STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535042	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/29/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Rehabilitation and Wellness	**60 Magnolia St , Casper, Wyoming, 82604**

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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 07/28/2026 and 07/29/2026. Requirements for Long Term Care Facilities Section 42 CFR 483.90(a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility (west and central wings) was a fully sprinklered one story building with a partial basement of Type V (000) and Type V (111) construction built in 1958 and 1987. The building was equipped with a supervised wet sprinkler system (west wing) and a dry sprinkler system (central wing), and an addressable fire alarm system. The facility had 192 certified Medicare and Medicaid beds with a census of 156 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K0000		
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide evidence of maintenance for the fire alarm system in accordance with 2012 NFPA 101, Life Safety Code, and 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain fire alarm systems could result in injury or death in the event of a fire. The deficiency could affect all residents, staff, and visitors at the facility. The findings were:	K0345	K345 SS=F Fire Alarm System- Testing and Maintenance Vendor performed the smoke detector sensitivity test 8/11/26. Maintenance director has the maintenance log of the fire alarm system checks. Audit performed by ED and Maintenance Department on 07/30/26 to validate compliance with fire alarm system testing. Any needed corrections were done at that time. Staff educated on smoke detector sensitivity test importance and regulations. Maintenance Director/Designee will audit the facility weekly for 12 weeks to validate compliance. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process for 90 days with recommendations made as necessary.	08/21/2026

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 reverse for further 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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K0345 SS = F Bldg. 01	Continued from page 1 Document review on 07/29/2026 starting at 9:45 AM revealed the facility failed to provide documentation of testing and maintenance of the fire alarm system in accordance with 2010 NFPA 72. The facility failed to provide documentation of the following tests: a) Smoke Detector sensitivity test - Table 14.4.5(15)(i) Interview with the facility manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Section 9.6.3.1, 9.6.1.5 2010 NFPA 72, Table 14.4.5	K0345		08/21/2026
K0351 SS = F Bldg. 01	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or	K0351	The observed sprinklers were corrected to meet compliance with Escutcheons and hanging bracket. Closet was removed to meet compliance of sprinkler spacing. Sprinklers that were too close together were corrected. Items that were stacked too close to the ceiling and/or sprinkler heads, were removed. Paint was removed from sprinkler head. Audit performed by ED and Maintenance Department on 7/30/26 to validate escutcheons and sprinkler heads were in compliance with regulations. Any needed corrections were done at that time. Staff were educated on escutcheons and sprinkler regulations and requirements. Maintenance Director/Designee will audit the facility for 12 weeks to validate compliance. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process for 90 days with recommendations made as necessary.	08/21/2026

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K0351 SS = F Bldg. 01	Continued from page 2 death in the event of a fire. The deficiency affected three (3) of numerous sprinkler heads throughout the facility. The findings were: Observation on 07/28/2026 at 1:38 PM in the basement training room closet revealed the area was not provided with sprinkler protection. Observation on 07/28/2026 at 1:47 PM in the basement men's bathroom adjacent to the training room revealed a fire sprinkler head with the escutcheon missing, exposing the annular space. Observation on 07/28/2026 at 2:30 PM in room 210 revealed paint and/or texture material on the sprinkler head. Further observation throughout the facility revealed numerous instances where objects were stacked too close to the ceiling, obstructing sprinkler head effective operation. Maintenance corrected on the spot and communicated deficiency to area personnel responsible. Interview with the facility manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 13, Sections: 19.3.5.1, 2010 NFPA 13, Sections: 6.2.7.1, 2012 NFPA 101, Sections: 19.3.5.1; 9.7.5, 2011 NFPA 25, Section 5.2.1.2	K0351		08/21/2026
K0223 SS = E Bldg. 01	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and	K0223	August 21, 2026 WAIVER REQUEST John Kopper Healthcare Licensing and Surveys 2300 Capitol Avenue Cheyenne, WY 82002 Dear Federal Life Safety Surveyors and whom it may concern,	01/23/2027

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K0223 SS = E Bldg. 01	Continued from page 3 * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain doors with self-closing devices in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain doors with self-closing devices as required could result in injury or death during an emergency. The deficiency affected numerous doors with self-closing devices throughout the facility. The findings were: Observation on 07/28/2026 at 1:36 PM in the sprinkler/HVAC room in the basement revealed that the self-closing door failed to operate as designed. When drop tested with no initial motion the door failed to close and latch. Observation on 7/28/26 at 2:12 PM at the basement training room exit door revealed the self-closing door failed to operate as designed. The lower right portion of the door was eroded to the extent that the door was no longer functional. Further observation throughout the survey revealed multiple additional self-closing doors that would not latch when dropped from the open position. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Sections: 19.2.2.2.1, 7.2.1.8	K0223	Continued from page 3 Please find this letter as our request for a limited time waiver for K223. During our Life Safety Survey conducted on 07/28/2026-07/29/2026, our facility received the following deficiency: K223- The standard was not met: The facility exit door failed to operate as designed, as it was not functional due to erosion to door. We are requesting a time-limited waiver request as noted on the August 20, 2026 Plan of Correction due to the amount of time the vendor needs to produce the product and install; please find this supportive letter with our detailed request: K223- waiver through 01/23/2027 Project Milestone: Month 1- Design Phase and Submission Phase for approval Month 2-4 - Construction commences Month 5- Construction completed Month 6- Re-inspect requested Thank you for your consideration and we await your approval. Should you have any questions please feel free to contact me at 307-797-4535 Sincerely, Jessica Miller Administrator	01/23/2027

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K0223 SS = E Bldg. 01		K0223	Continued from page 4 Maintenance repaired the self-closing doors to validate that they operate effectively. Door that was eroded and no longer functional, was replaced. Audit performed by ED and Maintenance Department on 07/30/26 to validate doors in facility are in proper working order. Any needed corrections were done at that time. Staff educated on door requirement and regulations. Maintenance Director/Designee will audit the facility weekly for 12 weeks to validate compliance. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process for 90 days with recommendations made as necessary.	01/23/2027
K0321 SS = E Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms	K0321	Maintenance repaired the drywall exposing pipes in the basement and in the boiler room. Audit performed by ED and Maintenance Department on 07/30/26 to validate drywall was in place and not damaged. Any needed corrections were done at that time. Staff educated on drywall replacement and repairs in regard to regulations. Maintenance Director/Designee will audit the facility weekly for 12 weeks to validate compliance. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process for 90 dayswith recommendations made as necessary.	08/21/2026

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K0321 SS = E Bldg. 01	Continued from page 5 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous areas as required could delay egress resulting in injury or death during an emergency. The deficiency affected two (2) of numerous rooms in the facility. The findings were: Observation on 07/28/2026 at 1:08 PM in the basement fire sprinkler room revealed penetrations for piping in the ceiling with the removal of the double layered drywall. Observation on 07/28/2026 at 5:29 PM in the boiler room revealed that a section of the fire-rated ceiling had collapsed, exposing space above. Interview with the facility manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101: Sections 19.3.2; 8.7.1; 8.3.1.2; 8.3.5.1	K0321		08/21/2026
K0100 SS = D Bldg. 01	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility	K0100	Maintenance replaced the fire rated door handle to the laundry area. Audit performed by ED and Maintenance Department on 7/30/26 to validate that fire rated doors were in working order. Any needed corrections were done at that time. Staff educated on fire rated doors and requirements with such. Maintenance Director/Designee will audit the facility weekly for 12 weeks to validate compliance.	08/21/2026

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K0100 SS = D Bldg. 01	Continued from page 6 failed to maintain obvious equipped safety features in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain obvious equipped safety features as required could result in injury or death due in an emergency. The deficiency affected one (1) smoke compartments in the facility. The findings were: Observation on 07/28/2026 at 5:29 PM at the laundry facility room door revealed that the existing 3-hour fire-rated door contained visible holes as a result of fire-door handle replacement. The integrity of fire-rated doors must be maintained at all times to ensure proper fire and smoke compartmentalization. Interview with the facility manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101: Section 19.1.1.1.3, 4.6.12.3	K0100	Continued from page 6 Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process for 90 days with recommendations made as necessary.	08/21/2026
K0200 SS = D Bldg. 01	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected one (1) of numerous doors. The findings were: Observation on 07/28/2026 at 2:12 PM at the Social Services Director/Office exit revealed that the force required to open the door was measured at greater than 25 lbf. Interview with the Facility Manager at time of the	K0200	Maintenance repaired the force required to open the Social Services office. Audit perfomed by ED and Maintenance Department on 7/30/26 to validate doors open with the regulatory force requirements. Staff educated on force required to open doors. Maintenance Director/Designee will audit the facility weekly for 12 weeks to validate compliance. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process for 90 days with recommendations made as necessary.	08/21/2026

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K0200 SS = D Bldg. 01	Continued from page 7 observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Sections: 19.2.2.2.1; 7.2.1.4.5.1	K0200		08/21/2026
K0293 SS = D Bldg. 01	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain exit signs in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain exit signs as required could result in injury or death during an emergency. The deficiency affected two (2) of numerous areas in the facility. The findings were: Observation on 7/28/2026 at 1:32 PM in the basement training room revealed no exit sign was observed above the doorway in the classroom and storage area. Observation on 7/28/2026 at 1:49 PM in the basement bulk storage area by the training room revealed no exit sign could be observed from the exit door leading to the interior of the main facility. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Sections: 19.2.10.1; 7.10.1.1, 7.10.1.5.1	K0293	Maintenance replaced exit signs in the basement training room and basement bulk storage area. Audit performed by ED and Maintenance Department on 7/30/26 to validate exit signs were placed to meet regulatory requirements. Staff educated on exit sign placement. Maintenance Director/Designee will audit the facility weekly for 12 weeks to validate compliance. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process for 90 days with recommendations made as necessary.	08/21/2026

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K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency affected one (1) of numerous areas throughout the facility. The finding was: Observation on 7/28/2026 at 1:42 PM indicated an electric ceiling-mounted heater within 12 inches of the basement training room sprinkler head. Sprinklers must be installed so they are not adversely affected by sources of heat. Interview with the facility manager at time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2010 NFPA 13, Section 8.3.2, Table 8.3.2.5(a)(2) Unit heater	K0353	The observed sprinklers heater was moved to meet regulation with spacing from sprinkler head. Audit performed by ED and Maintenance Department on 7/30/26 to validate items were not too close to sprinkler heads and were compliance with regulations. Any needed corrections were done at that time. Staff were educated on sprinkler regulations and requirements. Maintenance Director/Designee will audit the facility for 12 weeks to validate compliance. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process for 90 days with recommendations made as necessary.	08/21/2026

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K0511 SS = D Bldg. 01	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 National Electrical Code. Failure to maintain electrical systems as required could cause a fire resulting in injury or death. The deficiencies affected two (2) of numerous rooms in the facility. The findings were: Observation on 7/28/2026 at 1:12 PM in the basement HVAC room revealed an exposed outlet with no cover, exposing wires inside. Observation on 7/29/2026 at 9:20 AM in the kitchen revealed an exposed open junction box with no cover, exposing wires inside. Interview with the facility manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: NFPA 101 (2012), Sections 18/19.5.1.1, Section9.1.2, NFPA 70, article 4.6.5(F), 406.6	K0511	Maintenance corrected the exposed wires in the basement HVAC room and kitchen. Audit performed by ED and Maintenance Department on 7/30/26 to validate compliance with exposed wires. Staff were educated on regulations and requirements with exposed wires. Maintenance Director/Designee will audit the facility for 12 weeks to validate compliance. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process for 90 days with recommendations made as necessary.	08/21/2026
K0761 SS = D Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance	K0761	Maintenance corrected the issues with the latch on the laundry room door. Audit performed by ED and Maintenance Department on 7/30/26 to validate compliance with fire rated doors. Staff educated on fire rated doors and requirements with such.	08/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535042	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/29/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Rehabilitation and Wellness	**60 Magnolia St , Casper, Wyoming, 82604**

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K0761 SS = D Bldg. 01	Continued from page 10 program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure that doors had appropriate hardware in accordance with 2012 NFPA 101, Life Safety Code. Failure to ensure that fire-rated doors are equipped with correctly rated hardware as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous door hardware sets in the building. The findings were: Observation on 7/28/2026 at 5:30 PM at the entry to the laundry room door revealed that the fire-rated door was missing the door latch. Interview with the facility manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101 Sections 7.2.1.5.10, 19.2.2.2.1	K0761	Continued from page 10 Maintenance Director/Designee will audit the facility weekly for 12 weeks to validate compliance. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process for 90 days with recommendations made as necessary.	08/21/2026
K0923 SS = D Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from	K0923	Propane tanks by the outside patio door were removed. Audit performed by ED and Maintenance Department on 7/30/26 to validate no other propane tanks were unsecure. Staff education on proper storage of propane tanks. Maintenance Director/Designee will audit the facility weekly for 12 weeks to validate compliance with storage of combustibles. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process for 90 days with recommendations made as necessary.	08/21/2026

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K0923 SS = D Bldg. 01	Continued from page 11 combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to store propane tanks in accordance with the 2012 NFPA 99, Health Care Facilities Code. The failure to store propane as required may result in injury or death. The deficiency affected one (1) room out of numerous rooms in the facility. The findings were: Observation on 07/28/2026 at 3:07 PM at the exterior protected overhang revealed two (2) BBQ propane tanks that were unsecured. Interview with the facility manager at time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 99: Sections 11.3.2.6, 11.6.2.3(11)	K0923		08/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535042	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - EAST BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/29/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Rehabilitation and Wellness	**60 Magnolia St , Casper, Wyoming, 82604**

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K0000 Bldg. 02	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 07/28/2026 and 07/29/2026. Requirements for Long Term Care Facilities Section 42 CFR 483.90(a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility (east wings) was a fully sprinklered one story building of Type II (111) construction built in 1979. The building was equipped with a supervised wet sprinkler system (east wing) and an addressable fire alarm system. The facility had 192 certified Medicare and Medicaid beds with a census of 156 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K0000		
K0345 SS = F Bldg. 02	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide evidence of maintenance for the fire alarm system in accordance with the 2012 NFPA 101, Life Safety Code, and 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain fire alarm systems could result in injury or death in the event of a fire. The deficiency could affect all residents, staff, and visitors at the facility. The findings were: Document review on 07/29/2026 starting at 9:45 AM revealed the facility failed to provide documentation	K0345	K345 SS=F Fire Alarm System- Testing and Maintenance Vendor performed the smoke detector sensitivity test 8/11/26. Maintenance director has the maintenance log of the fire alarm system checks. Audit performed by ED and Maintenance Department on 07/30/26 to validate compliance with fire alarm system testing. Any needed corrections were done at that time. Staff educated on smoke detector sensitivity test importance and regulations. Maintenance Director/Designee will audit the facility weekly for 12 weeks to validate compliance. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process for 90 days with recommendations made as necessary.	08/21/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535042	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - EAST BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/29/2026**

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K0345 SS = F Bldg. 02	Continued from page 1 of testing and maintenance of the fire alarm system in accordance with 2010 NFPA 72. The facility failed to provide documentation of the following tests: a) Smoke Detector sensitivity test - Table 14.4.5(15)(i) Interview with the facility manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Section 9.6.3.1, 9.6.1.5 2010 NFPA 72, Table 14.4.5	K0345		08/21/2026
K0321 SS = E Bldg. 02	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons)	K0321	Maintenance repaired the fire caulking and ceiling tiles that were missing and/or damaged. Audit performed by ED and Maintenance Department on 07/30/26 to validate appropriate fire caulking and ceiling tiles were in place and not damaged. Any needed corrections were done at that time. Staff educated on fire caulking and ceiling tiles in regard to regulations. Maintenance Director/Designee will audit the facility weekly for 12 weeks to validate compliance. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process for 90 days with recommendations made as necessary.	08/21/2026

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K0321 SS = E Bldg. 02	Continued from page 2 f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous areas as required could delay egress resulting in injury or death during an emergency. The deficiency affected two (2) of numerous rooms in the facility. The findings were: Observation on 7/28/2026 at 3:57 PM in the east side sprinkler room revealed fire caulking had fallen from conduit penetrations at the ceiling, which exposed the space above. Observation on 7/28/2026 at 3:59 PM in the data/phone room (east), revealed several missing ceiling tiles. Further observation during the survey revealed several ceiling tiles needing replaced throughout facility, due to damage. Interview with the facility manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101: Sections 19.3.2; 8.7.1; 8.3.1.2; 8.3.5.1	K0321		08/21/2026

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Licensing and Surveys on 07/28/2026 and 07/29/2026. Based on the findings of the survey, the facility is in compliance with 42 CFR 483.73.	E0000		

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