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 11/09/2023

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 11/6/23 to 11/9/23. The survey was prompted by complaint intakes WY000003713 and WY000003721. The following common abbreviations are used throughout this document: DON: Director of Nursing MDS: Minimum Data Set BIMS: Brief Interview for Mental Status Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		12/8/23

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

Electronically Signed | 12/05/2023

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 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop and implement a comprehensive care plan for 2 of 5 sample residents (#1, #2). The finding were: 1. Review of the admission MDS assessment dated 9/21/23 showed the resident had a BIMS score of 10 out 15, which indicated moderate cognitive impairment, and diagnoses which included atrial fibrillation, heart failure, diabetes mellitus, thyroid disorder, and chronic respiratory failure with hypoxia. Further review showed no skin conditions indicated. The following concerns	F 656	1)The care plan for residents #1 was closed as resident is no longer residing at Shepherd of the Valley during time of deficiency. Resident #2 has a current and up to date care plan to include deficiency. 2)Facility wide audit was done by ED and DNS to ensure resident’s conditions were being treated and were addressed on their individual plan of care. 3)Education provided to nursing staff, to ensure skin concerns and/or wounds are communicated with nurse management and added to the individual plan of care.	

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F 656	Continued From page 2 were identified: a. Review of the physician orders showed weekly skin observations were to be completed every Friday on day shift beginning on 9/22/23. b. Review of a nursing progress note dated 9/19/23 at and timed 3 AM showed "Patient is requesting furosemide for edema in lower extremities." c. Review of a nursing progress note dated 9/22/23 and timed 9:45 PM showed "...[S/he] has +2 bilateral lower extremity edema and wears ted hose." d. Review of the baseline care plan initiated on 9/15/23 showed the facility failed to ensure a care plan was developed for the identified edema or other skin conditions. 2. Review of the admission MDS assessment dated 10/3/23 showed resident #2 was readmitted to the facility on 9/27/23, had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included pressure ulcer of the sacral region, paraplegia, pain, and sepsis. Further review showed the resident had treatments which included pressure ulcer/injury care, a turning/repositioning program, and a pressure reducing device for his/her bed. The following concerns were identified: a. Review of the "Admission-Readmission Nursing Evaluation" dated 9/27/23 showed the resident had an IV to the left upper arm with a dressing intact for antibiotic therapy only, a urinary catheter size 16 French with a 30 cc balloon, and a nonsurgical wound with a wound vacuum device in place on his/her sacrum. Further review showed the resident preferred to take a bath once a week and there was no mention of showers.	F 656	4)ED/Designee will audit each week to ensure staff are meeting the requirements of individual plan of cares, to include but not limited to, skin concerns, condition, and/or wounds, and meeting 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 correction compliance and discussion of continuation or discontinuation of audit based on results.	

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F 656	Continued From page 3 b. Review of a nurse progress note dated 9/28/23 and timed 9:58 PM showed the resident had a "midline picc" to his/her left upper extremity and received an antibiotics via IV and another antibiotic by mouth. Further review showed the resident had a pressure ulcer on the left buttock and sacral region and had a vacuum device in place which was to be changed three times a week. c. Review of the 10/10/23 care plan for resident #2 showed the facility failed to address the need for antibiotic therapy, pressure injuries, a wound vacuum device, and an intravenous device. 3. Interview with the DON on 11/7/23 at 12:50 PM confirmed it was the facility's expectation for a care plan to be developed if they were treating a resident for a specific condition.	F 656		