facility did not attempt to set up services for the resident because s/he was discharging across state lines. They stated the facility did not know the details of the discharge location, and safety was a concern at the time of discharge; however, review of the 10/14/19 discharge summary showed the resident was planning to go to Bismark, North Dakota. They stated at the time of discharge the resident was not on antibiotics and had 1 "blister" that was open to his/her lower extremity. Further it was revealed if the resident had discharged to a local homeless shelter the facility would have contacted adult protective services. 3. Interview with the resident's son on 12/9/19 at 1:55 PM revealed he did not perform any wound care for the resident after the resident left the facility, and the resident's wounds became infected resulting in hospitalization for sepsis 5 days after discharge and subsequent admission to another nursing home. 4. Interview with North Dakota APS worker #1 on 12/9/19 at 2:09 PM revealed APS received a report of concern on 10/21/19 related to a lack of care and smells of urine and feces coming from a local hotel room. The APS worker went to the hotel room on 10/24/19 and found the resident in a wheelchair with urine and feces-soiled dressings to his/her legs. The resident's son told the APS worker the resident had remained in the wheelchair for the several days they had been in	F 660		

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F 660	Continued From page 6 the hotel room, and had not been transferred to either bed or toilet. After removal of the resident's socks, the APS worker observed the resident's feet to be "red and inflamed" with "pus-filled" sores to the feet. The resident's son told the APS worker he had been instructed by the facility to not change the dressings. The resident was taken to a local hospital, admitted for sepsis and treated with intravenous antibiotics. The APS worker stated the resident was currently in a nursing home in North Dakota and a guardianship had been implemented.	F 660		