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 _____	01/31/2020

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 recertification survey was conducted by Healthcare Licensing and Surveys from 1/27/20 through 1/31/20. Also reviewed in the course of the survey were complaint intakes WY00002986, WY00002989, and WY00002990. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CAA- Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing Services LPN- Licensed Practical Nurse MAR- Medication Administration Record MDS- Minimum Data Set NHA- Nursing Home Administrator RN- Registered Nurse TAR- Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 582		3/5/20

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

Electronically Signed | 02/24/2020

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F 582	Continued From page 1 (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.	F 582		

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F 582	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the appropriate Notice of Medicare Provider Non-Coverage (NOMNC) and Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (ABN) were issued correctly for 3 of 3 sample residents (#78, #108, #334). The findings were: 1. Review of the NOMNC/ABN forms for resident #78 showed the last covered day for Medicare Part A services was 8/21/19 and both forms were signed by the resident. Review of the medical record showed the resident was deemed incompetent before that date, and his/her guardian was the one responsible for signing the notices. Further, neither of the notices were signed within the required timeframe; the NOMNC was signed on 8/20/19 and the ABN was signed on 8/22/19. 2. Review of the NOMNC/ABN forms showed the last covered day for Medicare Part A services for resident #108 was 1/1/20. A note on the form showed the resident's responsible party was "verbally notified on 12/20/19." However, there was no evidence of the notice being sent or given to the resident's responsible party. 3. Review of the NOMNC information showed resident #334 had a last covered day for Medicare Part A services on 12/12/19. However, the facility failed to provide the notice. 4. Interview with the social services director (SSD) and social services assistant (SSA) on 1/30/20 at 11:19 AM revealed the following:	F 582	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 exists, 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… 1. The NOMNC/ABN forms were corrected and completed on 2/11/20 for Resident 108 by her husband. No corrective action for Resident 78 as she is deceased. No corrective action for Resident 334 as he discharged himself from the facility. 2. Initial audit will be completed by Social Services by 3/5/20, to ensure NOMNCs/ABNs were done on anyone discharged from facility in last 60 days. Audit also addresses NOMNCs/ABNs, ensuring they were done on anyone remaining in the facility after a payer source change. The team will discuss change in payer sources and discharges daily at quality conference meeting for any payer source changes or discharges occurring within the upcoming week, to ensure forms are completed at the appropriate time. 3. Social Services, Business Office, and	

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F 582	Continued From page 3 a. Resident #78 had a guardian at the time the notice was signed, and the guardian should have been given the notice. b. The SSA stated she had contacted the responsible party for resident #108, who said he would be in to sign the form, however she did not mail a copy of the notice following the verbal notification. c. The SSD stated they did not know of any NOMNC form signed by resident #334. d. Regarding the ABN forms for residents #78 and #108: The SSD and SSA confirmed there were 3 options to choose from and they had been uncertain about what each of the options meant. They used a "default" of having the resident select the option of "I want the care listed above, but don't bill Medicare." For resident #78 and #108 this had been marked although neither of the residents wanted to pay privately to receive skilled services.	F 582	MDS personnel received education on 2/5/20 by Asst. ED, to ensure NOMNC/ABN are done any time it is appropriate to administer one, and on 2/17/20 by Asst. ED on how to complete and administer NOMNC/ABN forms. 4. The DNS or designee will audit all changes in payer source each week, to ensure there was a NOMNC/ABN completed. Audits will be weekly for four weeks and then monthly for two 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.	
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on personnel file review, staff interview,	F 607	This plan of correction is prepared and	3/5/20

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F 607	Continued From page 4 and policy and procedure review the facility failed to ensure screening was completed prior to resident contact for 3 of 11 personnel (volunteer #1, volunteer #3, volunteer #4) reviewed. The findings were: 1. Review of the personnel records showed the following concerns: a. Volunteer #1 started in the facility on 6/3/19 and the background check was completed on 1/29/20. b. Volunteer #3 started in the facility around 30 years ago per the administrator, (no hire date noted) and the background check was completed on 1/29/20. c. Volunteer #4 started in the facility on 1/3/20 and was released on 1/13/20. The background check was completed on 1/29/20. 2. Review of the "Volunteer Program" policy updated July 2015 showed ...3. A file is maintained for each volunteer that contains: ... f. Criminal background check (per state law). ... Review of the "Hiring Employment Policies" employee handbook showed ... Background checks: When considering an applicant for hire, an investigation of the applicant's background is conducted... 3. Interview with the DON and administrator on 1/31/20 at 9:58 AM confirmed screening of volunteers had not been done prior to the survey, but was now being implemented.	F 607	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 exists, 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… 1. Current volunteers have been vetted and oriented according to facility policy to include background check. 2. An audit was conducted on all personnel files to confirm the appropriate background check information has been obtained. Audit will be done by HR by 3/5/2020, and any identified concerns will be addressed. 3. Management personnel received education on 2/5/20 and 2/20/20 by Asst. ED on addressing background checks for all employees, volunteers, and contractors. The HR Director or designee will audit all employee, volunteer, and contractor files to verify policy was followed and background results were received, by 3/5/2020. Education also included policy on screening volunteers, employees, and contractors, ensuring background checks are completed prior to first shift in facility. 4. The HR Director or designee will audit all volunteers' files to ensure the volunteer program was conducted with every	

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F 607	Continued From page 5	F 607	working volunteer. Audits will then be done on any new volunteers moving forward. Audits will be weekly for four weeks and then monthly for two 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.	
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions.	F 636		3/5/20

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F 636	Continued From page 6 (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure completion of various CAAs for 7 of 28 sample residents (#6, #25, #29, #31, #63, #78, #95) with comprehensive assessments. The findings were:	F 636	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 exists, nor	

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F 636	Continued From page 7 1. Review of the 10/21/19 annual MDS assessment showed resident #6 triggered for care area assessments to be completed for the areas of Cognitive Loss/Dementia, Communication, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Activities, Falls, Nutritional Status, Feeding Tube, Dehydration/Fluid Maintenance, Pressure Ulcers, and Pain. Review of these CAAs showed one or more sections were not completed for this resident. 2. Review of the 6/3/19 admission MDS assessment showed resident #25 triggered for care area assessments to be completed for the areas of Cognitive Loss/Dementia, ADL Functional/Rehabilitation Potential, Falls, Pressure Ulcers, and Psychotropic Drug Use. Review of these CAAs showed one or more sections were not completed for this resident. 3. Review of the 5/23/19 admission MDS assessment showed resident #29 triggered for care area assessments to be completed for the areas of Cognitive Loss/Dementia, Communication, Urinary Incontinence and Indwelling Catheter, Falls, Pressure Ulcers, Psychotropic Drug Use, and Pain. Review of these CAAs showed one or more sections were not completed for this resident. 4. Review of the 5/17/19 annual MDS assessment showed resident #31 triggered for care area assessments to be completed for the areas of Cognitive Loss/Dementia, Visual Function, Communication, Urinary Incontinence and Indwelling Catheter, Behavioral Symptoms, Falls, Nutritional Status, Dental Care, Pressure Ulcers, and Psychotropic Drug Use. Review of	F 636	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… 1. CAA's on Resident's 6, 25, 29, 31, 63, 78, and 95 were reviewed for accuracy. Modification will be completed by MDS team by 3/5/20. 2. Audit of CAAs was completed by MDS on 2/19/20, auditing the last 6 months of MDSs, making necessary corrections/addendums for identified areas of deficiency. 90 comprehensive MDS assessments were reopened and audited by all MDS team members. All members of the MDS team were educated on the change in process, ensuring CAA worksheets are filled out to their entirety prior to closing any comprehensive MDS assessments. 3. MDS team were educated by AED on 2/17/20, to ensure all CAA's are completed with every trigger from MDS. 4. The MDS Coordinator or designee will audit random MDS assessments to ensure triggering CAA's were accurately completed. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	

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F 636	Continued From page 8 these CAAs showed one or more sections were not completed for this resident. 5. Review of the 11/18/19 significant change MDS assessment showed resident #63 triggered for care area assessments to be completed for the areas of Cognitive Loss/Dementia, Visual Function, Communication, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Pressure Ulcers, and Psychotropic Drug Use. Review of these CAAs showed one or more sections were not completed for this resident. 6. Review of the 9/26/19 significant change MDS assessment showed resident #78 triggered for care area assessments to be completed for the areas of Delirium, Cognitive Loss/Dementia, Behavioral Symptoms, Falls, Nutritional Status, Pressure Ulcers, and Psychotropic Drug Use. Review of these CAAs showed one or more sections were not completed for this resident. 7. Review of the 5/6/19 annual MDS assessment showed resident #95 triggered for care area assessments to be completed for the areas of Cognitive Loss/Dementia, Visual Function, Communication, Urinary Incontinence and Indwelling Catheter, Activities, Falls, Nutritional Status, Dental Care, Pressure Ulcers, Psychotropic Drug Use, and Pain. Review of these CAAs showed one or more sections were not completed for this resident. 8. Interview with the MDS coordinator and RNs #1 and #2 on 1/31/20 at 8:29 AM revealed there was a need to ensure all CAAs were being checked for completeness.	F 636		
F 641	Accuracy of Assessments	F 641		3/5/20

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F 641 SS=D	Continued From page 9 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the comprehensive assessment was accurate for 1 of 28 sample residents (#185) with comprehensive assessments. The findings were: Review of the 1/16/20 admission MDS assessment showed resident #185 was not coded for wandering or any other behaviors during the look-back period. The following concerns were identified: a. Review of the 1/13/20, and timed 1:53 AM nursing progress note showed the resident was confused about his/her location and "...is looking for a ride to get his family member who is in a nursing home being treated for cancer. Resident wonders [sic] [wanders] the unit; tries to open doors that are pad lock secure; staff stays in sight." Review of the nursing progress note dated 1/13/20, and timed 6:19 PM showed "Per observation of resident being at risk for elopement, a wanderguard was placed on resident on left ankle. Family aware and supportive of this." b. Interview with the MDS coordinator and RNs #1 and #2 on 1/31/20 at 8:29 AM revealed the information related to behaviors was missed and caused the section to be inaccurate.	F 641	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 exists, 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… 1. A modification was done on 2/5/20, for Resident 185, to correct the coding on the already submitted MDS. Social Services has made note to ensure his next MDS is correct regarding target behaviors. 2. Audit for accuracy was completed by Social Services Director on 2/18/20 and MDS Coordinator on 2/19/20. Audit included any MDS submitted in the last 30 days to ensure behaviors were identified correctly. Any corrections identified were made during audit process. Concerning behaviors of residents will be discussed each morning when reviewing progress notes in Quality Conference meeting. Concerning behaviors will also be addressed with the psych committee	

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F 641	Continued From page 10	F 641	during the weekly psych meeting. 3. Social Services and MDS were educated on 2/5/20 to ensure behaviors are correctly identified on the MDS and to correct any discrepancy noted. 4. The DNS or designee will audit random MDS' each week to ensure accuracy of the MDS. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the activity calendars, the facility failed to ensure residents were offered meaningful and ongoing activities to improve or maintain physical, mental, and psycho-social wellbeing for 2 of 2 sample residents in the secured dementia unit (#25, #78). The findings were:	F 679	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 exists, nor does the center admit to any statements, findings, facts, or conclusions that form	3/5/20

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SHEPHERD OF THE VALLEY REHABILITION AND WELLNESS	60 MAGNOLIA CASPER, WY 82604

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F 679	Continued From page 11 Review of the 6/3/19 initial activity assessment for resident #25 showed the resident identified all activity preferences as "somewhat important" or "very important." Review of the care plan showed the resident enjoyed playing a banjo, listening to music, fishing, and watching TV. Review of the 9/26/19 significant change activity assessment for resident #78 showed the resident identified 6 of 8 activity preferences as "somewhat important" or "very important." Review of the care plan showed the resident enjoyed "...cards, games, exercise, sports, reading & writing, shopping and being outdoors, gardening/planting, hobbies, socials/parties, socializing with others and some volunteering." Review of the the Secured Unit activity calendar for January 2020 showed 7 to 8 activities were scheduled each day, but with no scheduled times. The following concerns were identified: 1. Observations of the secured unit occurring on 1/27/20 from 1 PM to 6 PM, 1/28/20 from 8:30 AM to 11:55 AM and from 2:15 PM to 6:15 PM, and 1/29/20 from 9:30 AM to 12:05 PM, and from 1:25 PM to 6:10 PM revealed a single activity was observed on the morning of 1/29/20. This involved the activities aide using her phone to play various songs and asking the residents if they enjoyed those songs. Throughout the observation periods, residents #25 and #78 were not engaged in any meaningful activities. 2. Interview with RN #4 on 1/28/20 at 9:50 AM revealed activities in the secure unit sometimes occurred twice a day, however there were many days activities did not occur at all due to low staffing numbers.	F 679	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… 1. Residents #25 and #78 have been interviewed and their care plans reflects current activities preferences. These activities preferences are now part of the scheduled activities calendar on the unit. 2. The Activities Director/designee has completed audit of resident activity preferences and has developed an activities calendar based on those preferences. Any changes in activity preferences will be identified during future care conference meetings and preferences will be added to activities calendar. Calendars include times of activities throughout the day. Activities will continue to be discussed at monthly Resident Council meeting, where any desired activities can be discussed as well as desired changes to the calendars. 3. Activities staff were educated on 2/5/20 by Activities Director, on the importance of varying activities, including scheduled activities specifically designed for resident interest. Activities Director will create an activities calendar and provide for individual activities that are based upon resident interests and preferences, and will include times of activities. PCC logins were requested for all activities personnel. Education was done on 2/27/20 by Activities Director, ensuring activities staff are documenting levels of	

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 _____	01/31/2020

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SHEPHERD OF THE VALLEY REHABILITION AND WELLNESS	60 MAGNOLIA CASPER, WY 82604

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F 679	Continued From page 12 3. Interview with the activities director (AD) on 1/29/20 at 10:41 AM revealed the dementia care unit did not have scheduled times for activities to allow for more flexibility based on when the activities aides were available. The activities director acknowledged that the 7 to 8 daily activities on the calendar allowed the staff to adjust or skip activities based on resident participation. However, she could not confirm which activities occurred each day because she had not been observing the activities in the secured unit. Further, the AD stated that the activities aides charted which residents were present for the activities, but did not track the level of participation.	F 679	participation from residents during activities. 4. The Administrator or designee will audit Activity Programming to ensure calendar includes activities of interest of residents, times of activities are listed on the calendar, and activities are occurring at the time listed on the calendar. Additionally, five random residents and/or resident representatives, will be asked if activity programming is meeting their interest/needs. Audits will be weekly for four weeks and then monthly for two 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.	
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, review of the "24-Hour book", and policy and procedure review, the facility failed to adequately track behaviors and ensure meaningful, resident-specific dementia care interventions were developed and implemented for 1 of 5 sample residents (#78) with significant behaviors related to a diagnosis of dementia. The findings were:	F 744	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 exists, 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	3/5/20

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	535042	A. BUILDING _____ B. WING _____	01/31/2020

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SHEPHERD OF THE VALLEY REHABILITION AND WELLNESS	60 MAGNOLIA CASPER, WY 82604

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F 744	Continued From page 13 Review of the 12/10/19 quarterly MDS assessment showed resident #78 had diagnoses that included dementia, anxiety, and depression. The resident was independent or required supervision for ADLs with the exception of bathing. According to the MDS, the resident did not have any behaviors exhibited, and received routine anti-psychotic and anti-depressant medication. Review of the January 2020 TAR showed behavior monitoring for "thoughts of hopelessness, isolating, hallucinations, delusions, increased complaints, and refusing care." The following concerns were identified related to behaviors: a. Observation in the dining room on 1/27/20 at 5:04 PM showed resident #78 was trying to have unwanted interactions with another resident, believing that resident to be his/her spouse. Multiple staff members simultaneously attempted to redirect and pull him/her away from the other resident, which resulted in escalated aggression and disruptive behavior from the resident. As the situation escalated, the staff did not exhibit knowledge of any other interventions that could be used. After 40 to 45 minutes, the unit manager LPN #1 entered the unit and redirected the resident within the next ten minutes. b. Observation in the dining room on 1/28/20 at 9:56 AM showed the resident was attempting to provide unwanted help to the same resident from the prior night. Two CNAs immediately attempted to separate the residents and one CNA told resident #78 "No, this is not your [spouse]. [S/he] is a resident here", which once again escalated the behaviors of the resident. At that time, RN #4 intervened and directed the CNAs not to argue with the reality of the resident because it caused increased agitation. c. Observation on 1/30/20 at 10:50 AM	F 744	legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. The facility will ensure… 1. Care Plan of Resident #78 was reviewed by IDT on 2/17/20, and adjustments were made to include behavior monitoring, targeted behaviors, resident specific activities, and effective redirection strategies. 2. The AED or designee will audit residents charts for those exhibiting behaviors and will verify that appropriate interventions are identified and there is tracking of the interventions effectiveness, by 3/5/20. IDT will review progress notes in morning meeting to identify and discuss any progress notes written regarding behaviors with any residents. 3. Education will be completed with licensed nurses by 3/5/20, regarding order of behavior monitoring to be put on MAR with new orders of psychotropic medications and where to find resident specific information. 4. DNS or designee will audit MAR to ensure new orders of behavior monitoring of psychotropic medications, were added to resident's MAR. Audits will be weekly for four weeks and then monthly for two 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 744	Continued From page 14	F 744		

revealed the resident wandered into another resident's room and kicked that resident out of their own room. Staff once again attempted redirection unsuccessfully.

d. Interview with RN #4 on 1/28/20 at 2:18 PM revealed she was knowledgeable about dementia and knew of interventions that were typically successful with the resident. However, the nurse felt the education provided at the facility related to dementia was minimal. When asked about specific behaviors and interventions, the nurse stated s/he did not feel there was a consistent system in place to monitor behaviors or provide feedback on the success of individual interventions.

e. Interview with the social services director on 1/30/20 at 11:56 AM revealed behavioral interventions for the resident involved calling the resident's family or providing redirection for the resident. As part of the interdisciplinary team, the SSD worked to determine interventions, but could not identify specific interventions for this resident. Additionally, the process for behavior tracking involved the nursing staff informing social services of daytime behaviors, going through nursing notes to identify behaviors, and behaviors were expected to be monitored for three days following a facility-reported incident.

f. Interview with RN #3 on 1/27/20 at 5:50 PM revealed the resident's behaviors had worsened about 3 days prior. The nurse had contacted the physician, who increased the dose of the resident's anti-psychotic medication and recommended increased fluid intake. The nurse and the CNA present could not identify any other interventions that would be effective for the resident. The RN further stated to her knowledge, behaviors were written in nursing notes, management reviewed those notes in morning

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	535042	A. BUILDING _____ B. WING _____	01/31/2020

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SHEPHERD OF THE VALLEY REHABILITION AND WELLNESS	60 MAGNOLIA CASPER, WY 82604

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F 744	Continued From page 15 meetings, and offered interventions through the 24-Hour book and the care plan. To her knowledge, there had not been any assistance provided in the past week on how to address the resident's behaviors. g. Review of the 24-Hour book for resident #78 showed notes with dates ranging from 10/19/19 to 1/27/19, but did not show any recommended interventions related to behaviors. There were three notes for the month of January, all of which were related to medication orders. Review of the nursing progress notes showed one note on 1/2/20 at 1 PM related to behaviors, "...resident was redirected to [his/her] room and oriented to [his/her] personal surrounding." h. Review of the 10/29/19 revised care plan related to getting along with others showed generalized behavioral interventions of: monitoring, redirecting, and encouraging activity participation. There were no resident specific activities included or effective re-direction strategies shown. However, under the elopement and wandering section of the care plan which was revised on 12/19/19, there were specific structured activities and re-orientation strategies such as "signs, pictures, and memory boxes." i. Review of facility policy titled "Behavior Management" showed "Residents exhibiting new behaviors are communicated to the Interdisciplinary Team (IDT) via the 24-Hour report...If a resident exhibits a new behavior symptom, staff implements the Behavior Monitoring Flowsheet...The Behavior Monitoring Flowsheet (number of behaviors, trigger, intervention, and outcome) is completed as the indicated behaviors are exhibited."	F 744		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		3/5/20

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	535042	A. BUILDING _____ B. WING _____	01/31/2020

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SHEPHERD OF THE VALLEY REHABILITION AND WELLNESS	60 MAGNOLIA CASPER, WY 82604

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F 755	Continued From page 16 §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. §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 observation, staff interview, and review policy and procedure, the facility failed to ensure medications were secured during a random observation of the South unit medication cart (cart #1). The findings were:	F 755	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	

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SHEPHERD OF THE VALLEY REHABILITION AND WELLNESS	60 MAGNOLIA CASPER, WY 82604

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F 755	Continued From page 17 1. Random observation on 1/30/20 at 9:30 AM showed the South unit medication cart #1 was unattended with 4 medication bubble packs on the top of the medication cart. The packs contained medications. In addition, the large bottom drawer was partly open, and the cart was unlocked. Continuous observation showed multiple people passed by it. On 1/30/20 at 9:37 AM the nurse came out of a resident's room and returned to the cart. Interview at that time with RN #5 confirmed she had left the medications out and left the cart open. Additionally, she revealed she should have secured the medication cart prior to attending a resident. 2. Interview with the administrator on 1/31/20 at 9:03 AM revealed it was the expectation of the facility for nursing staff to keep all medications secure. 3. Review of the policy and procedure "Medication Storage in the Facility" effective Date: August 2018 showed "...B ..."Medication rooms, carts, and medication supplies are locked when not attended by person with authorized access. ..."	F 755	deficiency listed on this form exists, 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… 1. The medication cart was locked, and medications secured, at the time of discovery. 2. Initial audit of medication carts was done at time of discovery. Unit Managers will continue to monitor medication carts and storage areas for dates and security. 3. Nursing personnel will receive education by 3/5/20, that all items kept in the medication carts must be properly secured when unattended. 4. The DNS or designee will audit medication carts, to ensure the medication carts are locked when left unattended. Audits will be weekly for four weeks and then monthly for two 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.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental	F 758		3/5/20

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 _____	01/31/2020

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 758	Continued From page 18	F 758		

processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

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 _____	01/31/2020

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 758	Continued From page 19 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure residents were free from unnecessary psychotropic medication for 1 of 7 sample residents (#78) reviewed for medications. The findings were: Review of the 12/10/19 quarterly MDS assessment showed resident #78 had diagnoses that included dementia, anxiety, and depression. The resident was independent or required supervision for ADLs with the exception of bathing. According to the MDS the resident did not have any behaviors exhibited, and received routine anti-psychotic and anti-depressant medication. Review of the January 2020 MAR showed the resident was started on Seroquel 50 mg twice daily on 9/27/19 for dementia with behavioral disturbance. Orders started on 1/4/20 continued the twice daily 50 mg doses and included an additional dose of 25 mg at noon. An order on 1/11/20 showed the resident was started on 50 mg three times per day (the previous orders were discontinued). On 1/27/20 there was a new order to increase the 50 mg Seroquel to four times daily with a discontinue date of 1/28/20. However, on 1/28/20 there was an order that showed "Seroquel Tablet...Give 50 mg by mouth four times a day related to vascular dementia without behavioral disturbance." The MAR also showed a 1/2/20 order for lorazepam (anti-anxiety medication) 2mg/ml inject 1 mg	F 758	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 exists, 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… 1. IDT, reviewed Resident 78 in regards to behaviors, behavioral management, and medication needs. Medications are appropriate at this time. Resident 78 MAR/TAR and Care Plan was adjusted to include target behaviors for monitoring. 2. Audit was done by AED on 2/5/20 and 2/19/20, reviewing individuals utilizing psychotropic medications. Audit was done to ensure accuracy of Orders on MAR/TAR for behavior monitoring and side-effects of medications and care plans included non-pharmacological interventions and behaviors associated with need for medication. Behavior monitoring order was added to order set of any resident receiving antipsychotic	

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	535042	A. BUILDING _____ B. WING _____	01/31/2020

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 758	Continued From page 20	F 758		

intramuscularly every 4 hours as needed for anxiety and agitation. The discontinue date was 1/4/20. There was also a one time only order for Haldol 5 mg/ml inject 1 mg intramuscularly for aggressive behavior on 1/2/20. The following concerns were identified related to monitoring the effectiveness of the medications to treat behaviors:

a. Observation in the dining room on 1/27/20 at 5:04 PM showed the resident was trying to have unwanted interactions with another resident, believing that resident to be his/her spouse.

b. Interview with RN #3 on 1/27/20 at 5:50 PM revealed the resident's behaviors had worsened about 3 days prior. The nurse contacted the physician, who increased the dose of the resident's anti-psychotic medication and recommended increased fluid intake.

c. Interview with the resident's primary care physician on 1/28/20 at 9:30 AM revealed that he prescribed one extra dose of Seroquel each day for the resident's behaviors. If ineffective, his plan was to prescribe a single long-acting dose of Seroquel.

d. Review of the January 2020 TAR showed behavior monitoring was included for "thoughts of hopelessness, isolating, hallucinations, delusions, increased complaints, and refusing care." The behaviors identified for the use of the medications (anxiety, agitation, and aggressive behavior) were not included on the monitoring.

e. Review of the nursing progress notes for January 2020 failed to show ongoing monitoring of the target behaviors connected to the medications. There was a note on 1/2/20 timed 1 PM that documented behaviors of increased agitation and yelling at another resident. As a result of this behavior, the nurse notified the physician and received an order for an

medications, to ensure behaviors are tracked twice daily by nursing personnel. When/if behavior tracking on MAR/TAR indicates a trend of behaviors, nursing personnel will then reach out to physician for psychotropic medication orders.

3. Psychotropic Committee will meet weekly to discuss psychotropic medications and residents receiving psychotropic medications. Team members of the Psychotropic Meeting, will review any new orders of anti-psychotic medications each week during the meeting, ensuring care plans and behavior management orders are in place. Staff will receive education on psychotropic medication use, non-pharmacological interventions, behavior tracking, and documentation of trends in behaviors prior to new orders beings asked for, for psychotropic medications, by management by 3/5/20. During education, staff were encouraged to utilize the PCC conversation to communicate with management if new orders for psychotropic medications were ordered.

4. The DNS or designee will audit residents during the psychotropic medication meeting, to ensure psychotropic medications are order only after non-pharmacological interventions have been attempted and documented. Audits will be weekly for four weeks and then monthly for two 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.

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 _____	01/31/2020

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 758	Continued From page 21 intramuscular injection of Ativan. f. Review of facility policy titled "Psychotropic Drugs" showed "3. Treatment includes the use of environmental and/or behavioral interventions prior to initiating psychotropic medications... 6.a.iii dementia or dementia with behavioral disturbance itself is not an approved diagnosis for the use of antipsychotic medications..."	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		3/5/20

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 _____	01/31/2020

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 761	Continued From page 22 Based on observation, staff interview, review of policy and procedure, and review of the facility's medication reference guide, the facility failed to ensure medications for resident use were not expired in 4 of 7 medication storage areas (East medication cart, West medication cart, West medication room, and South 2 medication cart). The findings were: 1. Observation on 1/30/20 at 6:47 PM of the East medication cart showed 1 bottle of latanoprost (eye drops to treat glaucoma) 0.005% ophthalmic solution without an open date. Further, observation showed 1 bottle of Artificial Tears (lubricant) ophthalmic solution without an open date. Interview at that time with the unit manager LPN #2 revealed the facility goes by the expiration date on the eye drops and was not aware the bottles should be labeled with an open date. 2. Observation on 1/30/20 at 3:53 PM of the West medication cart showed the following concerns: a. A bottle of citalopram hydrobromide (antidepressant) 40 milligram (mg) tablets expired on 11/1/19. b. A bottle of gabapentin (nerve pain medication and anticonvulsant) 300 mg capsules expired on 11/1/19. 3. Observation on 1/30/20 at 4:05 PM of the West medication room showed the following concerns: a. 3 Dulcolax (laxative) 10 mg suppository bullets expired May 2018. b. 2 Tylenol (mild to moderate pain relief) 650 mg suppository bullets expired on 10/2019. c. Interview at that time with RN #3 confirmed the medications were expired and were available for resident use.	F 761	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 exists, 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… 1. The opened, undated, and outdated medication were discarded at the time of discovery by unit managers and DNS. 2. Initial audit completed of medication storage areas with any identified concerns corrected. Unit managers will ensure medications are not stored past their use by date, in the medication storage rooms, and/or medication carts. 3. Nursing staff will receive education from management by 3/5/20, on labeling, dating, and storage, as well as locking of medication carts. Review of policy on destroying and disposing of medications will be done at all-staff meetings on 2/27/20. 4. The DNS or designee will audit storage areas, fridges and freezers, medication storage rooms, medication carts, or any other area medication is kept, to ensure there are no outdated items and that all opened items have a use by date. Audits will be weekly for four weeks and then monthly for two months.	

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	535042	A. BUILDING _____ B. WING _____	01/31/2020

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F 761	Continued From page 23 4. Observation on 1/30/20 at 4:17 PM of the South 2 medication cart showed the following concerns: a. One Lantus (insulin) solostar injection pen 100 unit/milligram (ml) with no open date. b. One Novolog (insulin) flexpen 100 unit/ml with a written date of 12/16/19. c. One Lantus (insulin) solostar injection pen 100 unit/ml with a written date 12/17/19. d. Interview at that time with LPN #3 confirmed the medications were expired and were available for resident use. 5. Interview with the administrator on 1/31/20 at 9:03 AM revealed it was the expectation of the facility to follow the protocol for what the medications were on how to destroy the medication. Further, she revealed it was the facility expectation for nursing staff to keep all medications secure. 6. Review of FDA instructions found at www.fda.gov/drugs/emergencypreparedness/ucm085213.htm (retrieved 2/11/20) showed insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened) may be left unrefrigerated at a temperature between 59°F and 86°F for up to 28 days. 7. Review of the policy and procedure "Medication Storage in the Facility" effective date: August 2018 showed" ...H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or with secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal ..."	F 761	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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	535042	A. BUILDING _____ B. WING _____	01/31/2020

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F 761	Continued From page 24 8. Review of the "Medication Reference Guide," used by the facility showed eye drops and ointments should be discarded 6 months after opening or according to the manufacturer expiration date, whichever comes first.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure proper hand hygiene was used while serving/preparing food in 2 of 5 food service areas (South Kitchen, East Dining Room). The findings were: 1. Observation of the evening meal service on 1/27/20 from 4:41 PM to 5:50 PM showed nutrition aide #1 was taking food from the service	F 812	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 exists, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The	3/5/20

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 _____	01/31/2020

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SHEPHERD OF THE VALLEY REHABILITION AND WELLNESS	60 MAGNOLIA CASPER, WY 82604

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F 812	Continued From page 25 window to individual residents. While at the tables the nutrition aide would assist the residents with set-up needs related to the food and beverages. The aide failed to perform hand hygiene between residents. In addition, observation at 4:41 PM showed resident #64 had put his/her water cup into the water pitcher located on the table. Nutrition aide #1 assisted the resident with removing the cup from the water pitcher by using his bare hand. He took the cup from the pitcher and then filled the cup with the water from the pitcher. The aide failed to perform hand hygiene and continued to assist other residents. 2. Observation on 1/29/20 at 5:17 PM showed nutrition aide #2 was taking resident orders in the south dining room. She then entered the kitchen to begin serving resident meals from the steam table and did not perform hand hygiene. In addition, the aide opened the refrigerator to look for an item and upon not finding what she needed, she left the kitchen to go to the main kitchen. Upon return to the south kitchen, she failed to perform any hand hygiene and proceeded to serve resident food. 3. Interview with the certified dietary manager on 1/31/20 at 9:20 AM stated the server in the south unit was new; however, hand washing education was done frequently with all of the dietary staff. 4. According to Food Code 2017, U.S. Public Health Service: 2-301.14 "FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE	F 812	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… 1. Dietary aide #1 and #2 were educated on proper hand washing technique on 2/5/20. 2. Audit of staff in each dining area for proper hand hygiene was completed by AED on 2/17/20, with identified concerns corrected. 3. Kitchen staff received education from Dietary Manager on 2/5/20, on handwashing and proper food handling. 4. The Dietary Manager or designee will audit staff in the kitchen or dining areas, to ensure proper hand hygiene is conducted by staff when it is a need. One observation of staff will occur in each dining area, each week to ensure proper hand hygiene. Audits will be weekly for four weeks and then monthly for two 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 812	Continued From page 26 ARTICLE and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands."	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		3/5/20

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F 880	Continued From page 27	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

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F 880	Continued From page 28 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, policy and procedure review, and professional standard review, the facility failed to implement infection control processes to prevent transmission of infection in 5 random observations. In addition, the facility failed to ensure effective infection control practices were followed for 3 of 3 wound care observations (#98, #124, #235). The findings were: Random Observations: 1. Observation on 1/27/20 at 1:27 PM showed CNA #1 and #2 performed personal care for resident #96 who was on the bedside commode. CNA #1 wore gloves, performed peri-care, and pulled the resident's clothes up. The CNA continued to wear the gloves and transferred the resident to the recliner using a sit-to-stand lift. The CNA removed the gloves and failed to perform hand hygiene. Continued observation showed the bedside commode bucket had a plastic bag. CNA #2 who was not wearing gloves, removed the plastic bag that contained the	F 880	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 exists, 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… 1. Education provided to C.N.A. #1, C.N.A. #2, and LPN #1 by AED on 2/5/20, regarding policies and procedures on handwashing, dressing changes, biohazard waste, and glove use. 2. Initial audit on handwashing, dressing changes, biohazard waste, and glove use was completed by DNS immediately after	

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	535042	A. BUILDING _____ B. WING _____	01/31/2020

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F 880	Continued From page 29 resident's excrement from the bucket, carried the bag to the dirty utility room, and threw it in the garbage. Further observation showed CNA #2 failed to perform hand hygiene after throwing the plastic bag in the garbage. Interview on 1/30/20 at 9:44 AM with the infection prevention nurse, RN #7 revealed the expectation was for staff to wear gloves when handling body fluids, to remove gloves after performing perineal care and to immediately perform hand hygiene. Review of the Handwashing/Hand Hygiene policy, with a revision date 3/18 revealed ..."Use an alcohol-based hand rub containing at least 62% alcohol, or alternatively, soap and water for the following situations: ...b. before and after direct contact with residents;...h. before moving from a contaminated body site to a clean body site during resident care;...j. after contact with blood or body fluids; k. after handling used dressings...m. after removing gloves." 2. Observation on 1/27/20 at 1:15 PM showed LPN #1 disposed of a blood-filled wound vacuum storage container and tubing in the regular trash that was then taken out of the resident room. The clear trash bag was thrown away in the regular trash receptacle in the soiled utility room. 3. Observation on 1/28/20 at 10:30 AM showed LPN #1 disposed of soiled wound care supplies in a regular clear trash bag which was thrown in the regular trash receptacle in the soiled utility room. 4. Observation on 1/28/20 at 1:42 PM showed LPN #1 disposed of soiled wound care supplies in a regular clear trash bag which was thrown in the regular trash receptacle in the soiled utility room. 5. Observation on 1/29/20 at 11:25 AM showed	F 880	deficiency was brought to Administration by survey team, with identified concerns corrected as necessary. 3. All staff will receive education from management by 3/5/20, on handwashing, dressing changes, biohazard waster, and glove use. 4. The DNS or designee will audit nursing personnel to ensure proper hand washing, dressing changes, waste disposal, and glove use is being done according to policy. Audits will be weekly for four weeks and then monthly for two 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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	535042	A. BUILDING _____ B. WING _____	01/31/2020

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F 880	Continued From page 30	F 880		

resident #98 had a blood-filled wound vacuum storage container with tubing in the regular trash tied in a clear bag which was taken to the soiled utility room and thrown away in the regular trash receptacle. Interview at that time with LPN #1 revealed the soiled wound care supplies were always thrown away in the regular trash receptacle.

6. According to OSHA, https://www.osha.gov/laws-regs/standardinterpretations/1993-02-01-0#waste (accessed on 2/5/20), "Regulated waste shall be placed in containers which are: Closable; Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping; Labeled or color-coded, and closed before removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping." "A warning label that includes the universal biohazard symbol (see 29 CFR 1910.1030(g)(1)(i)(B) followed by the term "biohazard," must be included on bags/containers ... on bags/containers of regulated waste; ...and on bags/containers used to store, dispose of, transport, or ship blood..."

Regarding wound care:

1. Review of the 12/20/19 admission MDS assessment showed resident #98 had one or more unhealed pressure ulcers, coded as unstaged slough/eschar. Review of the physician orders dated 1/22/20 showed "Wound Care: Coccyx- Clean wound with wound cleanser, apply skin prep to peri-wound, put medihoney in wound bed only and cover with border gauze... every day." Observation on 1/28/20 at 10:30 AM showed the wound nurse LPN #1 performed a

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 _____	01/31/2020

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F 880	Continued From page 31	F 880		

dressing change to the resident's coccyx wound. The following concerns were identified:

a. The nurse placed a supply of gloves in her sweatshirt jacket pocket with a lanyard of keys, and a black marker.

b. The nurse donned her gloves and a barrier was placed. The dressing and gauze packets were opened at the edges and placed on the barrier. Further, the nurse grabbed a trash can with her gloved right hand, her thumb was inside the trash can. There was no change of gloves or hand hygiene performed after handling the trash can.

c. The nurse removed the old bandage and placed the dressing into the trash. There was no change of gloves or hand hygiene performed between the removal of the old dressing and handling the fresh new dressing.

d. The nurse measured the wound and applied the medihoney treatment on the inside of the wound with cotton applicators. The nurse changed her gloves at that time, however no hand hygiene was performed. She then continued to cover the pressure ulcer with a large dressing she had taken out of the packet. The nurse removed her gloves and took the trash to the soiled utility room, then went to the nurses' desk and washed her hands.

2. Review of the 1/8/20 quarterly MDS assessment showed resident #124 was at risk for pressure ulcers, and had no unhealed pressure ulcer. However, the resident had a surgical wound. Review of the physician order with a start date of 12/29/19 showed an order to cleanse wound on the right lower quadrant with wound cleanser, apply bactroban to wound, and cover with dressing twice a day until healed. Review of the physician orders started on 1/26/19 showed

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 _____	01/31/2020

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SHEPHERD OF THE VALLEY REHABILITION AND WELLNESS	60 MAGNOLIA CASPER, WY 82604

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F 880	Continued From page 32	F 880		

daily dressing change for the incision site. Review of the physician orders started on 1/22/20 showed the wound care included a wound vacuum and was done "by wound care only, every day shift." Further review showed on 1/24/20 the physician order changed to wound care on Monday, Wednesday, and Friday. Observation on 1/27/20 at 1:15 PM showed the wound nurse, LPN #1 performed a dressing change with a wound vacuum. The following concerns were identified:

a. Observation showed the nurse placed a supply of gloves, trauma shears, and packets of skin prep in her scrub top pocket. The nurse donned her gloves then a barrier was placed. The dressing, wound vacuum kit, and gauze packets were unopened and placed on the barrier. Further, the nurse grabbed a trash can and placed it close to the resident. No change of gloves or hand hygiene was observed after handling the trash can.

3. Review of the medical record showed resident #235 was admitted on 1/17/20 with physician orders to provide wound care. The orders showed "WOUND CARE: Coccyx- Clean wound with wound cleanser. Pack wound with moistened gauze sponges. Apply skin prep to peri-wound and apply bordered gauze dressing every day shift for skin integrity start date 1/28/20...WOUND CARE: RT HIP- Clean wound with wound cleanser. Pack wound with Santyl and moistened gauze sponges. Apply skin prep to peri-wound and apply bordered gauze every day shift for skin integrity start date 1/21/20." Review of the daily skilled evaluation dated 1/27/20 at 11:14 PM showed the resident had "wounds to the hip and buttocks with dressings in place that are changed on day shift and remain clean, dry, and intact."

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 _____	01/31/2020

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 880	Continued From page 33	F 880		

The following concerns were identified during a wound care observation on 1/28/20 at 1:42 PM:

a. Observation showed the wound care nurse, LPN #1, gathered supplies at the treatment cart, and placed the gloves and skin prep packets in her sweatshirt pocket. The nurse placed a paper towels barrier down then placed the unopened supplies down on towels in the resident room. The nurse washed her hands, closed the door to the room, and grabbed a trash bag and placed it onto the bed. The nurse donned gloves stored in her pocket.

b. Continued observation showed the nurse opened the gauze packets and took out the gauze then put the trash in the trash bag. The nurse used the gauze with a wound cleaner to clean to the right hip. She then removed her gloves and with no hand hygiene donned new gloves out of her pocket.

c. The nurse took the packets of skin prep out of her sweatshirt pocket, opened the packets and wiped around the wound. The nurse then dressed the wound as ordered by the physician.

4. Interview with the wound care nurse, LPN #1 on 1/28/20 at 2:02 PM revealed her usual practice was to store the supplies in her pocket. Further she stated she normally does not wash her hands between handling the soiled dressing and the new clean dressing.

5. Interview with the DON on 1/28/20 at 4:40 PM revealed it was the facilities expectation for the nurse to clean her hands and change gloves between dirty and clean when doing wound care.

6. Review of the facility procedures "Non-Sterile Dressing Change Observation" updated February 2009 showed ...8. Wash hands. Put on

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 _____	01/31/2020

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 880	Continued From page 34 disposable gloves ...remove soiled dressing 11. Pull glove over dressing and discard into appropriate receptacle. 12. Wash hands. 13. Set up clean field; prepare supplies (open dressings, etc.). 14. Pull on gloves. 15. Perform treatment. 16. Remove gloves and place in plastic bag. 17. Wash hands... 23. Wash hands. 7. Review of Elkin, Perry, and Potter, "Nursing Interventions & Clinical Skills," Sixth Edition, 2016. "Implementation for Treatment of Pressure Ulcers and Wound Management; 1. Standard Protocol - [hand hygiene]. Gather supplies as ordered. ...4. Open packages and topical solution containers. 5. Position patient... 6. Apply clean gloves. Remove old dressings and discard in plastic bag. Discard gloves; perform hand hygiene... 7. Apply clean gloves. Cleanse wound with prescribed solution ...wound dressed. ...10. Reposition patient. ...14 Dispose of used supplies and equipment. 15. Remove and dispose of gloves, Perform hand hygiene...	F 880		