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	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, 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 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.

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