

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Shepherd of the Valley Rehabilitation and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 resident representative and staff interview, medical record review, facility incident review, and policy review, the facility failed to ensure residents were free from abuse from other residents for 1 of 8 sample residents (#37) reviewed for abuse. This failure resulted in actual harm to resident #37. The findings were: The facility had implemented corrective action prior to the survey and was determined to be in substantial compliance as of 7/17/26. 1. Review of the annual MDS assessment dated [DATE] showed resident #37 had a BIMS score of 3 out of 15, which indicated severe cognitive impairment, and had diagnoses which included non-Alzheimer's dementia, depression, and psychotic disorder. Further review showed the resident had behaviors of wandering daily. Review of the admission MDS assessment dated [DATE] showed resident #13 had a BIMS score of 10 out of 15, which indicated moderate cognitive impairment, and a patient health questionnaire-9 (PHQ-9) score of 24, which indicated severe depression. Further review showed the resident had diagnoses which included schizophrenia and a personal history of traumatic brain injury. The following concerns were identified: a. Review of an incident report dated 7/15/26 and timed 2 PM showed a CNA observed resident #13 hit resident #37 on the left side of his/her face. Both residents were assessed and sent to the emergency department (ED). Resident #27 returned from the ED on 7/15/26, and resident #13 returned from the ED on 7/24/26. Upon return from the ED, resident #13 received one-to-one supervision from staff. b. Review of a progress note dated 7/15/26 and timed 6:05 PM showed .[name] had a reddened area 1 x 1 inches in diameter on the left side of [his/her] face, next to [his/her] left eye, that was abraded. [S/he] also has reddened areas on [his/her] left cheekbone. Ice pack applied to left side of face . c. Interview with the resident's representative on 7/28/26 at 9:39 AM revealed she visited the resident on 7/19/26 and the resident told her s/he did not feel safe and felt afraid. d. Interview with CNA #3 on 7/30/26 at 9:05 AM revealed she had been assisting another resident in the bathroom when she heard an aggressive voice through the wall. She reported she found the shower aide to assist the resident in the bathroom, and when she went to the room next door, she saw resident #13 hit resident #37 2 to 3 times with a closed fist. She separated the residents, and took resident #37 to the nurses' station where the resident was assessed by the nurse. Further interview revealed resident #37 had a small abrasion on the left side of his/her face, and was scared and skittish following the incident. e. Interview with LPN #1 on 7/30/26 at 12:26 PM revealed she had been called to the secure unit after the incident. She stated resident #37's cheek was a little red and she was not sure if it was from the ice pack or being hit. She stated resident #37's demeanor was typically apprehensive and the resident was shaken after the incident. f. Interview with the DON on 7/30/26 at 12:45 PM revealed resident #37 had an ice pack applied to his/her cheek but there was no open skin. g. Interview with RN #2 on 7/30/26 at 1:06 PM revealed she had been told resident #13 (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	punched resident #37. When she assessed the resident it was reddened. Further interview revealed the resident was quiet and stoic and afraid for [his/her] safety. 3. Review of the facility policy titled Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation last updated March 2025 showed .Each resident has the right to be free from abuse, including verbal, mental, sexual, or physical abuse .The Center implements policies and processes so that residents are not subjected to abuse by staff, other residents, volunteers, consultants, family members, and others who may have unsupervised access to residents . 4. The facility implemented the following corrective action by 7/17/26: a. Resident #37 was assessed and provided with an ice pack and sent to the ED on 7/15/26. The resident returned to the facility on 7/15/26. b. Resident #13 was assessed and sent to the ED on 7/15/26. The resident returned to the facility on 7/24/26, and received one-to-one supervision upon his/her return from the hospital. c. The facility reported the incident to the State Survey Agency and the Police Department on 7/15/26. d. All facility staff involved were interviewed.e. The DON completed an audit in the secure unit, to validate there were no skin concerns, and interviewed staff and residents to validate anyone that may not have reported previous abuse. f. The DON/designee educated staff immediately. g. The Executive Director/designee began a daily audit in the morning meeting and reviewed progress notes to ensure no abuse occurred. Audits to be done daily and reported monthly in the Quality Assurance (QAPI) Meeting for 90 days or until substantial compliance was achieved.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident representative, and staff interviews, medical record review, and policy and procedure review, the facility failed to ensure individual activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident were provided for 3 of 4 sample residents (#34, #123, #178) reviewed for activity participation. The findings were: 1. Review of the annual MDS assessment dated [DATE] showed resident #34's cognition was not assessed and they had diagnoses which included non-Alzheimer's dementia and depression. Further review showed the resident felt it was very important to go outside to get fresh air when the weather was good and somewhat important to have books, newspapers, and magazines to read, be around animals such as pets, keep up with the news, and perform his/her favorite activities. Review of the Activities care plan last revised on 3/31/26 showed interventions which included I would like staff to continue to invite me to activities of that [sic] may be of interest to me and Some of my activity interests include animals and pets, board games, volunteering, dining out, movies, spending time outdoors, listening to the radio, watching sports, and TV. The following concerns were identified: a. Interview with the resident's representative on 7/27/26 at 5:52 PM revealed she wished the facility would encourage the resident to participate in activities. She revealed the staff offered, but if the resident refused then staff did not attempt to reapproach him/her. b. Continuous observation on 7/29/26 beginning at 9:27 AM through 11:02 AM showed the resident was in his/her room seated in the recliner with his/her legs elevated, and no activities were offered during that time. Continuous observation on 7/29/26 from 2:26 PM through 4:15 PM showed the resident was in his/her room seated in the recliner with his/her legs elevated, and no activities were offered during that time. Review of the activity calendar for July 2026 showed the scheduled activities on 7/29/26 included daily chronicle, fun with fitness, reading time, treats, music, and reading/trivia. c. Review of the activity participation record from 4/28/26 through 7/29/26 showed the resident was documented as being offered activities 115 times which included 107 independent activities, 7 one to one activities, and 1 group activity. Further review showed the resident refused activities 52 out 107 activities offered which included refusing one to one activities once and independent activities 51 times. 2. Review of the admission MDS assessment dated [DATE] showed resident #123 had a BIMS score of 8 out 15, which indicated moderate cognitive impairment, and diagnoses which included progressive neurological conditions, non-Alzheimer's dementia, and seizure disorder or epilepsy. Further review showed the resident felt it was Very important to have books, newspapers, and magazines to read, to keep up with the news, and to go outside to get fresh air when the weather was good. Review of the Activities care plan last revised on 6/8/26 showed interventions which included The resident's preferred activities are: arts and crafts, ceramics, visiting with others, shuffleboard, watching sports, tv and movies, listening to 'oldies,' being outdoors, etc. Review of the I refuse to eat often r/t [related to] dementia and chemo treatments care plan last revised on 12/23/25 showed interventions which included Invite the resident to food-related activities and offer food, beverages of (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	choice to encourage intake. The following concerns were identified: a. Review of the activity participation record from 5/27/26 through 7/29/26 showed the resident was documented as being offered activities 75 times which included 69 independent activities, 5 one to one activities, and 1 group activity. Further review showed the resident refused activities 10 times out of 75 activities offered, which included refusing group activities once and independent activities 9 times. 3. Review of the admission MDS assessment dated [DATE] showed resident #178 had a BIMS score of 3 out of 15, which indicated severe cognitive impairment, and diagnoses which included nontraumatic intracerebral hemorrhage, and macular degeneration. Further review of the MDS assessment showed it was very important to the resident to be around animals such as pets and somewhat important to listen to music he/she liked, do his/her favorite activities, and get outside for fresh air when the weather was good. Review of resident #178's initial activity evaluation dated 7/27/26 at 9:33 AM showed listed activity preferences of games, bingo, board games, cards, television, movies, animals, and pets. Review of resident #178's care plan dated 7/27/26 showed the resident had the ability to attend activities. Documented preferences included directed/independent activities in room including: watching TV, reading, iPad games, etc. and has supplies needed for independent activities . preferred activities are: games, movies, animals, and going outdoors. The following concerns were identified: a. Observation of resident #178 throughout the survey showed the resident visited with his/her daughter, sat alone in his/her wheelchair in his/her room, and slept in bed. The resident did not participate in any group or individual activities. Further observation on 7/30/26 at 9:20 AM showed there were four copies of the Daily Chronicle in the resident's room, but no activity calendar. b. Interview with the resident's representative on 7/28/26 at 10:09 AM revealed staff had not invited the resident to any activities and the resident had not attended any activities since admission. Further interview revealed she had not seen an activity calendar in the resident's room. c. Review of the medical record showed no evidence of activity participation. 3. Interview with COTA #1 on 7/30/26 at 8:41 AM revealed she was consulting for the activity program because the facility did not have an activity director. She revealed she did not perform activities daily, she only checked in with the team. She revealed one to one activities should be attempted 2 to 3 times per week and all residents should be invited to every group activity. She confirmed the facility did not facilitate independent activities for resident #34 or resident #123. She revealed newly admitted residents received an initial activity evaluation within 3 to 14 days of admission and activities staff were expected to invite every resident to every activity, distribute the Daily Chronicle daily, and invite residents to activities during distribution. Further interview confirmed staff had not offered resident #178 the opportunity to participate in any activities. 4. Review of the policy titled Activity Program last revised 2015 showed .5. Activities include individual, small or large group, one-to-one, and independent activities to meet the resident's needs, abilities, and interests. For residents confined to, or who choose to, remain in their room, the Activity (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Department provides and assists with in-room activities/projects/leisure pursuits in keeping with needs, abilities, and interests .		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, professional standard review, and policy review, the facility failed to ensure insulin medications were dated with an open date in 1 of 7 medication storage units (rehabilitation unit cart A). The findings were: 1. Observation on [DATE] at 11:04 AM of the rehabilitation cart A, with RN #1 showed the following concerns: a. Insulin Glargin-yfgn 100 unit per (ml) milliliter pen with an open date of [DATE], 30 days prior to the observation. b. Insulin Glargin-yfgn 100 units per ml pen with no open date. c. Insulin Lispro KwikPen 100 units per ml with an open date of [DATE], 48 days prior to the observation. d. Insulin Lispro KwikPen 100 units per ml with no open date. 2. Interview with RN #1 on [DATE] at 11:04 AM revealed the insulin pens were good for 28 days, and confirmed the medications were available for resident use. 3. Interview with the DON on [DATE] at 2:13 PM revealed she expected staff to date the insulin when it was removed from the fridge and made available for use, and to discard the insulin when they expired. 4. Review of policy Medication Storage provided by the DON on [DATE] at 3 PM showed .12. Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used .14. Outdated, contaminated, discontinued or deteriorated medications .are immediately removed from stock, disposed of according to procedures for medication disposal . 5. Review of web page drxservices.com/did-you-know-insulin-glp-1-expiration-guide/ showed insulin lispro days good at room temperature was 28 days, and insulin glargine was good at room temperature for 28 days.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interviews, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 4 sample residents (#57). The findings were:1.Review of the significant change MDS assessment dated [DATE] showed resident #57 had a BIMS score of 5 out of 15, which indicated severe cognitive impairment, and had diagnoses which included cerebrovascular accident, depression, and benign prostatic hyperplasia. The MDS review showed the resident had bilateral impairment of the upper and lower extremities, required total assistance for toileting, upper and lower body dress, putting on footwear, and substantial/maximal assistance for personal hygiene. Further review showed the resident was always incontinent of bowel and bladder. Review of the ADL self-care performance deficit care plan showed Impaired balance. BED MOBILITY: I am Substantial/Maximum assistance on staff to routinely turn and reposition in bed and as necessary. DRESSING: I am Dependent assistance on staff of 1-2 to dress my upper body and lower body dressing. PERSONAL HYGIENE: I am Substantial/Maximum on staff of one with personal hygiene. The following concerns were identified: a. Observation on 7/27/26 at 3 PM showed the resident was lying on his/her bed with the resident's pants pulled down around his/her ankles and the bed sheet at the foot of the bed. The resident had a used brief rolled up under his/her upper legs, brown substance his/her left upper thigh, and his/her perineal area was exposed. The lift sling was positioned under the resident, the mechanical lift was positioned beside the bed, the bed was elevated up in the air, and the privacy curtain was open. The residents roommate was in the room. Continuous observation of the resident's room showed at 4:11 PM RN #3 entered the resident's room, and stated she was going to check on the roommate. Upon entering the room, the RN stated it looked like someone was changing resident #57, got called away, and did not finish the job. The RN covered the resident with the sheet and left the room to find help. At 4:20 PM the RN returned returned to the room, with CNA #4, donned gloves, provided perineal care, changed the brief, changed the resident's pants, and removed the dirty sling. At that time, CNA #4 stated CNA #1 had told her he had put the resident to bed at 1 PM, and she had planned to check the resident before the RN came and got her. b. Interview with CNA #1 on 7/27/26 at 4:28 PM revealed he got the resident in his/her bed around 12:45 PM and had his/her brief tucked under him/her. He revealed the resident was incontinent of bowel and bladder, and he had left the resident exposed for the nurse to do a skin check, because his/her peri area was bleeding and hurting. He revealed the nurse was going to give a medication and then go check resident #57's skin. c. Interview with the DON on 7/27/26 at 5:22 PM revealed she expected the staff to check residents every 2-3 hours, and to finish providing care. Interview with the DON on 7/28/26 at 10 AM revealed the facility did not have a policy related to providing turning, repositioning, or checking the residents. Further interview revealed staff should follow professional standards.2. Review of the policy titled Resident Rights hand delivered by the DON during the survey showed .Policy Statement: Residents are informed about their rights at admission and at least annually during their stay .		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on medical record review, resident representative and staff interview, and policy and procedure review, the facility failed to provide a written notice of transfer and bed-hold for 1 of 5 sample residents (#34) reviewed for transfer and discharge. The findings were: 1. Review of a progress note dated 11/20/25 and timed 12:48 PM showed resident #34 was transferred non-emergent to the hospital for evaluation. Review of a transfer notice dated 11/20/25 showed the resident's representative was verbally notified of the transfer; however, there was no evidence the transfer notice was provided in writing to the resident's representative. Review of a Bed Hold Agreement dated 11/20/25 showed the resident was notified verbally of the bed hold; however, there was no evidence the resident's representative was notified of the bed hold in writing. 2. Interview with the resident representative for resident #34 on 7/27/26 at 5:52 PM revealed the facility did not notify her of changes to the resident such as transfers to the hospital, new medication orders, or health status changes. Further she revealed when a resident was sick, the facility should notify the representative. 3. Interview with the DON on 7/30/26 at 12:54 PM confirmed the facility did not have evidence resident #34's representative was provided a written notice for transfer or bed-hold. 4. Review of the policy titled Transfer and Discharge last revised May 2025 showed .5. When a transfer or discharge is initiated, the resident receives written notice using the Resident Notice of Transfer or Discharge . 10. In case of emergency transfer, written notice including bed-hold policy is sent to the resident/responsible party .		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and CMS RAI manual review, the facility failed to complete a significant change MDS assessment for 1 of 5 sample residents (#123) reviewed for a significant change. The findings were: 1. Review of the admission MDS assessment dated [DATE] showed resident #123 had a BIMS score of 8 out of 15, which indicated moderate cognitive impairment, and diagnoses which included progressive neurological conditions, non-Alzheimer's dementia, and seizure disorder or epilepsy. Further review showed the resident had no upper or lower range of motion impairment, did not use mobility devices, and was independent or set-up/clean up help only for all activities of daily living (ADL). The following concerns were identified: a. Observation on 7/29/26 at 2:30 PM showed the resident and a staff member exited the resident's room with the resident using a walker for ambulation and a gait belt in place around the resident's torso. b. Review of the quarterly MDS assessment dated [DATE] showed the resident did not use a walker. Further review showed the resident required partial/moderate assistance with oral hygiene, personal hygiene and shower/bathe self. The resident was independent or required set-up/clean up help for all other ADLs. c. Review of the quarterly MDS assessment dated [DATE] showed the resident did not use a walker. Further review showed the resident required partial/moderate assistance with oral hygiene, toileting hygiene, and personal hygiene and required supervision or touching assistance with shower/bathe self and putting on/taking off footwear. d. Review of the resident's completed MDS assessments showed no evidence a comprehensive MDS assessment, including a significant change assessment, had been completed since the admission assessment. 2. Interview with MDS coordinator #1, MDS coordinator #2, and MDS coordinator #3 on 7/30/26 at 9:55 AM revealed they were not aware the resident was using a walker and the resident probably should not have been coded as independent for ADLs at the time of the admission MDS assessment. They revealed at times, the CNAs do not document accurately regarding resident needs. They confirmed a significant change MDS should have been completed and had not been. 3. Review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.30.1 dated October 2025 showed .Significant Change in Status Assessment (SCSA) (A0310A = 04) The SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date that the IDT's determination was made that the resident had a significant change. A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered 'selflimiting'; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan .		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, medical record review, resident and staff interview, and policy review the facility failed to ensure they had developed and implemented a comprehensive person-centered care plan for for 1 of 31 sample residents (#7). The findings were: 1. Review of the 5/19/25 significant change MDS assessment showed resident #7 had a BIMS score of 14 out of 15, which indicated intact cognition, and diagnoses which included hemiplegia, stroke, history of venous thrombosis and embolism. The resident received medications which included the anticoagulant apixaban. Review of the physician orders showed the resident received apixaban oral tablet (anticoagulant) 5 mg (milligrams) by mouth two times a day and ANTICOAGULANT MEDICATION SIDE EFFECT MONITORING: New Onset - Bleeding, bruising, black tarry stools, red urine, sudden severe headache, N/V. every shift Nurse Initials = Side effects monitored. If noted, document in Progress Notes and notify the Medical Provider. The following concerns were identified: a. Observation on 7/28/26 at 11:13 AM showed resident #7 had bruises on both lower arms. Interview with the resident at that time revealed the bruising happened at the hospital, and s/he was on an anticoagulant. b. Review of a progress note dated on 7/24/26 and timed 3:51 PM showed the resident had been readmitted from a hospital. His/her skin condition included scattered bruising to bilateral arms from IV starts and blood draws. c. Review of the care plan failed to show anticoagulant use or interventions as part of the plan of care. 2 Interview with the DON on 7/30/26 at 10 AM confirmed the facility did not have an anticoagulant care plan for the resident, and the facility had formatted an anticoagulant care plan that day.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and professional standard review, the facility failed to ensure necessary services were provided timely for 1 of 4 sample residents (#57) reviewed for activities of daily living. The findings were: 1. Review of the significant change MDS assessment dated [DATE] showed resident #57 had a BIMS score of 5 out of 15, which indicated severe cognitive impairment, and had diagnoses which included cerebrovascular accident, depression, and benign prostatic hyperplasia. The MDS review showed the resident had bilateral impairment of the upper and lower extremities, required total assistance for toileting, upper and lower body dress, putting on footwear, and substantial/maximal assistance for personal hygiene. Further review showed the resident was always incontinent of bowel and bladder. Review of the ADL self-care performance deficit care plan showed Impaired balance. BED MOBILITY: I am Substantial/Maximum assistance on staff to routinely turn and reposition in bed and as necessary. DRESSING: I am Dependent assistance on staff of 1-2 to dress my upper body and lower body dressing. PERSONAL HYGIENE: I am Substantial/Maximum on staff of one with personal hygiene. The following concerns were identified: a. Observation on 7/27/26 at 3 PM showed the resident was lying on his/her bed with the resident's pants pulled down around his/her ankles and the bed sheet at the foot of the bed. The resident had a used brief rolled up under his/her upper legs, brown substance on his/her left upper thigh, and his/her perineal area was exposed. The mechanical lift sling was positioned under the resident, the mechanical lift was positioned beside the bed, the bed was elevated, and the privacy curtain was open. Continuous observation of the resident's room showed at 4:11 PM RN #3 entered the resident's room, and stated she was going to check on the roommate. Upon entering the room, the RN stated it looked like someone was changing resident #57, got called away, and did not finish the job. The RN covered the resident with the sheet and left the room to find help. At 4:20 PM the RN returned to the room, with CNA #4, donned gloves, provided perineal care, changed the brief, changed the resident's pants, and removed the dirty sling. At that time, CNA #4 stated CNA #1 told her he had put the resident to bed at 1 PM, and she had planned to check the resident before the RN came and got her. b. Interview with CNA #1 on 7/27/26 at 4:28 PM revealed he got the resident in his/her bed around 12:45 PM and had his/her brief tucked under him/her. He revealed the resident was incontinent of bowel and bladder, and he had left the resident exposed for the nurse to do a skin check, because his/her peri area was bleeding and hurting. He revealed the nurse was going to give a medication and then go check resident #57's skin. c. Interview with the DON on 7/27/26 at 5:22 PM revealed she expected the staff to check residents every 2-3 hours, and to finish providing care. Interview with the DON on 7/28/26 at 10 AM revealed the facility did not have a policy related to providing turning, repositioning, or checking the residents. Further interview revealed staff should follow professional standards. 2. Review of the professional standard titled Tertiary Prevention provided by the DON on 7/29/26 at 3 PM showed Tertiary prevention addresses the treatment of established disease to avoid complications and death. The major areas of focus for the older adult and the adult with a disability are preventing the complications of immobility and rehabilitation .Positions. 2. The recommendation is to change body position every 2 hours and, preferably, more frequently for patients who have no spontaneous movement.		

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NAME OF PROVIDER OR SUPPLIER Shepherd of the Valley Rehabilitation and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 60 Magnolia St Casper, WY 82604	
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interview, medical record review, and policy and procedure review, the facility failed to ensure that 1 of 3 sample residents (#14) was provided with respiratory care, including tracheostomy care. The findings were: 1. Review of the comprehensive MDS assessment dated [DATE] showed resident #14 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included pneumonia, anxiety disorder, chronic lung disease, and respiratory failure. Further review showed the resident received tracheostomy care. Review of the medical record and hospital discharge instructions dated 7/14/26 showed the resident had a hospital admission from 7/3/26 to 7/14/26 for sepsis due to pneumonia. Review of the physician orders showed an order with a start date of 6/23/26 to change disposable inner cannula (6 internal diameter) every day and PRN [as needed] every day shift for Trach Care. The following concerns were identified:a. Interview with the resident on 7/27/26 at 1:57 PM revealed staff had not changed his/her inner tracheostomy cannula daily, and stated, They are supposed to change the inner cannula everyday, but they aren't doing it daily. They have been out of inner cannulas. Interview with the resident on 7/29/26 at 3:41 PM revealed the last inner cannula change s/he remembered occurred the previous Tuesday or Wednesday. S/he stated when no inner cannula was available, sometimes they pull it out and inspect it to make sure it's not dirty and reinstall it. They have talked about cleaning the inner cannula, but I haven't seen them clean it.b. Review of the treatment administration record (TAR) for June 2026 showed no evidence the inner cannula change was performed on 6/23/26, 6/25/26, 6/27/26, 6/28/26, and 6/29/26. Review of the TAR for July 2026 showed no evidence the inner cannula change was performed on 7/1/26, 7/2/26, 7/20/26, 7/21/26, 7/22/26, 7/23/26, 7/27/26, 7/28/26 and 7/29/26.c. Review of progress notes showed the disposable inner cannula was not changed and was documented not available on 6/23/26, 6/25/26, 6/27/26, 6/28/26, 6/29/26, 7/1/26, 7/2/26, 7/20/26, and 7/28/26.d. Interview with RN #1 on 7/29/26 at 3:04 PM revealed staff had not changed the inner cannula that day because the facility had only one inner cannula available, which was reserved for emergencies. He revealed the facility had difficulty obtaining inner cannulas from their supplier. Further interview revealed his expectation for tracheostomy care when no inner cannulas were available was to remove the inner cannula and assess for patency, cleanliness, and excessive secretions, or clean or sanitize the inner cannula and reuse it.e. Interview with the DON on 7/29/26 at 3:17 PM revealed her expectation was for the disposable tracheostomy inner cannula to be changed daily per physician orders. She stated when inner cannulas were unavailable, staff contacted the doctor and were given permission to clean the inner cannula with a tracheostomy cleaning kit. Further interview confirmed no physician order existed to clean the tracheostomy inner cannula if none were available. She stated the facility had ordered 45 inner cannulas two weeks prior and had not received the shipment.2. Review of the facility's policy and procedure titled Tracheostomy Care, dated December 2017, showed: .Unlock inner cannula by turning counterclockwise. Remove inner cannula. Place inner cannula in basin with hydrogen peroxide.Clean lumen and sides of inner cannula using pipe cleaners or sterile brush. Rinse inner cannula thoroughly by agitating in normal saline for several seconds.replace inner cannula into outer cannula.		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and staff interview, the facility failed to ensure behavioral health services were provided to 1 of 3 sample residents (#13) with a psychiatric diagnosis. The following concerns were identified: 1. Review of the admission MDS assessment dated [DATE] showed resident #13 had been admitted to the facility on [DATE], had a diagnosis of schizophrenia, and a BIMS score of 10 out of 15, which indicated moderate cognitive impairment. Review of the medication administration record (MAR) showed the resident received the antipsychotic medications haloperidol 2.5 mg, clozapine 12.5 mg, aripiprazole 15 mg. Review of the care plan initiated on 7/24/26 showed the resident had impaired psychosocial well-being as evidenced by behaviors requiring intervention and psychotropic drug utilization, and behaviors that included agitation, anger, cursing, grabbing, hitting and kicking. Interventions included redirection, remove from the situation, meaningful activity, reapproach, and one-to-one supervision. The following concerns were identified: a. Review of a facility incident report showed on 7/15/26 at 2 PM a CNA observed resident #13 hit resident #37 on the left side of his/her face. Both residents were assessed and sent to the emergency department (ED). b. Review of the medical record showed a preadmission screening and resident review (PASRR) Level II review had been completed on 4/23/26 and showed mental health rehabilitation services recommended were case management and a neurocognitive evaluation. c. Review of the medical record showed no evidence the resident received a neurocognitive evaluation or mental health services. d. Interview with the social services assistant #1 on 7/30/26 at 2:30 PM revealed she and the social services assistant #2 checked on the resident a couple of times a day, especially if [s/he] has behaviors. Further interview confirmed the resident had not received a neurocognitive evaluation upon admission and the resident did not receive case management services.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and staff interview, the facility failed to ensure a pharmaceutical services procedure related to accurate acquiring, receiving, dispensing and administration of medications for 1 of 6 sample residents (#65) reviewed for medication availability. The findings were: 1. Review of a quarterly MDS assessment dated [DATE] showed resident #65 had a BIMS score of 5 out of 15 which indicated severe cognitive impairment, and diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, and seasonal allergic rhinitis. Review of the physician orders showed the resident was to receive Sudafed Sinus Congestion Oral Tablet 1 time a day for sinus congestion. The following concerns were identified: a. Review of the medication administration record (MAR) showed the resident did not receive the medication on 6/28/26 and 6/29/26, and the medication was on order from the pharmacy. b. Review of a progress note dated 6/28/26 and timed 11:46 PM showed .Cough present. Productive cough .c. Review of a progress note dated 6/29/26 and timed 7:12 AM showed Sudafed Sinus Congestion Oral Tablet Give 1 tablet by mouth one time a day for sinus congestion. May dc [discharge] when sx [symptoms] resolve. d. Interview with the DON on 7/30/26 at 1:50 PM revealed her expectation was for nursing staff to check and verify medication was not in backup. Further interview confirmed the medication had been in the medication cart, the MA-Cs did not see it, and the resident did not receive the sudafed on the days identified.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure an infection prevention and control program was designed to help prevent the development and transmission of communicable diseases and infections for 1 of 9 sample residents (#178). The findings were: 1. Review of the admission MDS assessment dated [DATE] showed resident #178 had a BIMS score of 3 out of 15, which indicated severe cognitive impairment, and diagnoses which included non-traumatic brain dysfunction, cerebrovascular accident, and non-traumatic intracerebral hemorrhage. Further review showed the resident had an indwelling catheter and required supervision for personal hygiene. Review of the care plan EBP r/t a foley catheter last revised on 7/27/26 showed the resident had a foley catheter and interventions which included CDC guidelines for enhanced barrier precautions will be followed by personnel. Enhanced barrier precautions involve gown and glove use during high-contact care activities. The following concerns were identified: a. Observation on 7/29/26 at 11:21 AM showed CNA #2 applied hand sanitizer, donned gloves, drained the urine from the catheter bag, and wiped the end of the drainage tubing with an alcohol wipe. Further observation showed an Enhanced Barrier Precautions sign and a Personal Protective Equipment (PPE) cart was stationed outside the resident's room; however, no additional PPE was used during the catheter care. b. Interview with MA-C #1 on 7/30/26 at 12:50 PM revealed she did not wear a gown when she provided urinary catheter care; however, she was aware gowns and other PPE were available for use outside the resident's room.c. Interview with the infection preventionist on 7/30/26 at 2:02 PM revealed all residents with a urinary catheter were on enhanced barrier precautions and a gown, gloves, faceshield/goggles should be worn when providing catheter care. 2. Review of the policy and procedure titled Transmission Based Precautions dated May 2015 and updated March 2026, showed Enhanced Barrier Precautions (EBP), involve the use of gowns and gloves by care providers, during high contact resident care activities.EBP are used when caring for residents with colonization or infection with a targeted and epidemiologically important MDRO, chronic wounds, or indwelling medical device/s. Indwelling devices include.indwelling urinary catheter.High-contact care activities (gown and gloves required) Examples: .emptying drainage bags.		