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 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS	**60 MAGNOLIA CASPER, WY 82604**

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 9/9/24 through 9/10/24. The survey was prompted by complaint intakes WY00003967 and WY00003971. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		

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

Electronically Signed | 10/04/2024

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F 600	Continued From page 1 Based on medical record review, staff interview, review of incident and facility documentation, and policy and procedure review, the facility failed to ensure residents were free from physical abuse by other residents for 1 of 4 allegations reviewed, which resulted in actual harm to resident #1. The findings were: The facility had implemented corrective action prior to the survey and was determined to be in substantial compliance as of 9/6/24. 1. Review of the 8/18/24 quarterly MDS assessment showed resident #1 (victim) had severely impaired cognitive skills, had a diagnosis of non-Alzheimer's dementia, wandered daily, and exhibited physical behaviors 1-3 days a week. 2. Review of the 7/17/24 quarterly MDS assessment showed resident #2 (perpetrator) had a BIMS score of 10, indicating moderate impairment. In addition, the resident had diagnoses including traumatic brain injury and non-Alzheimer's dementia, and did not exhibit behaviors. Review of the the care plan, initiated 11/13/23, showed the resident had a behavior problem of making comments about being violent to women in the past, and stating how s/he was still capable of these actions. The resident would say that and then laugh, and say s/he would never do that. 3. Review of an incident report showed on 8/14/24 at 6:45 PM resident #1 approached resident #2 and was waving his/her fingers near the other resident's face and was saying something. Resident #2 said something back, and then resident #1 grabbed the arms of	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

resident #2. The two residents then were shoving back and forth. The residents were separated and neither had injuries.

4. Review of an incident report showed on 8/18/24 at 12:45 PM resident #1 approached resident #2 in the hallway and was "getting in [his/her] face." Resident #2 then punched resident #1 in the face, causing the resident to fall on his/her bottom. The incident report showed the resident stated s/he hit the other resident because the other resident "flipped me off and threatened to hit me, so I hit [him/her] first." The resident was taken to the hospital and found to have a nasal bone fracture.

5. Review of the history and physical from the hospital dated 8/18/24 showed resident #1 was punched in the face by another resident. The resident had a small skin tear and bruise noted to the bridge of the nose. The documentation showed "...[s/he] has a nasal bone fracture with what looks like chronic sinusitis on CT scan."

6. During an interview on 9/9/24 at 5:09 PM LPN #1 stated she was outside on the phone with a doctor on 8/18/24 when CNA students came out and got her and stated resident #2 punched resident #1 in the face. When she went inside she saw that resident #1 was on the ground, his/her nose looked broken, and his/her face was swelling.

7. During an interview on 9/9/24 at 5:11 PM CNA student #1 stated she witnessed resident #2 hit resident #1 in the face. She stated she saw his/her fist connect with the other resident's face, and then the resident fell down.

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F 600	Continued From page 3 8. Review of the facility's policy "Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation," updated October 2022, showed "...Each resident has the right to be free from abuse..." The definition of abuse was "The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish..."willful", as used in this definition of abuse, means the individual acted deliberately, not that the individual must have intended to inflict injury or harm." The definition of physical abuse included punching. 9. The facility implemented the following correction action by 9/6/24: a. Resident #2 was moved out of the secure unit with a wanderguard and increased supervision. b. Resident #1 had increased supervision when s/he returned from the hospital. c. A facility-wide audit was done to ensure no other physical altercations had taken place. d. Education was provided to staff to ensure escalating behaviors were being redirected before physical aggression took place. e. Weekly audits were started to ensure escalating behaviors were being redirected. Audits to be done weekly then monthly for 12 weeks and discussed in the QAPI meetings.	F 600		
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	F 656		10/11/24

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F 656	Continued From page 4 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). (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	F 656		

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F 656	Continued From page 5 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of incident reports, the facility failed to develop an individualized, comprehensive care plan for 1 of 5 sample residents (#2). The findings were: 1. Review of the 7/17/24 quarterly MDS assessment showed resident #2 had a BIMS score of 10, indicating moderate impairment. In addition, the resident had diagnoses including traumatic brain injury and non-Alzheimer's dementia, and did not exhibit behaviors. Review of the the care plan, initiated 11/13/23, showed the resident had a behavior problem of making comments about being violent to women in the past, and stating how s/he was still capable of these actions. The resident would say that and then laugh, and say s/he would never do that. The following concerns were identified: a. Review of an incident report showed on 8/14/24 at 6:45 PM resident #1 approached resident #2 and was waving his/her fingers near the other resident's face and was saying something. Resident #2 said something back, and then resident #1 grabbed the arms of resident #2. The two residents then were shoving back and forth. The residents were separated and neither had injuries. b. Review of an incident report showed on 8/18/24 at 12:45 PM resident #1 approached resident #2 in the hallway and was "getting in [his/her] face." Resident #2 then punched resident #1 in the face, causing the resident to fall on his/her bottom. The incident report showed the resident stated s/he hit the other resident	F 656	1. Care plan for Resident #1 was updated and is accurately displaying behavioral concerns. 2. Facility wide audit was done by ED and DNS to ensure residents behaviors are appropriately care planned. 3. Education provided to staff, to ensure care plans are updated as any new behaviors are learned and/or exhibitied. 4. ED/Designee will audit each week to ensure residents behaviors, both newly exhibited and/or newly learned by staff, are care planned appropriately. Audits will be weekly for 4 weeks then monthly, for a total of 12 weeks. Results of audits will be discussed at the monthly QAPI meeting to determin correction, compliance, and discussion of continuation or discontinuations of audit based on results.	

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F 656	Continued From page 6 because the other resident "flipped me off and threatened to hit me, so I hit [him/her] first." The resident was taken to the hospital and found to have a nasal bone fracture. c. Review of the care plan showed the care plan was updated on 8/18/24 to add an intervention of "I like to visit about sports, etc.; engage me in conversation as a distraction if I am anxious." However, the care plan did not address the physical behaviors of the resident, including punching another resident in the face. d. During an interview on 9/10/24 at 11:19 AM the DON confirmed the resident's care plan did not include potential or actual physical aggression, including the resident's history of punching another resident.	F 656		