STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535045	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Powell Valley Care Center	**777 Avenue H , Powell, Wyoming, 82435**

(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
F0000	INITIAL COMMENTS A complaint investigation was conducted on 12/1/25 to 12/2/25. The survey was prompted by complaints #1901513, #2572123, #2636834, #2646230, and #2663251. . The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F0000		12/16/2025
F0600 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;	F0600	Corrective actions for resident # 2 and resident # 4: 1. Resident # 2 was immediately assessed for injuries, emotional/psychosocial distress directly following incident (10/28/25). 2. Appropriate medical and psychosocial interventions were initiated for resident # 1, including immediate separation of both residents, increased 1:1 monitoring as much as possible along with individualized interventions to prevent combativeness already on resident plan of care. 3. Resident # 1 was immediately removed from the situation as a protective measure and while investigating, and all required reporting to the Office of Healthcare Licensing and Surveys and other contacts was completed within mandated timeframes. 1. Resident # 4 was immediately assessed for injuries, emotional/psychosocial distress directly following the incident (11/25/25)	01/05/2026

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 reverse for further 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

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F0600 SS = G	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, facility investigation review, and policy and procedure review, the facility failed to protect the residents' right to be free from physical abuse by a resident for 2 of 11 sample residents (# 2, #4) reviewed for allegations of abuse. This failure resulted in actual harm to resident #2 and resident #4. The findings were: 1. Review of the 10/21/25 annual MDS assessment showed resident #1 had a BIMS score of 0, indicating severe cognitive impairment, and diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, anxiety, and depression. Review of the care plan, initiated 5/23/23, showed the resident had impaired thought processes and impaired decision making. Review of the 10/28/25 quarterly MDS assessment showed resident #2 had a BIMS score of 0, indicating severe cognitive impairment, and diagnoses that included Alzheimer's disease, non-Alzheimer's dementia, and depression. Review of the care plan, initiated 11/12/24, showed the resident had the potential for a behavioral problem due to severely impaired cognition. The following concerns were identified: a. Review of an incident dated 10/28/25 showed resident #2 was found outside of the staff bathroom and was heard yelling “You fucking bitch! You pinched me! I oughta lay you out! I should kick your ass!.” Resident #1 was found with his/her hands near resident #2’s neck. Staff intervened and redirected the residents. After examining resident #2, nurse #1 noticed a 0.6 cm open wound on the right side of his/her neck. The wound was cleansed with wound wash and dressed with a band aid. b. Interview with RN #1 on 12/1/25 at 3:25 PM revealed she had been in the restroom when she heard yelling and quickly left the restroom, where she found resident #1 behind resident #2, and she noticed a small mark on resident #2’s neck. Resident #1 had yelled obscenities at the time. RN #1 took resident #2 to the DON who cleaned up the scratch on resident #2's neck. c. Interview with the DON on 12/2/25 at 2:12 PM confirmed she cleaned the area on resident #2's neck, and the skin was broken but did not require a dressing. 2. Review of the 11/4/25 annual MDS assessment showed resident #3 had a BIMS score of 8, indicating moderate cognitive impairment, and diagnoses that included non-Alzheimer's dementia, depression, and	F0600	Continued from page 1 2. Appropriate medical and psychosocial interventions were initiated for resident # 3, including behavior monitor every shift, hourly safety monitors, Notification to primary care Physician with medication review completed on 12/5/25, Root Cause Analysis completed on 12/8/25 with action plan to monitor medication change for effectiveness and if no improvement after 14 days, request will be made for case presentation with Wyoming Centers on Aging experts for additional professional review and recommendations. Re-education provided to staff on 12/12/25 related to findings from medication review, potential for case presentation, individualized care plan interventions for resident # 4 as well as addition to allow for natural sleep/wake patterns. 3. Resident # 3 was immediately removed from the situation as a protective measure and while investigating, and all required reporting to the Office of Healthcare Licensing and Surveys and other contacts was completed within mandated timeframes. Corrective actions for all residents as this has the potential to affect all residents: 1. A facility-wide audit of residents with similar risk factors (e.g., cognitive impairment, behavioral symptoms) will be completed by 12/30/2025 to identify potential abuse or neglect concerns. 2. Any identified concerns will be immediately addressed through care plan updates, increased supervision, and appropriate interventions. 3. Resident care plans will be reviewed and revised as needed to include individualized abuse-prevention interventions Systemic changes to prevent recurrence: The facility will review the "Abuse, Recognizing and Reporting "policy including Immediate reporting requirements, staff responsibilities and timelines, and interventions/protective measures for residents. All staff will be re-educated on abuse prevention, recognition, reporting, and resident rights by 1/5/2026.	

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F0600 SS = G	Continued from page 2 cerebrovascular accident (CVA). Review of the care plan, last revised on 9/14/22, showed "I can be verbally aggressive (calling people fat/mean and hateful comments, cussing and yelling)…" Review of the 9/30/25 quarterly MDS assessment showed resident #4 had a BIMS score of 0, indicating severe cognitive impairment, and diagnoses that included vascular dementia and CVA. The following concerns were identified: a. Review of an incident dated 11/25/25 showed RN #1 was notified by CNA #1 that resident #3 had hit resident #4 in the face with a spiral notebook. When resident #4 was assessed there were no visible injuries. Resident #4 stated s/he was not hurt, was crying and visibly upset, and asked "why would somebody do that"? When staff asked resident #3 why s/he hit resident #4, s/he stated "[s/he's] a bitch." Resident #3 was removed from the area and staff assisted him/her to the toilet, where s/he was combative with cares. Resident #3 was then left in his/her room to try and calm down. About 30 minutes later, RN #1 was in the kitchen with another resident when she heard screaming. She saw resident #4's head being pulled back and ran over to assess the situation, and found resident #3 grabbed resident #4's hair hard and yanked it backwards with force. It took nurse #1 and CNA #1 to get resident #3 to let go of resident #4's hair. Resident #3 again started calling resident #4 names. Resident #4 was assessed and asked if s/he was okay, and staff reported s/he had a clump of about 30 hairs pulled out of his/her head, and s/he cried and stated "why did [s/he] do that?" Staff reassured resident #4 they would handle the situation. Resident #3 was removed from the unit and taken to RN #2's office to separate residents. b. Interview with RN #1 on 12/1/25 at 3:25 PM revealed she heard yelling and saw resident #3 hit resident #4 in the face with a spiral notebook. Resident #4 stated "why did [s/he] do that?" after s/he was hit. RN #1 took resident #3 to the restroom in an attempt to calm him/her down. During the toilet transfer, resident #3 grabbed RN #1's scrub top, and it took several people to get him/her to let go. 30 minutes after resident #3 was toileted, s/he wheeled his/her wheelchair across the unit and grabbed resident #4 by the hair. c. Interview with RN #2 on 12/2/25 at 1:38 PM revealed the NHA and DON were in a meeting, and she had been asked to let them know that there had been an incident between resident #3 and resident #4. She reported resident #3 was in his/her room, and resident #4 was in the common hallway after s/he had been hit in the face. She reported she assisted RN #1 and CNA #1 to help	F0600	Continued from page 2 New hires will receive abuse prevention training during orientation prior to providing resident care. 4. Evaluation and development of criteria for plan for staff to complete dementia care training certification and ongoing dementia care training annually will be completed by 1/5/2026. Monitoring to assure compliance: Administrator or designee will conduct weekly audits of residents with similar risk factors (cognitive loss, at risk behaviors) during weekly risk meetings for four (4) weeks, then monthly audits for three (3) months to identify potential abuse concerns. Audit results will be reviewed in our Care Center QAPI meetings quarterly and reported up through our Quality Council. Corrective actions will be taken as needed.	

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F0600 SS = G	Continued from page 3 resident #3 use the lift to transfer to the toilet, and then left the room so there would not be so many people to increase agitation from resident #3. She reported she supervised resident #3 in the administration office after the incident. d. Interview with CNA #1 on 12/2/25 at 2:18 PM revealed she had been in another resident's room when resident #3 hit resident #4 in the face with the notebook. Further interview revealed resident #3 started crying and the staff separated resident #3 from resident #4. When she asked resident #4 what happened, she was told "[s/he] hit me in the face with a notebook and told me 'you're ugly and should go kill yourself'." She reported that approximately 30 minutes after resident #3 hit resident #4, she heard resident #4 yell "ow!", she saw resident #3 had a handful of resident #4's hair, and it took 2 staff members to get them separated. Resident #4 would not let anyone else touch him/her or brush his/her hair for the rest of the night. 3. Review of the facility policy titled "Abuse: Recognizing and Reporting" updated March 2023, showed "Abuse is identified as physical abuse, sexual abuse, mistreatment, neglect, or misappropriation of patient/resident property. This includes violations against spouses, vulnerable adults, and children. A vulnerable adult means any person eighteen (18) years of age or older who is unable to manage and take care of him or herself or his or her property without assistance as a result of advanced age or physical or mental disability…"	F0600		