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 _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey which included a COVID-19 focused infection control survey was conducted by Healthcare Licensing and Surveys from 7/26/21 to 7/29/21. The following common abbreviations are used throughout this document: BIMS- Brief interview for mental status CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set LPN- Licensed Practical Nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 563 SS=E	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access	F 563		8/20/21

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

Electronically Signed | 08/17/2021

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F 563	Continued From page 1 to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on observation, resident, staff and family interview, policy and procedure review, review of Centers for Medicare and Medicaid Services (CMS) guidance, and review of county positivity data, the facility failed to ensure visitation was accommodated for 3 of 28 sample residents (#74, #210, #212). The findings were: Review of CMS memo QSO-20-39-NH "Nursing Home Visitation - COVID-19", revised 4/27/21 showed the following guidance: "...Outdoor Visitation... while taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred even when the resident and visitor are fully vaccinated against COVID-19. Outdoor visits generally pose a lower risk of transmission due to increased space and airflow. Therefore, visits should be held outdoors whenever practicable... For outdoor visits, facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if applicable... Indoor Visitation... Facilities should	F 563	1) Residents #74, #210, and #212 are receiving visits per requests. 2) Residents wanting to have an unscheduled visit will be allowed. If family members are needing to come into the building to use the facilities, they will be screened in and accompanied to the restroom and then back outside. Facility wide audit with residents occurred, asking if they are allowed to have unscheduled visits and if they are aware of the process. 3) Education provided to Receptionist and Activities Personnel, to ensure they are aware of the policy on visitations, and to ensure they are accommodating requests of families and/or residents with both scheduled and unscheduled visitations. 4) DNS/Designee will audit visits each week to ensure accommodations were met with residents and/or families during their visit. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the	

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F 563	Continued From page 2 allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission... These scenarios include limiting indoor visitation for:...unvaccinated residents, if the nursing home's COVID-19 county positivity rate is >10% and <70% of residents in the facility are fully vaccinated... Residents with confirmed COVID-19 infection... Residents in quarantine... Facilities should consider how the number of visitors per resident at one time and the total number of visitors in the facility at one time (based on the size of the building and physical space) may affect the ability to maintain the core principles of infection prevention. If necessary, facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors...: The following concerns were identified: 1. Observation on 7/27/21 at 10:27 AM showed resident #74 had an unsupervised visit with his/her representative in the common area on the east wing. Interview with the resident's representative on 7/27/21 at 11:11 AM revealed the representative traveled 4 hours to the facility for a scheduled 30 minute visitation with the resident and she was not allowed to visit more than once per day. Further interview revealed the representative scheduled another visit on 7/28/21 and would be staying in town overnight so she could have more visitation time with the resident. The resident's representative revealed the facility's visitation schedule created limits to her ability to visit the resident. 2. Interview with resident #210 on 7/27/21 at 2:42 PM revealed s/he was unhappy with the facility's	F 563	monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5) Date of Compliance: 08/20/21	

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F 563	Continued From page 3	F 563		

visitation policy. The resident stated "On Saturday and Sunday" the resident had family traveling through town who wanted to visit the resident. The resident stated the visits had to occur in front of the building, and the visitors had to bring their own chairs. The resident revealed the visit had to be scheduled for 30 minutes and ended early because the resident's 90 year old mother's needed to use the restroom, and the facility would not allow her to use the restroom inside the facility. Further interview revealed the resident had a similar incident occur when his/her granddaughter previously visited. The resident revealed the granddaughter needed to use the restroom which also resulted in the visit ending early as the facility did not allow individuals under the age of 14 inside the building.

3. Interview with resident #212 on 7/27/21 at 2:28 PM revealed the resident admitted to the facility the previous day and his/her daughter was not allowed to visit. The resident revealed his/her daughter had called the facility to make an appointment and the facility did not have any visitation times available for the daughter to visit the resident on that day.

4. Interview with receptionist #1 on 7/29/21 at 11:36 AM confirmed visits were scheduled for 30 minutes at a time, and the facility did not allow more than 2 visitors at a time for indoor visits. The receptionist revealed more visitors could visit outdoors; however, the visitors would have to bring their own seating unless they visited in the facility's rose garden. Further interview revealed the facility did not allow visitors under the age of 14 years old to participate in any visitation, all visits were scheduled for no more than 30 minutes, regardless of travel time to the facility,

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F 563	Continued From page 4	F 563		

and no visitors were allowed to enter the facility to use the restroom.

5. Interview with the DON on 7/27/21 at 11:59 AM revealed the facility's visitation policy was provided by the facility's corporation, and was not specific to the building or local risk factors.

6. Review of Wyoming Department of Health county COVID-19 positivity rate data showed on 7/23/21, Natrona County's percent positivity rate for the prior 14 days was reported to be 1.7%. The report dated 7/29/21 showed the 14 day positivity rate was 2.3%.

7. Review of the policy titled "Limiting the Spread of COVID-19 in Skilled Nursing Facilities" dated 5/20/21 showed "...5. Indoor and Outdoor visits are permitted in accordance with the centers State Department of Health guidance. Outdoor visits are preferred whenever practicable. a. Visits will be arranged ahead of time, either via website or telephone call. Name and contact information is collected at this time. b. Visitors must accept the terms and conditions prior to visit which includes: i. Information on COVID-19 and how it is spread; ii. Recommend quarantine for 14 days prior to visit, symptoms to monitor for, and when to cancel visit; iii. Pre-visit testing recommendations (negative SARS-CoV-2 RT-PCR within 48 hours of visits is recommended but not required); iv. Instructions on social distancing, use of mask, and hand hygiene; v. Instructions on where to meet upon arrival; vi. Additional information regarding visiting restrictions...Visitation will be revoked for any of the following situations: a. The resident or visitor show signs/symptoms consistent with an infectious disease or refuses to follow

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F 563	Continued From page 5 requirements. b. The resident is in isolation of quarantine. c. For unvaccinated residents, if the county positivity rate is >10% AND <70% of the residents are fully vaccinated. d. Initially when an outbreak is identified and after outbreak testing, if the outbreak isn't contained to a single unit. e. Per direction from public health authorities..."	F 563		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and	F 604		8/20/21

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F 604	Continued From page 6 document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure a possible restraint was evaluated for 1 of 1 sample residents (#83) reviewed for physical restraints. The findings were: Review of the 7/7/21 significant change MDS assessment showed resident #83 had a BIMS of 3 out of 15 indicating the resident had significant cognitive impairment. The resident required extensive physical assistance of 1 person for transfers, as well as locomotion on and off the unit, and was coded as only walking in room and corridor once or twice during the assessment look back period. Additionally, the MDS assessment showed the resident had one fall with non-major injury since the previous quarterly assessment on 6/24/21, and there were no physical restraints used. The following concerns were identified: a. Observation on 7/27/21 at 9:18 AM showed the resident was in a recliner in the TV area on the east unit; the chair was reclined back with the footrest up. The resident made repeated movements and attempts to exit the chair while it was reclined, but was unsuccessful. The resident asked another resident in the area to help him/her get up. The other resident did not respond. Interview with LPN #1 who was walking through the area at that time verified the resident required assistance and she would return. Continued observation showed the resident was persistent and was able to move enough in the chair to get into more of an upright seated position. The resident never attempted to put the foot rest down on the chair.	F 604	1) Resident #83 was assessed for safety and for possible restraint. 2) Audit performed by AED and Nurse Management starting on 7/30/21, of residents that utilize the recliners, to ensure there were no other concerns with recliners being restraints. Any needed corrections were done at that time. 3) Staff educated on the policy on physical restraints and recliners being possible restraints if not used appropriately. 4) DNS/Designee will audit recliners to ensure compliance with policy on physical restraints. 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. 5) Date of Compliance: 08/20/21	

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F 604	Continued From page 7	F 604		

b. Observation on 7/27/21 at 9:29 AM showed the resident remained in the recliner; the footrest was still up and the chair remained reclined. The resident continued to try to get up from the reclined chair, and called out for help. On 7/27/21 at 9:31 AM the DON attended to the resident's calls for help. The DON asked the resident to "stay put" stating she did not want him/her to "fall out of the chair." She offered the resident something to drink, and asked about pain which the resident denied. She did not offer to get him/her up from the chair at that time and left the resident reclined with his/her feet up.

c. Observation on 7/28/21 at 2:17 PM showed the resident was seated in the recliner in the east unit TV area. At that time, the chair was not reclined. Continued observation showed the resident made two successful attempts within minutes of each other to move to the front of the seat, stand up, and walk a short distance forward, turn around and then returned to the chair and sat down.

d. Observation on 7/28/21 at 2:20 PM showed LPN #1 witnessed the resident stand up and walk forward without assistance. She ran over to the resident, and braced the resident who was in the process of sitting back in the chair. The nurse asked the resident to let her know if s/he wanted to go for a walk. She offered the resident a drink which was accepted, and the nurse left the area. The resident again stood, walked a short distance, turned around, and sat back down in the chair without assistance or incident. Observation on 7/28/21 at 2:23 PM showed CNA #2, brought a 4-wheeled walker and placed it next to the recliner. She then placed a gait belt on the resident, assisted the resident to his/her feet, and utilizing the walker, the two began walking around the unit.

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F 604	Continued From page 8 e. Interview with CNA #1 on 7/27/21 at 11 AM revealed the resident transferred easily. Further, she confirmed the resident was able to get up out of the chair and move, and staff monitored the resident to prevent falls. f. Review of the medical record failed to show any documentation the recliner had been evaluated as a possible restraint. g. Interview with the DON and the assistant administrator on 7/29/21 at 10:41 AM revealed they had not considered the recliner might be a restraint for the resident, and no evaluation has been completed.	F 604		
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 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	F 758		8/20/21

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F 758	Continued From page 9 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. §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 medical record review and staff interview, the facility failed to ensure the physician provided a rationale for refusing to order a dose reduction for 1 of 6 sample residents (#96) reviewed for psychotropic medications. The findings were: Review of the July 2021 medication administration record (MAR) showed resident #96 had an order for duloxetine (an antidepressant medication) 60 mg daily with a start date of 11/8/20. The medication was used for "Major Depressive Disorder, Recurrent, Mild." The	F 758	1) Resident #96 has current rationale for psychotropic medications. 2) Audit performed by AED and DNS starting on 7/30/21, of residents with recommendation by pharmacy in July. Recommendations sent to PCPs were reviewed to ensure any denials of GDRs had a rational for denial. Any needed corrections were done at that time. 3) Staff were educated on expectations with GDRs and pharmacy recommendations. Members at psychotropic medication management	

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F 758	Continued From page 10 following concerns were identified: a. Review of the 4/20/21 monthly medication review showed a physician-signed (4/23/21) pharmacy recommendation. The recommendation showed "The resident has been using duloxetine 60 mg QD [daily] for Major Depressive Disorder since 1/19/20. Could we please obtain new documentation if a dose reduction is still contraindicated? The most recent documentation we have on file is from February of 2020..." The physician had check marked the option that showed "Continue current antidepressant therapy; dose reduction contraindicated; see rationale below." However, continued review showed there was no rationale provided. b. Interview with the DON on 7/29/21 at 4 PM confirmed there was no documentation of the physician's rationale for declining to reduce the medication.	F 758	meeting will now follow GDR recommendations from the pharmacy to ensure compliance with expectations, moving forward. This committee with also monitor responses on GDRs to ensure rational is provided. A letter was sent to primary care physicians indicating need for rational when answering GDR requests. 4) DNS/Designee will audit GDR and pharmacy recommendations to ensure compliance. 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. 5) Date of Compliance: 08/20/21	
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 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		8/20/21

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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 by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

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SHEPHERD OF THE VALLEY REHABILITATION 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 12 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 and staff interview, the facility failed to ensure appropriate hand hygiene and personal protective equipment use during 6 random observations. The findings were: 1. Interview with the infection preventionist and assistant administrator on 7/29/21 at 2:44 PM revealed staff who were vaccinated should wear a surgical mask and staff who were unvaccinated should wear an N95 mask and a face shield. Further interview revealed the mask should be worn covering the mouth and nose and all staff received education about mask use. The following concerns were identified related to mask use: a. Observation on 7/28/21 at 11:10 AM on the east unit showed dietary aide #1 was wearing a surgical mask while working in the dining room and kitchen area, however, it was worn below her nose. b. Observation on 7/26/21 at 5:28 PM showed dietary aide #2 wearing a face shield and an N95 mask. However, the dietary aide was wearing the mask under her chin. c. Observation on 7/27/21 at 11:39 AM showed kitchen aide #2 wearing a face shield and N95 mask; however, the mask was under her	F 880	1) Dietary aide #1, dietary aide #2, kitchen aide #2, cook #1, dietary aide #4, C.N.A. #3, LPN #2, and medication aide #1, have been made aware of surveyor observations. These staff have also been educated on appropriate PPE use and are currently using PPE appropriately. 2) Audit performed by AED and DNS, of entire building, randomly observing staff and units, to ensure compliance with hand hygiene and PPE policies. Any needed corrections were done at that time. 3) Staff were educated on expectations with hand hygiene and PPE policies. 4) DNS/Designee will audit hand hygiene and use of PPE to ensure compliance. 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. 5) Date of Compliance: 08/20/21	

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 _____	07/29/2021

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F 880	Continued From page 13	F 880		

chin. Continued observation showed cook #1 wearing a surgical mask; however, the mask was under her chin. Continued observation at 12:08 PM showed cook #1 wearing her mask under her nose.

d. Observation on 7/28/21 at 9:39 AM showed dietary aide #4 in the south kitchen wearing a surgical mask; however, the mask was under her chin.

2. Observation on 7/26/21 at 5:15 PM showed CNA #3 delivering meal trays to resident rooms. She delivered a tray to room 27, with no hand hygiene observed prior to entry, or when she exited the room. She then retrieved another tray from the cart and entered room 15. She was observed moving items on the resident's tray table, and assisted the resident in setting up the meal. She then exited the room, and no hand hygiene was observed upon exit. She then retrieved another tray from the meal cart and delivered the meal to room 24, with no hand hygiene observed prior to entry.

3. Observation on 7/29/21 at 9:33 AM showed south unit manager LPN #2 entered room 24, with no hand hygiene observed prior to entry. She was observed moving resident items on the tray table and window ledge, and picking items up off the floor. She exited at 10:00 AM without performing hand hygiene.

4. Interview with south unit manager LPN #2 on 7/29/21 at 4:50 PM revealed her expectation was for all staff to perform hand hygiene when entering and exiting residents rooms, after contact with residents and their belongings, and after contact with potentially contaminated items. Interview with medication aide #1 at that time

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F 880	Continued From page 14 revealed she was " ... distracted and rushed, not paying attention to when I should be washing my hands." She confirmed hand hygiene should be performed when entering and exiting rooms, and after contact with residents and their belongings. 5. Interview with the assistant executive director, the director of nursing, and infection preventionist on 7/29/21 at 4:20 PM revealed they all expected staff to perform hand hygiene prior to entering resident rooms " ... because you don't know what you'll have to do when you get in there, and you need to be prepared ..." They further confirmed hand hygiene needed to be performed after contact with residents, their belongings, and the surfaces in their room. Further, contact with potentially contaminated items and items from the floor require hand hygiene after touching, washing with soap and water " ... after 5 uses of alcohol based rub, or as often as possible."	F 880		