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	12/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Rehabilitation and Wellness	60 Magnolia Casper, WY 82604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25745 Based on medical record review, resident interview, staff interview, incident review, and policy and procedure review, the facility failed to ensure 1 of 2 sample residents (#3) was free from unwanted sexual touching. The findings were: Review of the 12/18/21 admission minimum data set (MDS) assessment showed resident #4 was admitted to the facility on [DATE], and a brief interview for mental status (BIMS) score of 13, indicating the resident was cognitively intact. Review of the progress note of 12/13/21 timed 8:59 PM showed under skilled needs: . Other abnormal findings include: Sexually inappropriate with female staff. This statement was repeated in progress notes on 12/14/21, 12/15/21, and 12/16/21. The following concerns were identified: 1. Review of the care plan for resident #4 showed the following plan dated 12/16/21: Problem: Resident has dis-inhibited sexual behavior r/t: Bold behaviors, Fondling, Verbal comments (sexual), Flirting. Goal: I will have the best possible physical well-being. Interventions: Praise positive actions. There were no other interventions for the identified problem, and no interventions designed to ensure resident safety. 2. Review of a progress note dated dated 12/18/21 at 3:57 PM showed, A [gender] resident came to staff nurse on Rapid and verbalized that this resident touched [his/her] shoulder and breast. Management notified. MD notified. Local police notified. At approximately 12:45 PM resident (alleged perpetrator) escorted from facility with local authorities (due to an unrelated outstanding warrant). MD gave verbal order for discharge from facility. 3. Review of the 12/18/21 facility incident report showed resident #3 reported that resident #4 had been sexually inappropriate with him/her on 12/17/21 in the restorative dining area without witnesses, and s/he reported it to a nurse on 12/18/21 because staff were busy on 12/17/21. The facility's investigation showed staff reported resident #4 behaved inappropriately toward them, including an attempt to initiate a kiss from from a CNA on 12/17/21 by withholding a thermometer. The resident was educated by staff at that time regarding the behavior being inappropriate. (continued on next page)

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.

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

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	12/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Rehabilitation and Wellness	60 Magnolia Casper, WY 82604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Interview with resident #3 on 12/28/21 at 1:35 PM confirmed that s/he was in the Rapid Recovery Unit dining area sometime on 12/17/21, when resident #4 approached and grabbed his/her shoulders with his/her hands, and then his/her breast. Resident #3 stated that s/he told resident #4 to stop. Resident #4 stopped, walked to the door, came back, and repeated the behavior. Resident #3 stated that s/he again told resident #4 to stop, then resident #3 left the dining area. Resident #3 stated that no staff or other residents witnessed this interaction, and because staff were busy, s/he reported it the next day. The resident further stated s/he felt safe in the facility since resident #4 had been discharged . Review of the 12/4/21 significant change MDS assessment showed resident #3 had a BIMS score of 13, indicating the resident was cognitively intact. 5. Interview with RN #1, who worked on the Rapid Recovery Unit, on 12/29/21 at 11:15 AM revealed he was unaware of resident #4's inappropriate behavior until after the resident was discharged . 6. Interview with the administrator and RN #2 on 12/29/21 at 4:30 PM confirmed resident #4 showed unacceptable sexual behavior toward staff, but the administrator stated there was no evidence the resident showed unacceptable sexual behavior toward residents. The administrator stated the facility had 14 days from admission to formulate a comprehensive care plan and that was the reason for the lack of safety interventions. The administrator further stated the multiple dates in the progress notes for the documentation, .Other abnormal findings include: Sexually inappropriate with female staff did not mean multiple occurrences had happened, but was meant as an alert to staff. 7. Review of the policy titled Abuse Investigation dated September 2017 showed, .7. The Center investigates patterns, trends, or events that suggest the possible presence of abuse, neglect, misappropriation of resident property, exploitation, mistreatment, and injuries of unknown source, identified through analysis conducted by the QAA Committee, with intervention, reporting, or policy/process modification conducted as appropriate.

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	12/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Rehabilitation and Wellness	60 Magnolia Casper, WY 82604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25745 Based on medical record review, and staff and physician interview, the facility failed to ensure timely assessments and physician notification in accordance with professional standards for 1 of 2 sample residents (#1) who had a significant change in condition. This failure resulted in harm to resident #1, who experienced a significant delay in receiving medical intervention after a change in condition. The findings were: Review of the [DATE] significant change MDS assessment showed resident #1 was admitted to the facility on [DATE]. The resident had a brief interview for mental status (BIMS) score of 15, indicating the resident was cognitively intact. S/he required supervision of 1 staff member for transfers and walking. Review of oxygen saturation data for [DATE] through [DATE] showed the resident consistently maintained oxygen saturation levels of 88% or greater. Review of the [DATE] progress note timed at 6:33 AM showed .Note Text: 0300 [3 AM] Medaide informed this nurse about resident O2 [oxygen saturation] being 55% on 2 liters [supplemental oxygen], R [respirations] 22, P [pulse] 146, BP [blood pressure] ,d+[DATE], resident was put in a high fowlers position, oxygen tubing and nasal cannula changed, resident O2 came up to 87% on 2L [2 liters of oxygen]. At 0530 AM [5:30 AM] resident was found laying at the foot end of [his/her] bed, with no oxygen on, [s/he] was cold and clammy to touch, sweating, foaming in [his/her] mouth and [his/her] under pants and pants were below [his/her] knees. Resident was quickly put in a high fowlers position, oxygen placed back on with a venturi mask, [s/he] was slightly awake but oriented times 4. Resident's O2 started increasing and got to 86% on 4L, R 22, P106, BP ,d+[DATE]. Review of the [DATE] progress note timed at 7:45 AM showed .Note Text: Resident O2 keeps dropping, put resident on 10L [10 liters of oxygen] rebreather mask brought up to 92%. 8:20 [8:20 AM] covid test done neg [negative]. Resident took to the BR [bathroom] by the nurse on 5L [5 liters of oxygen] NC [nasal cannula] assist back to bed O2 drops to 46 [46%]. Son [son's name] notified and wants [resident] sent to [local emergency department (ED)]. [Physician] agrees to have resident sent to [local ED]. Resident alert and left for [local ED] 9:10 [9:10 AM] per ambulance. Review of the [DATE] progress note times at 8:30 AM showed .Note Text: Resident was placed on 10mL [10 liters per minute] rebreather mask O2 92%. Resident assisted to BR, O2 drops to 46 [46%] on 5L NC. Resident in high fowlers with O2 rebreather mask on at 10L comes back up to 92%. This is a new onset of shortness of breath. Resident lungs are coarse and wet throughout cough wet. Covid test at 8:20 [8:20 AM] negative. VS [vital signs] 97.2 [temperature] 104 [pulse] 32 [respirations]. Resident is alert. [Child of resident, and POA] called and wants [him/her] seen and [physician] gives order for [resident] to be seen. The following concerns were identified: 1. Review of the [DATE] progress notes showed no evidence the physician was notified of the resident's change in condition until [DATE] at 8:20 AM (5 hours and 20 minutes after the resident's oxygen saturation was first noted to be low). 2. Further review of the [DATE] timed at 6:33 AM progress note showed no evidence the resident's breath sounds were assessed by the nurse when the resident's oxygen saturation was noted to be 55 % on 2 liters of oxygen. (continued on next page)

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	12/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Rehabilitation and Wellness	60 Magnolia Casper, WY 82604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	3. Interview on [DATE] at 11:30 AM with LPN [licensed practical nurse] #1, who cared for the nurse on [DATE] during the night shift, confirmed he wrote the night shift progress notes which documented the resident's significant change in condition. He stated he felt the resident had stabilized, and he was going to pass the information on to the day shift nurses. He left the resident in order to pass medications and perform other tasks for residents in the 2 hallways he was assigned to. The LPN stated he documented everything he did, and confirmed he failed to notify the physician. 4. Interview on [DATE] at 11:50 AM with RN #3, who cared for the resident on [DATE] during the day shift revealed she felt the resident was 'okay' until the note showing she took the resident to the bathroom. At that time, she realized the resident had a significant change, and she notified the physician and family member. 5. Interview with the primary physician on [DATE] at 1:45 PM showed her expectation was for the night nurse on [DATE] to have notified her when it became obvious the resident had a significant change in condition. She stated the on-call physician service was ,d+[DATE] for the purpose of timely intervention in the case of a significant change in condition, as was the case with the resident. She stated that the facility failed to notify her in a timely manner, which was important, and the resident was diagnosed at the ED on [DATE] with pseudomonas pneumonia. She stated the POA agreed to hospice services when the resident was at the local hospital, where the resident was placed and died shortly thereafter.