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	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Snf Operations LLC	60 Magnolia St 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident representative and staff interview, facility incident review, and performance improvement plan review, the facility failed to protect the residents' right to be free from physical abuse by another resident for 1 of 8 sample residents (#12). This failure resulted in actual harm to resident #12. Corrective measures were implemented prior to the survey and compliance was determined to be met on 5/16/25. The findings were: 1. Review of the discharge MDS assessment dated [DATE] for resident #12 showed the resident admitted to the facility on [DATE] and a brief interview for mental status score of 2 out of 15, which indicated severe cognitive impairment. Further review showed the resident had wandering behaviors which occurred daily and diagnoses which included encephalopathy and restlessness and agitation. The following concerns were identified: a. Review of a facility incident report dated 4/28/25 and timed 3:50 PM showed resident #12 wandered into the room of resident #11, which was located on the memory care unit. Resident #11 asked resident #12 to leave and when s/he didn't, resident #11 hit resident #12 in the nose, which resulted in a bloody nose. Further review showed resident #11 admitted to hitting resident #12 in the nose. b. Review of a progress note dated 4/28/25 and timed 3:30 PM showed Resident wandered into another residents room and that resident punched [him/her] in the nose. Resident did have a nose bleed but was able to stop the bleeding. c. Interview with the resident representative for resident #12 on 5/21/25 at 2:32 PM revealed she was notified the resident was punched by another resident the day s/he admitted to the facility. d. Interview with RN #1 on 5/22/25 at 8:09 AM revealed following the altercation between the residents, she performed an assessment. She confirmed resident #12 had a bloody nose, which continued to bleed for 2 minutes, and she thinks his/her feelings were hurt after the incident. She confirmed resident #11 admitted to punching resident #12 because s/he was in his/her room. She revealed a stop sign and 1 to 1 staffing was implemented immediately as a result. (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

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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 0600 Level of Harm - Actual harm Residents Affected - Few	2. Interview with the DON on 5/21/25 at 4:37 PM confirmed resident #11 punching resident #12 resulted in a bloody nose for resident #12. She confirmed immediate correction included implementing 1 to 1 staffing for resident #11 and placement of a stop sign to resident #11's door. Additionally, she revealed resident #11's care plan was updated and verbal training was provided to staff. She revealed resident #12 was discharged on 5/3/25, as s/he was at the facility for respite care, and resident #11 remained on 1 to 1 staffing until s/he was hospitalized on [DATE]. 3. Interview with the DON on 5/22/25 at 8:58 AM revealed the IDT reevaluated the 1 to 1 staffing and determined on 5/5/25 that it was not necessary for resident #11. Further she revealed the facility's plan of correction was fully implemented on 5/16/25. 4. The following plan of correction was implemented by the facility by 5/16/25 and verified during the survey: a. Resident #12 discharged from the facility on 5/3/25. Resident #11 had 1 to 1 staffing implemented and a stop sign was placed on the resident's door immediately following the incident. b. Medication reviews and care plan review and updates were performed for resident #11. c. Staff education was performed for the use of stop signs, redirecting residents, and caring for residents with dementia. d. Audits were performed to evaluate the stop sign placement and effectiveness. e. Review and removal of 1 to 1 staffing for resident #11 following return from the hospital.