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	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

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 - 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. 16146 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 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. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	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. 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 16146 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 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.