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 10/26/2022

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 from 10/25/22 through 10/26/22. The survey was prompted by complaint intake WY000003469, WY000003472, WY000003475. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the complaint investigations. In addition, a COVID-19 focused infection control survey was conducted by Healthcare Licensing and Surveys.	F 000		
F 880 SS=D	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, 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;	F 880		10/26/22

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

Electronically Signed | 11/09/2022

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 880	Continued From page 1 §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 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.	F 880		

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F 880	Continued From page 2 §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, staff interview, and policy and procedure review, the facility failed to ensure infection control measures were followed during 1 of 1 observation of a resident room (room 116) with isolation precautions. The findings were: 1. Observation of room 116 showed an isolation cart outside the room, and a sign on the door indicating isolation precautions were required. The following concerns were identified: a. Observation on 10/25/22 at 10:00 AM showed nurse aide in training (NAT) #1 had an N95 mask on, and glasses that did not have eye shields. Further observation showed the NAT donned gloves and a yellow isolation gown and entered the isolation room. Continued observation showed when the NAT exited the room she doffed her gown and gloves, but not the N95 mask. Further she left the unit, returned and entered another resident room without changing the mask. b. Interview on 10/25/22 at 10:15 AM with the NAT #1 confirmed she went into an isolation room with a resident who had COVID-19. She further stated she did not change her mask when she left the room. c. Interview on 10/25/22 at 8:30 AM with the assistant director of nursing revealed the expectation was for staff to wear eye protection, either a face shield, or eye shields for staff who wore glasses. d. Review of the facility policy "Limiting the Spread of COVID-19 in Skilled Nursing Facilities," with a revision date 10/13/22, showed..."Covid-19	F 880	Will follow DPOC 1)CNA was made aware of surveyor observations at time of discovery and immediately verbally educated. 2)Audit performed by AED and DNS, of entire building, randomly observing staff and units, to ensure compliance with hand hygiene and PPE. Any needed corrections were done at that time. 3)Staff were educated on expectations with hand hygiene and PPE. 4)DNS/Designee will audit hand hygiene ensure compliance. Audits will be weekly for 12 weeks and then monthly for three 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 880	Continued From page 3 Isolation and Outbreak Status: 8. PPE (personal protective equipment) upon entry to isolation rooms: a. Appropriate PPE upon entry to isolated rooms include: eye protection (preferrably a face shield), respirator, gown and gloves...c. PPE should be removed and discarded as appropriate upon leaving an isolation room...i. If goggles or safety glasses are used instead of face shields, then masks or respirators should be removed when leaving the isolation room...." 2. Interview on 10/25/22 at 2:30 PM with the administrator revealed the employee changed her mask, and they provided education related to proper PPE use to mitigate the spread of the COVID-19 virus. She further stated they will be auditing staff for proper PPE use when entering and exiting rooms that are on isolation precautions.	F 880		