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 10/31/2024

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 recertification survey was conducted by Healthcare Licensing and Surveys from 10/28/24 to 10/31/24. Also reviewed in the course of the survey were complaint intakes WY00004008 and WY00004022. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant DON: Director of Nursing RN: Registered Nurse MDS: Minimum Data Sheet BIMS: Brief Interview for Mental Status Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...	F 676		12/6/24

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

Electronically Signed | 11/25/2024

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 676	Continued From page 1 §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, medical record review, and policy and procedure review, the facility failed to ensure restorative nursing care was provided to maintain residents' ability to carry out activities of daily living for 2 of 3 sample residents (#22, #100) reviewed for restorative nursing. The findings were: 1. Review of the annual MDS assessment dated 9/12/24 showed resident #22 had a BIMS score of 15 out 15, which indicated the resident was cognitively intact, and had diagnoses which included an unspecified fracture of right lower leg, morbid obesity, and other muscle spasms. Further review showed the resident had functional limitation in range of motion for bilateral upper and lower extremities and no restorative	F 676	Restorative services are being provided to Residents #22 and #100 to ensure residents are given the treatment and services to maintain abilities in activities of daily living. Audit of restorative programs was done to ensure residents are receiving services to appropriately meet their restorative needs and care plan. Staff were educated to provide restorative services based on the restorative plan written and the needs of the residents. The DNS/Designee will audit randomly to ensure accuracy. Audits will be weekly for	

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F 676	Continued From page 2 programming was performed during the 7-day lookback period. The following concerns were identified: a. Interview with the resident on 10/29/24 at 2:12 PM revealed s/he recently declined with transfers and now had to use a full body mechanical lift instead of a sit-to-stand mechanical lift. The resident revealed s/he had an active restorative nursing plan, which was not being performed, and s/he would like to complete the restorative plan; however, the restorative staff was being pulled to the floor to work open shifts. Further interview revealed s/he mentioned his/her desire to participate in restorative during the last care plan meeting and was told the facility was short staffed. b. Review of the August 2024 "Documentation Survey Report" showed the resident was to receive "Nursing Rehab/Restorative: Active ROM [range of motion] Program: Bike 1-2x/week [1 to 2 times per week] as tolerated and "Nursing Rehab/Restorative: Transfer Program: Standing neurogym/parallel bars 1-2x/week as tolerated." Further review showed each of the programs were provided twice during the month, on 8/13/24 and 8/14/24. Review of the September 2024 "Documentation Survey Report" showed the resident received each program once during the month, on 9/19/24. Review of the October 2024 "Documentation Survey Report" showed the resident received each program once during the month, on 10/24/24. 2. Review of the quarterly MDS assessment dated 7/23/24 showed resident #100 had a BIMS score of 7 out 15, which indicated severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia, fibromyalgia,	F 676	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.	

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F 676	Continued From page 3	F 676		

inflammatory polyarthropathy, and unspecified neuralgia and neuritis. Further review showed the resident had no range of motion impairment and no restorative programming was performed during the 7-day look back period. The following concerns were identified:

a. Review of the August 2024 "Documentation Survey Report" showed the resident was to receive "Nursing Rehab/Restorative: Active ROM Program: Bike or NuStep 1-2x/week as tolerated and "Nursing Rehab/Restorative: Walking Program: Ambulate distance tolerated with assist 1-2x/week as tolerated." Further review showed each of the programs were provided four times during the month, on 8/2/24, 8/15/24, 8/21/24, and 8/30/24. Review of the September 2024 "Documentation Survey Report" showed the resident received each program once during the month, on 9/30/24. Review of the October 2024 "Documentation Survey Report" showed the resident received each program twice during the month, on 10/8/24 and 10/24/24.

3. Interview with the DON and MDS coordinator on 10/31/24 at 8:30 AM confirmed the lack of restorative nursing was due to restorative aides working the floor.

4. Review of the policy titled "Restorative Program," last updated March 2019, showed "...The following residents may be appropriate for a restorative program: Any resident identified and evaluated to be appropriate on admission for a restorative program to reach their highest potential. Any resident who has a decline in level of function from baseline. Any resident discontinued from active therapy that requires ongoing restorative to maintain their functional

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F 676	Continued From page 4 gains. Any resident at risk for declining in function..."	F 676		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and medical record review, the facility failed to ensure activities meet the interest/needs of each resident for 4 of 6 sample residents (#22, #30, #41, #61) reviewed for activities. The findings were: 1. Review of the significant change MDS assessment dated 10/15/24 showed resident #30 had a BIMS score of 15 out 15, which indicated the resident was cognitively intact, and diagnoses which included amputation. Further review showed the resident indicated it was very important to go outside and get fresh air when the weather was good and somewhat important to listen to music s/he liked and to do his/her favorite activities. Review of the care plan last revised on 10/22/24 showed the resident would like staff to continue to invite him/her to activities that may be of interest, and encourage him/her to participate in activities of interest. The following	F 679	Activity services are being provided to Residents #22, #30, #41, and #61 to ensure residents are offered activities that meet their needs. Audit of activities programs was done to ensure residents are receiving activities of interest and activities that meet their needs. Staff were educated to provide activities based on the residents needs and interests. The DNS/Designee will audit 10 residents randomly to ensure accuracy. 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	12/6/24

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F 679	Continued From page 5 concerns were identified a. Interview with the resident on 10/28/24 at 2:45 PM revealed s/he was unaware of any group activities that were available. b. Review of the activity participation log for the resident showed the resident actively participated in the independent activities of watching television and sensory stimulation on 11 of 48 days reviewed, and actively participated in the independent activities of reading, puzzles, and newspaper on 3 of 48 days reviewed. There was no participation in any other activities indicated. c. Interview with the activity director on 10/31/24 at 1:31 PM revealed activity aides should tell residents about activities upon admission. 2. Review of the significant change MDS assessment dated 10/3/24 showed resident #61 had a BIMS score of 10 out of 15, which indicated moderate cognitive impairment, and diagnoses which included depression, partial amputation of right foot, and phantom limb syndrome with pain. Review of the care plan last revised on 10/8/24 showed the resident would like staff to continue to invite him/her to activities that may be of interest, and encourage him/her to participate in activities of interest. a. Interview with resident #61 on 10/29/24 at 8:59 AM revealed s/he would like to play BINGO. b. Review of the activity participation log showed the resident actively participated in the independent activities of watching television and sensory stimulation on 12 of 64 days reviewed, and actively participated in the independent activities of reading, puzzles, and newspaper on 5 of 64 days reviewed. There was no participation in any other activities indicated, including BINGO.	F 679	compliance and discussion of continuation or discontinuation of audit based on results.	

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F 679	Continued From page 6	F 679		

3. Review of the annual MDS assessment dated 9/17/24 showed resident #41 had a BIMS score of 15 out 15, which indicated the resident was cognitively intact, and had diagnoses which included hemiplegia or hemiparesis, seizure disorder or epilepsy, anxiety disorder, and depression. Further review showed the resident indicated it was very important to listen to music s/he liked, to be around animals, to do his/her favorite activities, to go outside to get fresh air when the weather was good, and to participate in religious services or practices. In addition, the resident indicated it was somewhat important to have books, newspapers, and magazines to read and do things with groups of people. Review of the care plan last revised on 10/21/24 showed the resident would like staff to continue to invite him/her to activities that may be of interest, and encourage him/her to participate in activities of interest.

a. Interview with the resident on 10/29/24 at 10:23 AM revealed the resident would attend activities when "...they're good enough to go to. I would go if they weren't for old people and if it was interesting."

b. Review of the activity participation log for the resident showed s/he actively participated in the independent activities of watching television and sensory stimulation on 25 of 96 days reviewed, and actively participated in the independent activities of reading, puzzles, and newspaper on 4 of 96 days reviewed. There was no participation in any other activities indicated.

c. Interview with the activity director on 10/31/24 at 1:26 PM revealed the resident participated in fishing, fair and rodeo events last summer; however, she revealed the facility was not able to do many outings at that time due to

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F 679	Continued From page 7	F 679		

low staffing and the facility only having one van in use. She confirmed the resident did not participate in the group activities they provided at the facility.

4. Review of the annual MDS assessment dated 9/12/24 showed resident #22 had a BIMS score of 15 out 15, which indicated the resident was cognitively intact, and had diagnoses which included an unspecified fracture of right lower leg, morbid obesity, and other muscle spasms. Further review showed it very important to the resident to have books, newspapers, and magazines to read, listen to music s/he liked, keep up with the news, do his/her favorite activities, and go outside to get fresh air when the weather is good. Review of the resident's care plan, last revised on 9/16/23 showed activities of interest included animals and pets, helping others and volunteering, cooking and baking, dining out, movies, politics, listening to the radio, reading, shopping, television, and theater/plays. The following concerns were identified:

a. Interview with the resident on 10/29/24 at 2:12 PM revealed s/he taught first and second grade and felt the activities s/he did with his/her classes were the same kind of activities offered at the facility and s/he did not care for them.

b. Review of the activity participation record from 9/1/24 through 10/30/24 showed the resident was an active participant in independent activities on 26 out of 60 days reviewed. Further review showed no other type of activity participation was documented and the independent activities included reading, puzzles, television, sensory stimulation, mail delivery, newspaper, and snacks.

c. Interview with the activity director on 10/31/24 at 1:11 PM revealed she was aware the

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F 679	Continued From page 8 resident did not like to participate in the offered group activities and the resident had been offered 1 to 1 activities. She revealed staff check in with the resident once each month and they try to have outings. 5. Interview with the activity director on 10/31/24 at 1:31 PM revealed the facility needed to get better about activity aides inviting residents from all the units and the activity department had been without full staff for a few months. The activity director had been trying to hire two more staff for most of the summer. Further interview revealed they try to assess residents for activities they would like to participate in.	F 679		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff 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 the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and	F 725		12/6/24

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F 725	Continued From page 9 (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and medical record review, the facility failed to ensure sufficient staffing to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident on 2 of 5 resident care units (south, east). The census was 155. The findings were: 1. Interview with 10 residents during the resident council meeting on 10/29/24 at 9:28 AM revealed turnover in CNAs and the facility being short-staffed has resulted in care not being provided timely, call lights were not answered for 30 to 40 minutes, beds were not made, and rooms did not look nice. The group felt the facility needed more staff. 2. Interview with resident #41 on 10/29/24 at 10:21 AM revealed there was never enough staff. 3. Interview with resident #67 on 10/29/24 at 2:42 PM revealed "sometimes" the facility did not have enough staff. 4. Interview with resident #24 on 10/29/24 at 10:03 AM revealed s/he felt the facility could use more staff and call lights were not always answered timely. 5. Interview with resident #22 on 10/29/24 at 2:12	F 725	Restorative services for resident #100, and bathing for residents #22, #27, and #130, are being provided to Residents to ensure residents are given the treatment and services to maintain abilities in activities of daily living. Audit of restorative programs and bathing were done to ensure residents are receiving services to appropriately meet their needs and care plan preferences. Staff were educated to provide restorative services and showers based on the restorative plan written and the needs of the resident on the care plan. The DNS/Designee will audit 10 residents randomly to ensure accuracy. 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.	

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PM revealed s/he did not always receive showers. The resident revealed s/he "went without showers for a while" at the end of September and beginning of October and then was only provided 1 shower per week due to staffing issues. S/he revealed s/he recently declined with transfers and now had to use a full body mechanical lift instead of a sit-to-stand mechanical lift. The resident revealed s/he had an active restorative nursing plan, which was not being performed, and s/he would like to complete the restorative plan; however, the restorative staff was being pulled to the floor to work open shifts. Further interview revealed s/he mentioned his/her desire to participate in restorative during the last care plan meeting and was told the facility was short staffed. The following concerns were identified:

a. Review of the 30-day bathing record on 10/30/24 showed the resident received no showers prior to 10/21/24 and the resident was marked "not applicable" on 10/10/24 and 10/16/24. Review of the updated 30-day bathing record on 10/31/24 showed the resident received showers on 10/3/24, 10/8/24, and 10/14/24, which were not previously documented. Further review showed the showers were documented by the DON. Review of "East Station Bath Schedule" logs for 10/3/24, 10/8/24, and 10/14/24 showed the resident was listed with other residents, there were 8 columns, and there was no evidence the resident received showers.

b. Review of the August 2024 "Documentation Survey Report" showed the resident was to receive "Nursing Rehab/Restorative: Active ROM [range of motion] Program: Bike 1-2x/week [1 to 2 times per week] as tolerated and "Nursing Rehab/Restorative: Transfer Program: Standing neurogym/parallel

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bars 1-2x/week as tolerated." Further review showed each of the programs were provided twice, on 8/13/24 and 8/14/24. Review of the September 2024 "Documentation Survey Report" showed the resident received each program once, on 9/19/24. Review of the October 2024 "Documentation Survey Report" showed the resident received each program once, on 10/24/24.

6. Review of the 30-day bathing record on 10/30/24 showed resident #27 received a bath 10/8/24 and was marked "not applicable" on 10/1/24, 10/15/24, 10/17/24, 10/22/24, and 10/24/24. Review of the updated 30-day bathing record on 10/31/24 showed the resident received showers on 10/1/24, 10/15/24, 10/24/24, and 10/29/24 which were not previously documented. Further review showed the showers were documented by the DON. Review of "East Station Bath Schedule" logs for 10/1/24, 10/15/24, 10/24/24, and 10/29/24 showed the resident was listed with other residents, there were 8 columns, and there was no evidence the resident received showers.

7. Review of the 30-day bathing record on 10/30/24 showed resident #130 received no bathing and was marked "not applicable" on 10/16/24 and 10/23/24. Review of the updated 30-day bathing record on 10/31/24 showed the resident received showers on 10/3/24, 10/10/24, 10/17/24, and 10/24/24 which were not previously documented. Further review showed the showers were documented by the DON. Review of "East Station Bath Schedule" logs for 10/3/24, 10/10/24, 10/17/24, and 10/24/24 showed the resident was listed with other residents, there were 8 columns, and there was no evidence the

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	535042	A. BUILDING _____ B. WING _____	C 10/31/2024

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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 725	Continued From page 12 resident received showers. 8. Review of the August 2024 "Documentation Survey Report" showed resident #100 was to receive "Nursing Rehab/Restorative: Active ROM Program: Bike or NuStep 1-2x/week as tolerated and "Nursing Rehab/Restorative: Walking Program: Ambulate distance tolerated with assist 1-2x/week as tolerated." Further review showed each of the programs were provided four times, on 8/2/24, 8/15/24, 8/21/24, and 8/30/24. Review of the September 2024 "Documentation Survey Report" showed the resident received each program once, on 9/30/24. Review of the October 2024 "Documentation Survey Report" showed the resident received each program twice, on 10/8/24 and 10/24/24. 9. Interview with the DON and MDS coordinator on 10/31/24 at 8:30 AM revealed the shower information was updated in the system because the bath aides keep a bath schedule log list in the bath house with showers that were provided. They confirmed the system was updated, after the bathing records were requested, with information from the bath schedule logs and the staff member who completed the logs no longer worked at the facility. Further interview confirmed the lack of restorative nursing was due to restorative aides working the floor. 10. Interview with the administrator and regional clinical director on 10/31/24 at 1:55 PM revealed the "East Station Bath Schedule" logs were not part of resident records. Further interview confirmed bathing was expected to be documented in resident records when they occurred.	F 725		

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F 758	Continued From page 13	F 758		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		12/6/24

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or

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F 758	Continued From page 14 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure target symptoms were identified for 5 of 5 sample residents (#45, #96, #72, #114, #120) reviewed for unnecessary psychotropic medications. The findings were: 1. Review of the quarterly MDS assessment dated 9/3/24 showed resident #45 had a BIMS score of 7 out of 15, which indicated severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia, seizure disorder, anxiety disorder, depression, psychophysiological insomnia, and severe intellectual disabilities or severe mental retardation. Further review showed the resident received antipsychotic medication, antianxiety medication, and antidepressant medication during the look back period. Review of the physician orders showed the resident received Ativan (antianxiety) 1 milligram (mg) by mouth three times per day for anxiety, bupropion (antidepressant) 300 mg by mouth daily for depression, buspirone (antianxiety) 10 mg by mouth three times per day for anxiety, sertraline (antidepressant) 60 mg by mouth daily for major	F 758	The targeted behaviors for psychotropic medications were added to the TAR and Care Plan of residents #45, #96, #72, #114, and #120. Initial audit completed of residents receiving psychotropic medications with any identified concerns corrected. Management will ensure targeted behaviors are added to the TAR and Care Plan when psychotropic medications are ordered and/or changed and will be reviewed during the weekly psych meeting. Staff were educated on expectations with psychotropic medications and identifying targeted behaviors for said medications. DNS/Designee will audit randomly to ensure compliance. 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	

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F 758	Continued From page 15 depressive disorder, and trazadone (antidepressant) 25 mg by mouth daily for insomnia. a. Review of the physician orders showed no evidence the facility had identified or was monitoring medication or resident specific target symptoms to evaluate the effectiveness of each medication. b. Review of the care plan showed no evidence the facility had identified medication or resident specific target symptoms. 2. Review of the quarterly MDS assessment dated 9/16/24 showed resident #96 BIMS score of 12 out 15, which indicated the resident was cognitively intact, and had diagnoses which included non-Alzheimer's dementia, depression, unspecified sequelae infarction, cognitive communication deficit, and suicidal ideation. Further review showed the resident received antipsychotic and antidepressant medication during the look back period. Review of the physician orders showed the resident received quetiapine (antipsychotic) 25 mg by mouth daily for sleep and agitation and sertraline (antidepressant) 150 mg by mouth daily for major depressive disorder. The following concerns were identified: a. Review of the physician orders showed no evidence the facility had identified or was monitoring medication or resident specific target symptoms to evaluate the effectiveness of each medication. b. Review of the care plan showed no evidence the facility had identified medication or resident specific target symptoms. 3. Review of the 5-day Medicare MDS assessment dated 9/20/24 showed resident #120	F 758	discontinuation of audit based on results.	

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F 758	Continued From page 16	F 758		

had a BIMS score of 3 out of 15, which indicated severe cognitive impairment, and diagnosis which included non-Alzheimer's dementia, depression, and post-traumatic stress disorder (PTSD). Review of the physician orders showed the resident received escitalopram (antidepressant) 5mg by mouth daily for major depressive disorder, olanzapine (antipsychotic) 10mg by mouth daily for mood disorder, and divalproex (anticonvulsant) 500 mg by mouth three times a day for unspecified dementia with other behavioral disturbance. The following concerns were identified:

a. Review of the physician orders showed no evidence the facility had identified or was monitoring medication or resident specific target symptoms to evaluate the effectiveness of each medication.

b. Review of the care plan showed no evidence the facility had identified medication or resident specific target symptoms.

4. Review of the annual MDS assessment dated 9/27/24 showed resident #72 had a BIMS score of 0 out of 15, which indicated severe cognitive impairment, and diagnosis which included non-Alzheimer's dementia and anxiety disorder. Review of the physician orders showed the resident received Seroquel (antipsychotic) 50 mg by mouth daily for unspecified dementia, behavioral, psychotic and mood disturbance, mirtazapine (antidepressant) 7.5mg by mouth daily for unspecified dementia and anxiety disorder, and fluoxetine (antidepressant) 40mg by mouth daily for unspecified dementia. The following concerns were identified:

a. Review of the physician orders showed no evidence the facility had identified or was monitoring medication or resident specific target

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symptoms to evaluate the effectiveness of each medication.

b. Review of the care plan showed no evidence the facility had identified medication or resident specific target symptoms.

5. Review of the significant change MDS dated 10/11/24 showed resident #114 had a BIMS score of 5 out of 15, which indicated severe cognitive impairment and diagnosis which included dementia, depression, and bipolar disorder. Review of the physician orders showed the resident received fluoxetine (antidepressant) 20mg by mouth daily for bipolar disorder and olanzapine (antipsychotic) 10 mg by mouth daily for bipolar disorder. The following concerns were identified:

a. Review of the physician orders showed no evidence the facility had identified or was monitoring medication or resident specific target symptoms to evaluate the effectiveness of each medication.

b. Review of the care plan showed no evidence the facility had identified medication or resident specific target symptoms.

6. Review of the policy titled "Psychotropic Drugs" last updated October 2022, showed "...2. Psychotropic drugs can be therapeutic and enhancing quality of life for residents suffering from mental illnesses (schizophrenia, depression, etc.), the Interdisciplinary Team (IDT) validates there are appropriate diagnoses of behavioral symptoms, so the underlying cause of the symptoms is recognized, and the condition is treated appropriately...5...d. The Interdisciplinary Team (IDT) evaluates the resident's medication regime to validate the resident is not receiving duplicate drug therapy. Duplicate drug therapy is

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F 758	Continued From page 18 any drug that duplicates a particular drug effect on the resident, whether from the same drug class or not..."	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to label and provide the date medications were opened in 2 of 6 medication storage areas (south hall medication cart #1, south hall medication cart #2). The	F 761	The opened and undated medications were discarded at the time of discovery by unit managers and DNS. Initial audit completed of medication	12/6/24

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F 761	Continued From page 19 findings were: 1. Observation of the South Hall medication cart #1 on 10/29/24 at 2:50 PM showed the following three Lantus Solostar Insulin pens, two Novolog Insulin Aspart pens, and a Humalog Insulin pen which were opened and not dated. 2. Observation of the South Hall medication cart #2 on 10/29/24 at 2:35 PM showed the following one Novolog Insulin Aspart pen which was opened and not dated. 3. Interview with the RN #1 on 10/29/24 at 2:35 PM revealed insulin pens should be labeled with the date they were opened. 4. Interview with the DON on 10/31/24 at 10:41 AM revealed the nursing staff were responsible for labeling multidose medications with the resident's name and the date the medication was opened. 5. Review of the policy titled "Medication Storage and Handling" dated 6/23 showed "...multi-dose vials which have been opened or accessed should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial..."	F 761	storage areas with any identified concerns corrected. Nurse management will ensure insulin pens are dated when they are removed from the refrigerator. Staff were educated on expectations with medication labeling, handling, and storage. DNS/Designee will audit randomly to ensure compliance. 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.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		12/6/24

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F 842	Continued From page 20	F 842		

agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained

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F 842	Continued From page 21 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, medical record review, bath schedule log review, and policy and procedure review, the facility failed to ensure medical records were accurately documented for 3 of 5 sample residents (#22, #27, #130) reviewed for bathing. The findings were: 1. Interview with resident #22 on 10/29/24 at 2:12 PM revealed s/he did not always receive showers. The resident revealed during the beginning of October, s/he "went without showers for a while" at the end of September and beginning of October and then only provided 1 shower per week due to staffing issues. Review of the 30-day bathing record on 10/30/24 showed the resident received no showers prior to 10/21/24 and the resident was marked "not	F 842	Residents #22, #27, and #130 are receiving appropriate shower documentation in the medical record. Audit performed by AED and DNS, of entire building, randomly observing staff and units, to ensure compliance with documentation. Any needed corrections were done at that time. Staff were educated on expectations with documentation in PCC at end of shift. DNS/Designee will audit randomly to ensure compliance. Audits will be weekly for 4 weeks and then monthly for three months. Results of audits will be discussed at the monthly QAPI meeting to	

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F 842	Continued From page 22 applicable" on 10/10/24 and 10/16/24. Review of the updated 30-day bathing record on 10/31/24 showed the resident received showers on 10/3/24, 10/8/24, and 10/14/24, which were not previously documented. Further review showed the showers were documented by the DON. Review of "East Station Bath Schedule" logs for 10/3/24, 10/8/24, and 10/14/24 showed the resident was listed with other residents, there were 8 columns, and there was no evidence the resident received showers. 2. Review of the 30-day bathing record on 10/30/24 showed resident #27 received a bath 10/8/24 and was marked "not applicable" on 10/1/24, 10/15/24, 10/17/24, 10/22/24, and 10/24/24. Review of the updated 30-day bathing record on 10/31/24 showed the resident received showers on 10/1/24, 10/15/24, 10/24/24, and 10/29/24 which were not previously documented. Further review showed the showers were documented by the DON. Review of "East Station Bath Schedule" logs for 10/1/24, 10/15/24, 10/24/24, and 10/29/24 showed the resident was listed with other residents, there were 8 columns, and there was no evidence the resident received showers. 3. Review of the 30-day bathing record on 10/30/24 showed resident #130 received no bathing and was marked "not applicable" on 10/16/24 and 10/23/24. Review of the updated 30-day bathing record on 10/31/24 showed the resident received showers on 10/3/24, 10/10/24, 10/17/24, and 10/24/24 which were not previously documented. Further review showed the showers were documented by the DON. Review of "East Station Bath Schedule" logs for 10/3/24, 10/10/24, 10/17/24, and 10/24/24 showed the	F 842	determine correction compliance and discussion of continuation or discontinuation of audit based on results.	

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F 842	Continued From page 23 resident was listed with other residents, there were 8 columns, and there was no evidence the resident received showers. 4. Interview with the DON and MDS coordinator on 10/31/24 at 8:30 AM revealed the shower information was updated in the system because the bath aides keep a bath schedule log list in the bath house with showers that were provided. Further interview confirmed the system was updated, after the bathing records were requested, with information from the bath schedule logs and the staff member who completed the logs no longer worked at the facility. 5. Interview with the administrator and regional clinical director on 10/31/24 at 1:55 PM revealed the "East Station Bath Schedule" logs were not part of resident records. Further interview revealed bathing was expected to be documented in resident records when it occurred.	F 842		
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:	F 880		12/6/24

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	535042	A. BUILDING _____ B. WING _____	C 10/31/2024

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 880	Continued From page 24 §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 §483.71 and following accepted national standards; §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.	F 880		

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 10/31/2024

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F 880	Continued From page 25 §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. §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 review, the facility ensure infection control procedures were implemented for 1 of 2 sample residents (#77) reviewed for enhanced barrier precautions. The findings were: 1. Observation of resident #77's room door on 10/29/24 at 9:56 AM revealed an Enhanced Barrier Precaution (EBP) stop sign posted on the outside of the room door. Observation of personal care for the resident at that time showed RN #2, wore gloves and no gown and was crawling on the residents' mattresses, which were on the floor. The RN removed the resident's gastric tube dressing then assisted CNA #1 to reposition the resident to the edge of the mattress. RN #1 bear hugged the resident and lifted him/her up and onto the shower chair while CNA #1 held and positioned the shower chair. Further observation showed there were no gowns in the room; however, the RN stated "there was a whole box at one time." Further interview with the RN at that time revealed the EBP sign on the door indicated that staff were supposed to wear a gown along with gloves for high contact resident care;	F 880	Nurse was made aware of surveyor observations at time of discovery and immediately verbally educated. Proper PPE is provided per policy for resident #77. Audit performed by AED and DNS, of entire building, randomly observing staff and units, to ensure compliance with PPE. Any needed corrections were done at that time. Staff were educated on expectations with PPE. DNS/Designee will audit randomly to ensure compliance. Audits will be weekly for 4 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 26 however, she stated "we didn't." 5. Interview with CNA #2 on 10/30/24 at 11:10 AM revealed she had never heard about wearing gowns when assisting residents until 10/29/24. Further interview revealed staff were told to wear PPE when caring for residents with wounds and catheters; however, she was unsure why. 6. Interview with infection preventionist (IP) #1 and #2 on 10/31/24 at 12:45 PM revealed EBP are to be used with high contact care on residents with wounds, catheters, feeding tubes, central lines, PICC lines, and residents receiving dialysis. IP #2 stated stop signage was on the door to make staff aware of EBP. IP #1 stated the expectation of staff and EBP was for gowns and gloves to be worn with high contact care. 7. Review of policy titled "Enhanced Barrier Precautions" last revised on 3/26/24 showed EBP were used in conjunction with standard precautions and to expand the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of multi-drug resistant organisms to staff hands and clothing. Further review showed EBP were indicated for residents with indwelling medical devices and examples included feeding tubes.	F 880		