

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535042		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/29/2021	
NAME OF PROVIDER OR SUPPLIER SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS				STREET ADDRESS, CITY, STATE, ZIP CODE 60 MAGNOLIA CASPER, WY 82604			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 12/28/21 to 12/29/21. The survey was prompted by complaint intakes WY00003321, WY00003329, and WY00003342. In addition, a COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted by Healthcare Licensing and surveys from 12/28/21 to 12/30/21. Based on the findings of the survey team, it was determined that no deficiencies were identified pertaining to the infection control survey.			F 000			
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on medical record review, resident interview, staff interview, incident review, and policy and procedure review, the facility failed to ensure 1 of 2 sample residents (#3) was free			F 600	IDR REQUESTED 1)Resident #4 has discharged from the facility. Resident #3 has discharged from		1/28/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/24/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 from unwanted sexual touching. The findings were: Review of the 12/18/21 admission minimum data set (MDS) assessment showed resident #4 was admitted to the facility on 12/12/21, and a brief interview for mental status (BIMS) score of 13, indicating the resident was cognitively intact. Review of the progress note of 12/13/21 timed 8:59 PM showed under skilled needs: ..."Other abnormal findings include: Sexually inappropriate with female staff." This statement was repeated in progress notes on 12/14/21, 12/15/21, and 12/16/21. The following concerns were identified: 1. Review of the care plan for resident #4 showed the following plan dated 12/16/21: "Problem: Resident has dis-inhibited sexual behavior r/t: Bold behaviors, Fondling, Verbal comments (sexual), Flirting. Goal: I will have the best possible physical well-being. Interventions: Praise positive actions." There were no other interventions for the identified problem, and no interventions designed to ensure resident safety. 2. Review of a progress note dated dated 12/18/21 at 3:57 PM showed, "A [gender] resident came to staff nurse on Rapid and verbalized that this resident touched [his/her] shoulder and breast. Management notified. MD notified. Local police notified. At approximately 12:45 PM resident (alleged perpetrator) escorted from facility with local authorities (due to an unrelated outstanding warrant). MD gave verbal order for discharge from facility." 3. Review of the 12/18/21 facility incident report showed resident #3 reported that resident #4 had been sexually inappropriate with him/her on	F 600	the facility. 2)Facility wide audit conducted by Executive Director to ensure that residents exhibiting sexually inappropriate behaviors, have an appropriate care plan and monitoring from staff. 3)Education provided to staff regarding abuse and neglect policy. Staff educated on care plan goals. Staff educated on recognizing potential harm and notification to management. 4)ED/Designee will audit each week to ensure residents were free from abuse and neglect. 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: 01/28/22		

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F 600	Continued From page 2 12/17/21 in the restorative dining area without witnesses, and s/he reported it to a nurse on 12/18/21 because staff were busy on 12/17/21. The facility's investigation showed staff reported resident #4 behaved inappropriately toward them, including an attempt to initiate a kiss from from a CNA on 12/17/21 by withholding a thermometer. The resident was educated by staff at that time regarding the behavior being inappropriate. 4. Interview with resident #3 on 12/28/21 at 1:35 PM confirmed that s/he was in the Rapid Recovery Unit dining area sometime on 12/17/21, when resident #4 approached and grabbed his/her shoulders with his/her hands, and then his/her breast. Resident #3 stated that s/he told resident #4 to stop. Resident #4 stopped, walked to the door, came back, and repeated the behavior. Resident #3 stated that s/he again told resident #4 to stop, then resident #3 left the dining area. Resident #3 stated that no staff or other residents witnessed this interaction, and because staff were busy, s/he reported it the next day. The resident further stated s/he felt safe in the facility since resident #4 had been discharged. Review of the 12/4/21 significant change MDS assessment showed resident #3 had a BIMS score of 13, indicating the resident was cognitively intact. 5. Interview with RN #1, who worked on the Rapid Recovery Unit, on 12/29/21 at 11:15 AM revealed he was unaware of resident #4's inappropriate behavior until after the resident was discharged. 6. Interview with the administrator and RN #2 on 12/29/21 at 4:30 PM confirmed resident #4 showed unacceptable sexual behavior toward staff, but the administrator stated there was no	F 600			

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F 600	Continued From page 3 evidence the resident showed unacceptable sexual behavior toward residents. The administrator stated the facility had 14 days from admission to formulate a comprehensive care plan and that was the reason for the lack of safety interventions. The administrator further stated the multiple dates in the progress notes for the documentation, ..."Other abnormal findings include: Sexually inappropriate with female staff" did not mean multiple occurrences had happened, but was meant as an alert to staff. 7. Review of the policy titled "Abuse Investigation" dated September 2017 showed, "...7. The Center investigates patterns, trends, or events that suggest the possible presence of abuse, neglect, misappropriation of resident property, exploitation, mistreatment, and injuries of unknown source, identified through analysis conducted by the QAA Committee, with intervention, reporting, or policy/process modification conducted as appropriate."	F 600			
F 658 SS=G	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff and physician interview, the facility failed to ensure timely assessments and physician notification in accordance with professional standards for 1 of 2 sample residents (#1) who had a significant change in condition. This failure resulted in harm	F 658	1)Resident #1 has discharged from the facility. 2)Facility wide audit to ensure residents meeting the criteria of a significant change in condition, have been evaluated and physicians and families have been notified		1/28/22

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F 658	Continued From page 4 to resident #1, who experienced a significant delay in receiving medical intervention after a change in condition. The findings were: Review of the 11/9/21 significant change MDS assessment showed resident #1 was admitted to the facility on 4/10/14. The resident had a brief interview for mental status (BIMS) score of 15, indicating the resident was cognitively intact. S/he required supervision of 1 staff member for transfers and walking. Review of oxygen saturation data for 10/29/21 through 11/11/21 showed the resident consistently maintained oxygen saturation levels of 88% or greater. Review of the 11/12/21 progress note timed at 6:33 AM showed "...Note Text: 0300 [3 AM] Medaide informed this nurse about resident O2 [oxygen saturation] being 55% on 2 liters [supplemental oxygen], R [respirations] 22, P [pulse] 146, BP [blood pressure] 140/78, resident was put in a high fowlers position, oxygen tubing and nasal cannula changed, resident O2 came up to 87% on 2L [2 liters of oxygen]. At 0530 AM [5:30 AM] resident was found laying at the foot end of [his/her] bed, with no oxygen on, [s/he] was cold and clammy to touch, sweating, foaming in [his/her] mouth and [his/her] under pants and pants were below [his/her] knees. Resident was quickly put in a high fowlers position, oxygen placed back on with a venturi mask, [s/he] was slightly awake but oriented times 4. Resident's O2 started increasing and got to 86% on 4L, R 22, P106, BP 138/72." Review of the 11/12/21 progress note timed at 7:45 AM showed "...Note Text: Resident O2 keeps dropping, put resident on 10L [10 liters of oxygen] rebreather mask brought up to 92%. 8:20	F 658	of such change. 3)Education provided to licensed nurses, to ensure they are notifying physicians and family/responsible parties of change in condition at the time of the first intervention provided and ongoing until resolved. Education provided to licensed nurses that an assessment of the bodily system related to the change of condition must occur when the change of condition occurs and routinely until resolved. 4)ED/Designee will audit each week to ensure notifications of change were done in a timely manner as well as change of condition assessments are completed appropriately. 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: 01/28/22		

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F 658	Continued From page 5 [8:20 AM] covid test done neg [negative]. Resident took to the BR [bathroom] by the nurse on 5L [5 liters of oxygen] NC [nasal cannula] assist back to bed O2 drops to 46 [46%]. Son [son's name] notified and wants [resident] sent to [local emergency department (ED)]. [Physician] agrees to have resident sent to [local ED]. Resident alert and left for [local ED] 9:10 [9:10 AM] per ambulance." Review of the 11/12/21 progress note times at 8:30 AM showed "...Note Text: Resident was placed on 10mL [10 liters per minute] rebreather mask O2 92%. Resident assisted to BR, O2 drops to 46 [46%] on 5L NC. Resident in high fowlers with O2 rebreather mask on at 10L comes back up to 92%. This is a new onset of shortness of breath. Resident lungs are coarse and wet throughout cough wet. Covid test at 8:20 [8:20 AM] negative. VS [vital signs] 97.2 [temperature] 104 [pulse] 32 [respirations]. Resident is alert. [Child of resident, and POA] called and wants [him/her] seen and [physician] gives order for [resident] to be seen." The following concerns were identified: 1. Review of the 11/12/21 progress notes showed no evidence the physician was notified of the resident's change in condition until 11/12/21 at 8:20 AM (5 hours and 20 minutes after the resident's oxygen saturation was first noted to be low). 2. Further review of the 11/12/21 timed at 6:33 AM progress note showed no evidence the resident's breath sounds were assessed by the nurse when the resident's oxygen saturation was noted to be 55 % on 2 liters of oxygen.	F 658			

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F 658	Continued From page 6 3. Interview on 12/29/21 at 11:30 AM with LPN [licensed practical nurse] #1, who cared for the nurse on 11/12/21 during the night shift, confirmed he wrote the night shift progress notes which documented the resident's significant change in condition. He stated he felt the resident had stabilized, and he was going to pass the information on to the day shift nurses. He left the resident in order to pass medications and perform other tasks for residents in the 2 hallways he was assigned to. The LPN stated he documented everything he did, and confirmed he failed to notify the physician. 4. Interview on 12/29/21 at 11:50 AM with RN #3, who cared for the resident on 11/12/21 during the day shift revealed she felt the resident was 'okay' until the note showing she took the resident to the bathroom. At that time, she realized the resident had a significant change, and she notified the physician and family member. 5. Interview with the primary physician on 12/29/21 at 1:45 PM showed her expectation was for the night nurse on 11/12/21 to have notified her when it became obvious the resident had a significant change in condition. She stated the on-call physician service was 24/7 for the purpose of timely intervention in the case of a significant change in condition, as was the case with the resident. She stated that the facility failed to notify her in a timely manner, which was important, and the resident was diagnosed at the ED on 11/12/21 with pseudomonas pneumonia. She stated the POA agreed to hospice services when the resident was at the local hospital, where the resident was placed and died shortly thereafter.	F 658			