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 **03/13/2026**

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 survey was conducted by Healthcare and Licensing Surveys from 3/10/26 through 3/13/26. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Aide COTA: Certified Occupational Therapy Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set NA: Nursing Aide RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F0000		
F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...	F0676	Resident #11 had his/her care plan updated to show desires of 1-2 showers per week, and PRN. Facility wide audit done by Executive Director, DNS, and Nurse Management, to validate care plans match the desire and request of the resident. Audit also completed to validate showers were occurring according to resident preference. Education provided to staff, to validate care plans match the desire of the resident for shower frequencies and that residents are showered based on preference and choice. DNS/Designee will audit each week to validate compliance with showers and care plans.	04/03/2026

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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F0676 SS = D	Continued from page 1 §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, medical record review and review of the bathing schedule, the facility failed to ensure activities of daily living were maintained based on the needs and choices of 1 of 3 sample residents (#11) reviewed for bathing. The findings were: 1.Review of the 1/23/26 quarterly MDS assessment for resident #11 showed a BIMS of 3 out of 15, which indicated severe cognitive impairment and diagnoses which included a history of hip fracture, stroke, anxiety and depression. Review of the care plan dated 10/24/25 showed the resident preferred bathing twice a week. Further review showed s/he required maximum assist with bathing and showering. a. Review of the resident's bathing record from 12/10/25 through 1/6/25 showed showers were completed twice weekly until 1/14/26, at which time they were decreased to once a week.	F0676	Continued from page 1 Audits will be completed for 12 weeks, pending compliance. Results of audits will be discussed at the monthly QAPI meeting for 90 days to determine correction compliance and discussion of continuation or discontinuation of audit based on results. Date of Compliance: 04/03/26	

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F0676 SS = D	Continued from page 2 b. Interview with the administrator on 3/12/26 at 10:50 AM revealed the resident had moved from another unit on 12/30/25 and his/her shower preferences should have been reassessed and had changed; however, no evidence of reassessment was provided. c. Interview with bath aide #1 on 3/12/26 at 11:40 AM revealed the facility encouraged maintaining bathing schedules when residents moved to other units. d. Interview with bath aide #2 revealed she would have asked the resident what their bathing preference was when she had received a new resident on her unit. e. Review of the current facility bathing schedule confirmed the resident was scheduled for weekly showers. f. Review of the resident's medical record showed no evidence of a reevaluation of preferences or change to the resident's bathing schedule.	F0676		
F0689 SS = SQC-K	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, staff interview, incident report review, medical record review, manufacturer's recommendation review, and mechanical lift reference guide review, the facility failed to ensure safe staff practices and safe working condition of assistive devices for 1 of 4 sample residents (#1) reviewed for accident hazards. This failure resulted in a cervical fracture to resident #1 who fell during a mechanical lift transfer which resulted in the determination of immediate jeopardy due to a failure to follow manufacturer's instructions for safe mechanical lift transfers. Corrective measures were implemented prior to the survey and compliance was determined to be met on 2/16/26. The findings were:	F0689	"Past Noncompliance - no plan of correction required"	03/31/2026

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F0689 SS = SQC-K	Continued from page 3 1. Review of the 11/13/25 quarterly MDS assessment showed resident #1 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact and had diagnoses which included morbid obesity, heart failure and renal insufficiency. Further record review showed the resident was dependent with transfers and required the use of a full body mechanical lift. The following concerns were identified: a. Review of the incident report dated 2/13/26 showed resident #1 fell out of a full body mechanical lift sling on 2/12/26 at approximately 1 PM while being transferred from his/her bed to a recliner by CNA #1 and nursing aide #1 using a full body mechanical lift. Further review of the incident description showed "…The left shoulder strap on the hoyer sling came loose from the hoyer causing the resident to fall to the floor…" Review of the "Conclusion" section showed "The resident had a tendency to shift weight and reposition while in the sling, it is a reasonable conclusion that the sling strap came up on one side, and the weight of the resident caused it to come off the lift..." Further review of the incident report showed the resident was transferred to the emergency room. b. Review of the Emergency Room Report dated 2/12/26 and timed 5:10 PM showed the resident sustained a fall from a full body mechanical lift while s/he was being transferred and complained of a headache, neck pain, shoulder pain, and left distal femur and knee pain. Imaging results showed "Mildly displaced fracture of the left C2 transverse process with extension into the left aspect of the C2 vertebral body…" Review of the "Critical Care/Intensivist Consultation" note dated 2/12/26 and timed 11:14 PM, showed the resident went into cardiac arrest and death was pronounced at 9:19 PM. c. Review of the "Witness Statement" for RN #1 dated 2/12/26 showed "…Observed resident on the floor, laying face down with legs over one leg of the hoyer lift." Further review showed all but one sling strap remained attached to the full body mechanical lift. d. Interview with CNA #1 on 3/11/26 at 11:20 AM revealed the full body mechanical lift did not have safety clips at the time of the incident and one of the sling shoulder straps had detached from the full body mechanical lift. e. Interview with nursing aide #1 on 3/11/26 at 12:01 PM revealed "… the strap loop came off of the hook and I heard a loud pop…". Further interview revealed the	F0689		

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F0689 SS = SQC-K	Continued from page 4 full body mechanical lift did not have safety clips at the time of the incident. f. Interview with RN #1 on 3/11/26 at 12:41 PM confirmed there were no safety clips on the full body mechanical lift at the time of the fall on 2/12/26. The interview further revealed the safety clips were installed on all of the lifts following the fall on 2/12/26. At that time, RN #1 pointed to the Tollos Titan mechanical lift and indicated it was the device used at the time of the fall. g. Observation on 3/11/26 at 10:56 AM showed safety clips were present on the lift. Further observation showed a laminated “Quick Reference Guide”, for the Ultralift & Titan Tollos was attached to the Tollos Titan X full body mechanical lift. h. Review of the full body mechanical lift “Quick Reference Guide” last revised 2/2014 provided by the DON on 3/12/26 at 3:18 PM showed “…Ensure safety clips on spreader bar is in position after sling has been applied…” and “…Check spreader bar safety clips are present and used properly”. i. Interview with the DON on 3/10/26 at 11:46 AM revealed the safety clips were removed “at some point because they would come off” and were ineffective. Further interview confirmed the safety clips had been replaced. 2. Based on the facility’s failure to follow manufacture instructions, it was determined there was an immediate jeopardy situation on 2/12/26 at 1 PM when resident #1 fell from the full body mechanical lift after the shoulder strap detached from the spreader bar. There was a need for immediate action after the incident because other residents continued to be transferred using a mechanical lift and were at risk for serious injury, serious harm, serious impairment, or death. 3. Review of the facility's “Performance Improvement Plan” dated 2/12/26 showed the following interventions were implemented as a result of the incident: a. Hoyer lift inspections to ensure good working order b. Sling inspections and removal of any in need of replacement c. ADHOC (A meeting to instantly address incident) QAPI (Quality Assurance and Performance Improvement) review with IDT (Interdisciplinary Team)	F0689		

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F0689 SS = SQC-K	Continued from page 5 d. Medical record review e. Random weekly audits of mechanical lift transfers X 4 weeks, then monthly X 2 months f. All nursing staff education and competency evaluations on mechanical lifts. 4. The implementation of the “Performance Improvement Plan” was verified during the survey and immediate jeopardy was determined to have been removed on 2/16/26.	F0689		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F0880	Residents #7, #8, and #9 were provided a dated, clean, new urinal at the time of deficiency. Facility wide audit done by Executive Director, DNS, and Nurse Management, to validate urinals were replaced and dated for each resident requiring one. Education provided to staff, to validate urinals are clean and replaced timely, to include a date. DNS/Designee will audit each week to validate compliance with urinals. Audits will be completed for 12 weeks, pending compliance. Results of audits will be discussed at the monthly QAPI meeting for 90 days to determine correction compliance and discussion of continuation or discontinuation of audit based on results. Date of Compliance: 04/03/26	04/03/2026

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F0880 SS = E	Continued from page 6 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure infection prevention practices were implemented for 3 of 3 sampled residents (#7, #8, #9) reviewed for infection control. The findings were: 1.Review of the 2/20/26 quarterly MDS assessment for resident #7 showed a BIMS score of 2 out of 15, which indicated severe cognitive impairment and had diagnoses which included cancer, depression, and non alzheimer's dementia. In addition the resident had lower extremity impairment, was wheelchair bound, and required	F0880		

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F0880 SS = E	Continued from page 7 substantial to maximal assistance with toileting hygiene. a. Observation on 3/10/26 at 11:58 AM showed approximately 100 milliliters of amber colored urine in a urinal hanging from a trash can next to resident #7's recliner. Further observation showed a dark blue and black discoloration inside the urinal and a dried yellow substance around the opening of the urinal. The urinal was not labeled with a date. b. Interview with CNA # 3 on 3/10/26 at 1:18 PM revealed residents' urinals were emptied every 2 hours and replaced with a new one monthly. c. Interview with CNA #3 on 3/10/26 at 1:54 PM confirmed the urinal was not dated, and appeared to have blue and black discoloration inside with a dried yellow substance around the opening of the urinal. She further stated that urinals were discarded and replaced once monthly (around the beginning, or end of the month) and weekly as needed. 2. Observation on 3/10/26 at 2 PM showed two empty urinals dated 1/28/26 hanging from a trash can next to resident #8's bed. Interview with CNA #3 on 3/10/26 at 2:02 PM confirmed the urinals were not replaced after 1 month of use. 3. Observation on 3/12/26 at 11:06 AM showed a urinal hanging from the nightstand of resident #9. The urinal was empty; however, there was yellow, amber, and dark blue colored staining on the inside. The urinal was not labeled with a date. Interview with CNA # 2 on 3/12/26 at 11:18 AM revealed urinals were changed monthly and as needed. She confirmed the urinal appeared soiled and was not dated. 4. Interview with LPN #1 on 3/12/26 at 11:17 AM revealed staff were expected to throw out soiled urinals and replace them with new ones when they appeared soiled. 5. Interview with the infection preventionist on 3/10/26 at 2:10 PM revealed staff were expected to label urinals and replace them at least monthly, or when visibly soiled. 6. Interview with the DON on 3/10/26 at 2:18 PM confirmed urinals should have been replaced when they were visibly soiled. She further stated there were no facility policies regarding urinals.	F0880		