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	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, 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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 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.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.

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 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: 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 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 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 orderb. Sling inspections and removal of any in need of replacementc. ADHOC (A meeting to instantly address incident) QAPI (Quality Assurance and Performance Improvement) review with IDT (Interdisciplinary Team) d. Medical record reviewe. Random weekly audits of mechanical lift transfers X 4 weeks, then monthly X 2 monthsf. 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.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 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 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.