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	03/22/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37603 Based on medical record review, family and staff interview, and the resident's family's written timeline, the facility failed to ensure timely assessment and treatment for 1 of 5 sample residents (#1) with a change of condition. This failure resulted in actual harm for resident #1 who was transferred to the hospital and passed away while in the emergency room waiting area. The findings were: 1. Review of the admission MDS assessment dated [DATE], showed resident #1 had a brief interview for mental status score of 9 out of 15, which indicated moderate cognitive impairment, and required moderate assistance with toileting, dressing, and personal hygiene. Further review showed the resident received antiplatelet therapy (to prevent blood clots). 2. Review of the physician orders for February 2024 showed resident #1 received Reglan (anti-emetic) 10 mg by mouth 4 times a day for 7 days for treatment of enteritis and ondansetron (anti-emetic) 4 mg by mouth every 6 hours as needed for nausea/vomiting. Further review showed the Reglan order had a start date of [DATE] and end date of [DATE]. 3. Review of the Nutrition/Hydration care plan initiated on [DATE] showed resident #1 was at increased nutritional risk impacted by diagnoses, fluctuating oral intake, and a history of slightly elevated body mass index. Interventions included .Observe for s/s [signs and symptoms] dehydration: i.e. [id est or that is] dry mouth, cracked lips, dry skin, concentrated urine/decrease urine output, rapid weight loss, dry or sunken eyes, changes in mental status, fever, vomiting, dizziness, increased combativeness or confusion . 4. Review of the [DATE] at 4:55 PM Situation, Background, Assessment, and Recommendation showed the resident's change in condition, at that time, was decreased food and/or fluid intake, functional decline, and nausea and vomiting which began on [DATE]. Review of a progress note dated [DATE] and timed 8:21 PM showed Note Text: 6:02 PM non-emergent [transport] called per MD [orders]. 6:20 PM EMTs arrived and assisted the Pt to the ER. 6:37 PM report called to ER. Review of a progress note dated [DATE] and timed 2:42 AM showed the resident was returning to the facility from the hospital with a prescription for Reglan 10mg by mouth 4 times per day and s/he should return to the hospital with any worsening abdominal pain, inability to tolerate oral intake, concern for dehydration or any other concerns. Review of a progress note dated [DATE] and timed 00:59 AM PM showed the resident returned to the facility with a diagnosis of enteritis (inflammation of the small intestine.) The following concerns were identified: (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	03/22/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	a. Review of the medication administration record for February 2024 showed the resident received ondansetron on [DATE] at 4:09 PM, on [DATE] at 5:15 PM and 8:41 PM (3 hours and 26 minutes after the previous dose), and on [DATE] at 5:24 AM and 10 25 AM (5 hours and 1 minute after the previous dose). Further review showed all administration times were indicated as effective except the 10:25 AM dose on [DATE]. b. Review of a progress noted dated [DATE] and timed 6:38 PM showed the resident had refused all meals and his/her only intake was a small orange in the morning and Pepsi. In addition, the resident had vomited around 5 PM and Zofran (ondansetron) was administered. Further review showed no evidence the physician was notified at that time. c. Review of a Medical Change of condition note dated [DATE] and timed 1:56 AM showed the resident had small amounts of emesis about every 2 hours and Zofran was administered. At that time the resident was asked if s/he wanted to go to the hospital and s/he declined stating s/he would wait until the physician came to the facility. Further review showed no evidence the physician was notified at that time. d. Review of a progress note dated [DATE] and timed 8:09 AM showed the resident had emesis and nausea; however, the order for Reglan had been discontinued after 7 days per the hospital discharge orders. Further review showed .MD to consider restarting the same medication or please advise on other course of action; however, further review showed no evidence the physician was contacted or notified of the resident's condition, at that time. e. Interview with the DON on [DATE] at 12:15 PM revealed the facility did not consider the resident's condition critical and his/her vital signs were stable. Further interview revealed the resident was transported via facility van because the van was at the facility and emergency medical services would have taken between 30 and 40 minutes to get to the facility. f. Review of a progress note dated [DATE] and timed 3:14 PM showed the resident had three to four episodes of emesis which were dark in color, all liquid. The resident's spouse was in contact with the facility and requested the resident be taken to the emergency room for evaluation. Further review showed the physician was contacted at 1:57 PM, 19 hours and 19 minutes after the first episode of vomiting, and the physician ordered non-emergent transport to the hospital related to multiple emesis episodes. Further review showed the resident left the facility at approx. [approximately] 2:45 PM, 48 minutes after the physician notification. There was no evidence the resident's vital signs were assessed prior to the transfer. g. Interview with the resident's son on [DATE] at 11:10 AM revealed the resident's family kept a written timeline of events during the resident's stay, including the day the resident passed away. Further interview revealed no facility health care staff members accompanied the resident during the transfer to the hospital and the resident was transferred via the facility van. (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	03/22/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	h. Review of the written timeline provided by the resident's family showed on [DATE] at 8:57 AM the resident called family to express s/he had a horrible night, had not stopped throwing up, and s/he was being taken back to the emergency room . Review of the timeline showed on [DATE] at approximately 1:35 PM the resident's spouse contacted the facility and they had decided to wait until the doctor came in on Tuesday [[DATE]]; however, the timeline confirmed the spouse wanted the resident transported due to the resident still throwing up after days and couldn't even keep water down and s/he would take the resident to the hospital or meet the resident at the hospital if necessary. The timeline showed on [DATE] at approximately 2:15 PM the resident was transported to the hospital via facility van, no facility healthcare staff was present, and s/he was left in the emergency department waiting area with his/her spouse and facility staff. The timeline showed on [DATE] at 3:50 PM the son called the spouse while in the waiting area. At that time the resident was bent over and throwing up. Further review of the timeline showed on [DATE] at approximately 4:15 PM the resident had collapsed in the waiting room and there was blood all over. i. Review of a SNF/NF to Hospital Transfer Form dated [DATE] and timed 1:59 PM showed the reason(s) for transfer was indicated as Nausea/vomiting. j. Interview with the facility transportation administrator on [DATE] at 11:40 AM revealed on [DATE] the facility transportation staff member took the resident to the emergency room , checked him/her in, and left the resident at the hospital with his/her spouse. The transportation administrator revealed facility staff normally go with the resident or stay in the waiting room with the resident when there was no family, the resident had dementia, or the resident was really sick. Further interview revealed normally when a resident was really sick they were transported via ambulance and not the facility van. k. Interview with the facility transportation administrator and transportation staff member on [DATE] at 11:50 AM confirmed the transportation staff member took the resident to the emergency room and revealed a nurse said the resident had to go related to complaints of nausea and the resident was going to throw up. The transportation staff obtained a vomit bag for the resident and described him/her as doubled over with his/her chest to his/her thighs. Further interview revealed the normal procedure was to transport stable residents by facility transportation and transport unstable resident by ambulance. l. Interview with the DON on [DATE] at 1:30 PM revealed the facility sends a CNA with residents when they were transferred to the emergency room at times; however, it was up to the nurse's judgement to determine when a CNA should accompany a resident. Further interview revealed the facility did not feel the resident needed a staff member to accompany him/her even when s/he was doubled over. m. Interview with the DON on [DATE] at 11:47 AM confirmed the resident was doubled over and nauseated at the time of transfer to the emergency room . n. Review of a progress note dated [DATE] and timed 7:30 PM showed the resident's family .came by the facility to notify [the facility the] pt [patient] deceased at hospital.