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 _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS	60 MAGNOLIA CASPER, WY 82604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys 5/21/25 through 5/22/25. The survey was prompted by complaint intake WY00004391. The following common abbreviations are used throughout this document: DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on medical record review, resident representative and staff interview, facility incident review, and performance improvement plan	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/06/2025

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 _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS	**60 MAGNOLIA CASPER, WY 82604**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 1	F 600		

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 5/3/25 for resident #12 showed the resident admitted to the facility on 4/28/25 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

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 _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS	**60 MAGNOLIA CASPER, WY 82604**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 2	F 600		

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.

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 4/30/25.

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.

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 _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS	**60 MAGNOLIA CASPER, WY 82604**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 3 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.	F 600		