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 05/18/2023

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 5/15/23 to 5/18/23. The survey was prompted by complaint intakes WY00003591, WY00003592, WY00003593, WY00003596, and WY00003600.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a chronic condition was addressed for 1 of 4 residents (#3) reviewed for an ongoing chronic condition. The findings were: 1. Review of the 3/13/23 admission minimum data set (MDS) assessment showed resident #3 was admitted to the facility on 3/6/23 with diagnoses which included disabling cardiorespiratory conditions, respiratory failure, and disseminated intravascular coagulation. The review showed the resident had a brief interview for mental status score of 13, indicating the resident was cognitively intact. Review of the 3/6/23 "Admission-Readmission Nursing Evaluation" showed the resident had pitting edema bilaterally to the lower extremities. The	F 684	1)The resident is currently discharged from the facility. 2)Facility wide audit was done by ED and DNS to ensure resident's chronic conditions were being met and addressed. 3)Education provided to nursing staff, to ensure chronic conditions were being addressed and that orders and care plans matched the needs of the residents. 4)ED/Designee will audit each week to ensure staff are meeting the needs of the residents' chronic conditions, have appropriate orders, and are meeting the needs for treatments and the needs of the residents. Audits will be weekly for 12 weeks. Results of audits will be discussed at the monthly QAPI meeting to determine	6/15/23

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

Electronically Signed | 06/09/2023

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F 684	Continued From page 1 following concerns were identified: a. Review of the resident's care plan showed the facility failed to include a plan to address the resident's bilateral pitting edema of the lower extremities. b. Review of the physician orders showed no order to address the resident's bilateral pitting edema of the lower extremities. c. Review of the nursing progress notes from 3/6/23 to discharge on 4/26/23 showed periodic notes that included the resident having had bilateral lower extremity wraps. However, review of the March and April 2023 medication administration record and treatment administration record showed no documentation to indicate facility staff were wrapping and/or unwrapping the resident's bilateral lower extremities. d. Interview with the DON on 5/16/23 at 1 PM showed she was aware the resident had a chronic condition of bilateral lower leg edema upon admission. She further stated the facility disagreed with the treatment of wraps that was utilized prior to admission by the resident's family member, and the family member insisted on continuing to apply the wraps as utilized prior to admission. She stated the facility then left the interventions to address the resident's bilateral lower extremity edema up to the family member, and when there were issues related to the wraps the staff called the family member to address them. She confirmed the facility failed to contact the physician, no physician order was obtained, and no care plan was implemented to address the resident's chronic bilateral lower extremity edema.	F 684	correction compliance and discussion of continuation or discontinuation of audit based on results. 5)Date of Compliance: 06/15/2023	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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F 689	Continued From page 2 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and resident and staff interview, the facility failed to ensure staff were trained in the appropriate use of a mechanical lift for 1 of 5 sample residents (#4) reviewed for falls. This failure resulted in actual harm to resident #4 who suffered back pain, and head impact causing a hematoma as a result of the fall. The facility implemented corrective actions prior to the survey. These actions were verified by the survey team and the facility was determined to be in compliance on 3/8/23. The findings were: 1. Review of the 4/23/23 quarterly minimum data set (MDS) assessment showed resident #4 had a brief interview for mental status (BIMS) score of 11 out of 15 indicating moderate impairment. The resident had diagnoses which included multiple sclerosis and weakness, and was dependent on staff for transfers. Additionally, the resident had a history of falls and a fall risk score of 40 indicating the resident was at moderate risk of failling. a. Review of the 2/17/23 care plan showed staff used a mechanical lift with 2 staff members for transferring the resident, and that the resident had experienced a fall on 2/17/23. b. Review of the 2/17/23 nurse progress note time stamped 9:28 AM showed "The resident was	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 3	F 689		

in the hoyer sling when the hoyer hook lifted and unhooked the sling and the resident fell to the ground. The resident did hit [his/her] head and has a goose egg on the back of [his/her] head." Review of the 2/17/23 at 10:56 AM nurse progress note showed the resident wanted to go to the hospital due to the fall and was experiencing back pain.

c. Interview on 5/16/23 at 12:45 PM with resident #4 confirmed a fall from the mechanical lift causing a hematoma to his/her head, and back pain.

d. Interview on 5/18/23 at 8:30 AM with CNA #4 and LPN #2, who were transferring the resident with the mechanical lift on 2/17/23, confirmed after getting the resident into the sling on the mechanical lift the sling became unhooked and the resident fell to the floor hitting his/her head causing a bump. Both staff members revealed they had not been trained on how to use that specific type of lift until after the resident fall. Interview on 5/18/23 at 10:56 AM with CNA #3 revealed she had not been trained how to use that specific lift until after resident #4 fell during transfer with the lift, and that "other staff didn't like to use that lift because it was crappy." Interview on 5/17/23 at 4:35 PM with LPN #3 revealed she did not like to use that specific lift because it felt "sketchy and not safe."

e. The facility implemented a performance improvement plan which included maintenance checks all mechanical lifts on 2/20/23 to include the type of lift that was used when resident #4 fell, training of all staff who use lifts on 3/8/23, and ongoing audits of lift safety. These interventions were reviewed, and the facility was determined to be in substantial compliance as of 3/8/23.