STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535045	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Powell Valley Care Center	777 Avenue H Powell, WY 82435

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. (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	Based on medical record review, staff interview, facility investigation review, and policy and procedure review, the facility failed to protect the residents' right to be free from physical abuse by a resident for 2 of 11 sample residents (# 2, #4) reviewed for allegations of abuse. This failure resulted in actual harm to resident #2 and resident #4. The findings were: 1. Review of the 10/21/25 annual MDS assessment showed resident #1 had a BIMS score of 0, indicating severe cognitive impairment, and diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, anxiety, and depression. Review of the care plan, initiated 5/23/23, showed the resident had impaired thought processes and impaired decision making. Review of the 10/28/25 quarterly MDS assessment showed resident #2 had a BIMS score of 0, indicating severe cognitive impairment, and diagnoses that included Alzheimer's disease, non-Alzheimer's dementia, and depression. Review of the care plan, initiated 11/12/24, showed the resident had the potential for a behavioral problem due to severely impaired cognition. The following concerns were identified:a. Review of an incident dated 10/28/25 showed resident #2 was found outside of the staff bathroom and was heard yelling You fucking bitch! You pinched me! I oughta lay you out! I should kick your ass!. Resident #1 was found with his/her hands near resident #2's neck. Staff intervened and redirected the residents. After examining resident #2, nurse #1 noticed a 0.6 cm open wound on the right side of his/her neck. The wound was cleansed with wound wash and dressed with a band aid. b. Interview with RN #1 on 12/1/25 at 3:25 PM revealed she had been in the restroom when she heard yelling and quickly left the restroom, where she found resident #1 behind resident #2, and she noticed a small mark on resident #2's neck. Resident #1 had yelled obscenities at the time. RN #1 took resident #2 to the DON who cleaned up the scratch on resident #2's neck.c. Interview with the DON on 12/2/25 at 2:12 PM confirmed she cleaned the area on resident #2's neck, and the skin was broken but did not require a dressing. 2. Review of the 11/4/25 annual MDS assessment showed resident #3 had a BIMS score of 8, indicating moderate cognitive impairment, and diagnoses that included non-Alzheimer's dementia, depression, and cerebrovascular accident (CVA). Review of the care plan, last revised on 9/14/22, showed I can be verbally aggressive (calling people fat/mean and hateful comments, cussing and yelling). Review of the 9/30/25 quarterly MDS assessment showed resident #4 had a BIMS score of 0, indicating severe cognitive impairment, and diagnoses that included vascular dementia and CVA. The following concerns were identified:a. Review of an incident dated 11/25/25 showed RN #1 was notified by CNA #1 that resident #3 had hit resident #4 in the face with a spiral notebook. When resident #4 was assessed there were no visible injuries. Resident #4 stated s/he was not hurt, was crying and visibly upset, and asked why would somebody do that? When staff asked resident #3 why s/he hit resident #4, s/he stated [s/he's] a bitch. Resident #3 was removed from the area and staff assisted him/her to the toilet, where s/he was combative with cares. Resident #3 was then left in his/her room to try and calm down. About 30 minutes later, RN #1 was in the kitchen with another resident when she heard screaming. She saw resident #4's head being pulled back and ran over to assess the situation, and found resident #3 grabbed resident #4's hair hard and yanked it backwards with force. It took nurse #1 and CNA #1 to get resident #3 to let go of resident #4's hair. Resident #3 again started calling resident #4 names. Resident #4 was assessed and asked if s/he was okay, and staff reported s/he had a clump of about 30 hairs pulled out of his/her head, and s/he cried and stated why did [s/he] do that? Staff reassured resident #4 they would handle the situation. Resident #3 was removed from the unit and taken to RN #2's office to separate residents. b. Interview with RN #1 on 12/1/25 at 3:25 PM revealed she heard yelling and saw resident #3 hit resident #4 in the face with a spiral notebook. Resident #4 stated why did [s/he] do that? after s/he was hit. RN #1 took resident #3 to the restroom in an attempt to calm him/her down. During the toilet transfer, resident #3 grabbed RN #1's scrub top, and it took several people to get him/her to let go. 30 minutes after resident #3 was toileted, s/he wheeled his/her wheelchair across the unit and grabbed resident #4 by the hair. c. Interview with RN #2 on 12/2/25 at 1:38 PM revealed the NHA and DON were in a meeting, and she had been asked to let them know that there had been an incident between resident #3 and resident #4. She reported resident #3 was in his/her room, and resident #4 was in the common hallway after s/he had been hit in the face. She reported she assisted RN #1 and CNA #1 to help resident #3 use the lift to transfer to the toilet, and then left the room so there would not be so many people to increase agitation from resident #3. She reported she supervised resident #3 in the administration office after the incident.d. Interview with CNA #1 on 12/2/25 at 2:18 PM revealed she had been in another resident's room when resident #3 hit resident #4 in the face with the