STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	C 05/04/2022

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 complaint survey was conducted by Healthcare Licensing and Surveys on 5/3/22 through 5/4/22. The survey was prompted by complaint intakes WY00003371, WY00003399, WY00003400, and WY00003404. In addition a review for compliance with the Omnibus COVID-19 Health Care Staff Vaccination requirements was conducted. The following common abbreviations are used throughout this document: BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide MA-C- Medication Aide-Certified Nurse Aide MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 741 SS=E	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training	F 741		5/27/22

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

Electronically Signed | 05/24/2022

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 741	Continued From page 1 and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, medical record review and review of the 24 hour staffing board, the facility failed to ensure adequate staff were scheduled daily for 1 of 4 units (East unit). The findings were: 1. Review of the "24 hour Staffing Board" for March 2022 and April 2022 showed the facility required 3 CNAs daily for day shift and 3 CNAs daily for night shift on the East unit, which did not include restorative CNAs or bath aides. Further review showed 25 out of 61 days where only 2 CNAs worked the day shift, 19 out of 61 days where only 2 CNAs worked the night shift, and an additional 5 out of 61 days where only 1 CNA worked the day shift, on the East unit. 2. Interview with resident #6 on 5/3/22 at 12:15 PM revealed "last Saturday there was only 1 CNA working the floor in the East unit for 50 to 60 residents." S/he stated the facility staffed 1 to 3 CNAs on the unit. Further interview revealed s/he	F 741	1. The facility is currently staffing to meet acuity levels on each unit. 2. Facility wide audit was done by ED and DNS to ensure residents needs were being met and that staffing was appropriate. ED has hired 10 Nurse Aides in Training who are currently enrolled in a C.N.A. class in the community, and they will be doing their "clinical rounds" in Shepherd of the Valley, with current approved waiver to make this happen. Testing for these NATs will be conducted on 6/6/22 to obtain their C.N.A. license. Additionally, the IDT meets monthly for a recruitment and retention meeting to help meet staffing needs. Lastly, 7 additional NATs have been hired to take a C.N.A. class in June when this class ends. 3. Education provided to nurse management staff, to ensure they are ensuring appropriate staffing levels on their units and on all units within the	

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F 741	Continued From page 2 required assistance to use the toilet, and usually had incontinence before staff came to assist due to how long s/he had to wait. Review of the quarterly MDS assessment dated 3/3/22 showed the resident had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and the resident required extensive assistance to total dependence for all activities of daily living, except eating. 3. Interview with resident #10 on 5/4/22 at 12:33 PM revealed the facility had only been staffing 1 to 2 CNAs on the floor for 60 residents on the East unit and s/he required assistance to use the bathroom. Further interview revealed s/he was "surprised" to see administration answering call lights because s/he had not seen that occur previously during his/her stay. Review of the readmission MDS assessment dated 3/4/22 showed the resident had a BIMS score of 15 out of 15 which indicated the resident was cognitively intact, and required extensive assistance for mobility and dressing. Further review showed the resident was totally dependent of staff for transfers, toileting, and bathing. 4. Interview with MA-C #1 on 5/4/22 at 12:22 PM revealed s/he tried to help the CNAs if s/he had time; however, it was "pretty busy" on the East unit. 5. Interview with the administrator on 5/4/22 at 3:15 PM confirmed the "24 hour Staffing Board" indicated actual daily staff for each unit. Further interview revealed the facility attempted to provide additional help with Nurse aides in training; however, they were not able to perform some tasks due to no being licensed or certified.	F 741	building, when they are on-call. 4. Ed/Designee will audit each week to ensure staffing levels re appropriate and resident needs are being met. Audits will be weekly for 12 weeks. 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.	