STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535042	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/29/2026

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

(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 performed on 1/28/26 through 1/29/26. The survey was prompted by complaints 2699170, 2704969, 2709022, 2712541, 2712568, 2716670, 2724185, 2724369, and 2726808. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental StatusCNA: Certified Nursing AssistantDON: Director of NursingMDS: Minimum Data SetNHA: Nursing Home Administrator	F0000		02/19/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to ensure adequate supervision and assistance devices to prevent accidents for 1 of 3 sample residents (#1). The following concerns were identified: Review of the admission MDS assessment dated 12/16/25 showed resident #1 had a BIMS score of 12 out of 15 which indicated s/he had moderately impaired cognition, and diagnoses which included non-Alzheimer's dementia, depression, and cancer. Review of the care plan last revised on 11/19/25 showed the resident was a moderate risk for falls related to confusion, gait and balance problems, and psychoactive drug use. Further review showed a care plan intervention initiated on 11/25/24 was to be sure the resident's call light was within reach. Review of the Braden Scale for Predicting Pressure Sore Risk dated 1/2/26 showed the resident	F0689	Resident #1 was checked and validated that he/she had call light at the time of deficiency. Facility wide audit was done by Executive Director, DNS, and Nurse Management, to ensure call lights were within reach of residents. Education provided to all staff, to ensure call lights are within reach of residents. DNS/Designee will audit a sample of residents each week to ensure compliance with call lights. Audits will be completed for 12 weeks, pending compliance. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	02/02/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535042	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/29/2026

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Shepherd of the Valley Rehabilitation and Wellness	**60 Magnolia St , Casper, Wyoming, 82604**

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F0689 SS = D	Continued from page 1 scored 16 out of 23, which indicated the resident was at risk for skin breakdown. The following concerns were identified: a. Observation on 1/28/26 at 9:55 AM showed the resident was in his/her recliner that was situated at the foot of the bed, the call light was located at the head of the bed, and was not within reach. The resident had a blanket covering his/her lower body. Observation on 1/28/26 at 10:35 AM showed the resident's call light was located at the head of the bed and was not within reach. b. Interview with the resident on 1/28/26 at 11:28 AM revealed the resident did not know where his/her call light was located, and stated "It should be around here somewhere." Interview with the resident on 1/28/26 at 11:33 confirmed his/her brief was wet and s/he could not request assistance because s/he did not know where the call light was. c. Interview with the resident's representative on 1/28/26 at 11:33 AM revealed the resident's brief was wet and s/he was covered in a blanket and did not have any pants on under the blanket. Further, the call light had not been in reach to request assistance. d. Observation on 1/28/26 at 11:48 showed the resident's call light was activated by his/her guest. Observation on 1/28/26 at 11:53 showed a CNA answered the resident's call light, closed the door, exited the room and returned with a clean blanket, and exited the room at 12:04 PM with 2 bags of soiled linens. e. Interview with the DON on 1/29/26 at 6:55 PM confirmed the expectation for staff when they left a resident alone in their room was to set up the resident with the call light and and any other needs, and wash their hands. f. Interview with the NHA on 1/29/26 at 7:15 PM revealed the facility did not have a policy on call light use.	F0689		