STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Horn Rehabilitation and Care Center	1851 Big Horn Ave Sheridan, WY 82801

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident representative, and staff interview, medical record review, and policy and procedure review, the facility failed to ensure resident representatives were notified of a change in condition for 1 of 3 sample residents (#1) who were transferred to the hospital. The census was 79. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #1 had a BIMS score of 15 out of 15 which indicated intact cognition, and diagnoses which included coronary artery disease (CAD), heart failure, hypertension. Further review showed the resident had acute systolic (congestive) heart failure, need for assistance with personal care, and a colostomy. The following concerns were identified:a. Review of a progress note dated 9/25/25 showed .Resident presented with diaphoresis, pallor, c/o chest pain, constant coughing with bloody sputum, wheezes, course lung sounds, shortness of breath, and weakness. Vital signs: 145/82 manual, oxygen 97% 4L[liters] NC [nasal cannula], HR [heart rate] 79, RR 24 even and labored, temp 99.3. Physician on call notified, recommended to present to ED for further evaluation. 0708- Admin on call notified, told to continue to monitor, transfer to ED when driver became available through facility at 0800. 0815- Driver available, resident sent to ED by wheelchair.b. Review of a transfer notice dated 9/25/25 showed the notice was not signed by the resident, and the resident's representative will get copy when she comes to p/u [resident's] kindle. c. Interview with the resident's representative on 10/1/25 at 10:06 AM revealed she was not notified of the resident's transfer to the ED. Further interview revealed she went to the facility that morning to visit the resident, and was told by the nurse the resident had been sent to the hospital. She reported she had not received a phone call from the facility regarding the transfer, and had not received any paperwork from the facility regarding the transfer. d. Interview with the DON on 10/2/25 at 1:25 PM confirmed the resident's representative had not been called about the resident's transfer to the ED. e. Review of the policy titled Notification of Changes and dated 2025 showed .The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification.Circumstances requiring notification include: .2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status.4. A transfer or discharge of the resident from the facility.

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 - Minimal harm or potential for 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 staff interview, facility investigation review, and policy and procedure review, the facility failed to ensure residents were free from abuse from staff for 1 of 11 sample residents (#4) reviewed for allegations of abuse. The findings were:1. Review of the quarterly MDS assessment dated [DATE] showed resident #4 had a BIMS score of 3/15 which indicated severely impaired cognition, and diagnoses which included non-traumatic brain dysfunction, renal insufficiency, Alzheimer's disease, non-Alzheimer's dementia, anxiety, and depression. In addition, the resident had behaviors which included physical and verbal behavioral symptoms directed toward others that occurred 1 to 3 days in the look-back period, and other behavioral symptoms not directed toward others that occurred daily in the look-back period. Further review showed the resident was dependent on toileting hygiene and required partial/moderate assistance for toilet transfers. 2. Review of an incident dated 8/5/25 showed the SSD was contacted by a family member of a resident who saw a video on social media on 7/21/25 that CNA #1 had posted of herself in resident #4's bathroom. Resident #4 could be heard on the video saying please let me out of here and CNA #1 responded you've pooped your pants 4 times today you have to try to use the bathroom. This was repeated back and forth several times before resident #4 responded to the CNA I don't know how. Further review showed the SSD contacted the administrator immediately, and suspended CNA #1 on 8/5/25 at 7:04 PM. The SSD spoke with CNA #1 on 8/6/25 and she stated, I think I know what this is about and disclosed that she had taken video of herself in resident #4's bathroom, confirmed all of the details given by the reporter, and did not understand what she had done that was so wrong. CNA #1 was terminated on 8/7/25. Two attempts to contact CNA #1 were unsuccessful. 3. Interview with the DON on 10/2/25 at 1:25 PM revealed CNA #1 had been terminated, the resident had been monitored by nursing, and the staff had been given education on abuse and neglect, but no further action had been taken to assure it would not happen again. She confirmed the incident was not reviewed in Quality Assurance and Performance Improvement (QAPI). Further interview revealed the SSD had walked out three weeks ago and was unavailable for interview.4. Review of the policy titled Abuse, Neglect and Exploitation dated 2025 showed .IV. Identification of Abuse, Neglect and Exploitation.B. Possible indicators of abuse include, but are not limited to: .9. Evidence of photographs or videos of a resident that are demeaning or humiliating in nature, regardless of whether the resident provided consent and regardless of the resident's cognitive status. Further review showed .VII. Coordination with QAPI.1. Cases of physical or sexual abuse, for example by facility staff or other residents, will be reviewed for and receive corrective action and tracking by the QAA committee. This coordinated effort results in the QAA Committee determining: a. If a thorough investigation is conducted; b. Whether the resident is protected; c. Whether an analysis was conducted as to why the situation occurred; d. Risk factors that contributed to the abuse 9e.g., history of aggressive behaviors, environmental factors); and e. Whether there is further need for systemic action such as: i. Insight on needed revisions to the policies and procedures that prohibit and prevent abuse/neglect/misappropriation/exploitation, ii. Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about, iii. Efforts to educate residents and their families about how to report any alleged violations without fear of repercussions, iv. Measures to verify the implementation of corrective actions and timeframes, and v. Tracking patterns of similar occurrences.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility investigation review, Office of Healthcare Licensing and Surveys ([NAME]) incident report log review, and policy and procedure review, the facility failed to report the results of abuse investigations within 5 working days to the State Agency for 4 of 11 sample residents (#7, #8, #9, and #10) reviewed for allegations of abuse. The findings were: 1. Review of a facility reported incident (FRI) dated 7/28/25 showed an allegation of verbal abuse between resident #7 and a staff member had occurred on 7/20/25 at 2:30 PM. The incident had been reported to the SSD on 7/28/25 at 12:00 PM and the administrator was made aware at 1:00 PM. The initial incident report was sent to [NAME] at 2:35 PM, and an investigation was begun. On 9/12/25 at 10:23 AM the [NAME] requested the investigation for the incident to be submitted. Further review showed no investigation was completed or reported by the facility as of 9/26/25.2. Review of a FRI dated 8/21/25 showed an incident of abuse between resident #8 and resident #9 had occurred on 8/21/25 at 9:45 AM. Staff was aware of the incident at 9:45 AM, the administrator was made aware at 10:05 AM, and the initial incident report was sent to [NAME] at 12:01 PM. Further review showed no investigation was completed or reported by the facility as of 9/26/25. 3. Review of a FRI dated 8/28/25 showed an incident of abuse between resident #10 toward LPN #1 had occurred on 8/28/25 at 2:57 PM. Staff was aware of the incident at 3:00 PM, the administrator was made aware of the incident at 12:00 AM, and the initial incident report was sent to [NAME] at 4:21 PM. Further review showed no investigation was completed or reported by the facility as of 9/26/25.4. Interview with the NHA on 10/1/25 at 11:36 AM revealed the investigations were not in the facility. 5. Interview with the regional nurse on 10/1/25 at 12:30 PM revealed the reportable investigations binder had been in the facility 3 weeks ago, was not in the facility at that time, and the administration had called the police to report it was missing. 6. Interview with the DON on 10/1/25 at 2:45 PM confirmed investigations should have been submitted by the former SSD but were not. Further interview revealed the DON did not have access to submit investigations. 7. Review of the facility policy titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation dated 2025 showed .Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation: .2. The Administrator or designee will: a. Notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than 2 hours after discovery or forming the suspicion. b. Obtain statements from direct care staff. C. Suspend the accused employee pending completion of the investigation. d. Follow up with appropriate agencies, during business hours, to confirm the report was received. E. Report to the state nurse aide registry or nursing board any knowledge of any actions which would indicate an employee is unfit for service. F. Within 5 working days of the incident, report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility investigation review, [NAME] incident report log review, policy and procedure review, the facility failed to ensure a thorough investigation was completed and failed to report the results of the investigation to the State Agency for 4 of 11 sample residents (#7, #8, #9, and #10) reviewed for allegations of abuse. The findings were: 1. Review of a facility reported incident (FRI) dated 7/28/25 showed an allegation of verbal abuse between resident #7 and a staff member had occurred on 7/20/25 at 2:30 PM. The incident had been reported to the SSD on 7/28/25 at 12:00 PM and the administrator was made aware at 1:00 PM. The initial incident report was sent to [NAME] at 2:35 PM, and an investigation was begun. On 9/12/25 at 10:23 AM the [NAME] requested the investigation for the incident to be submitted. Further review showed no investigation was completed or reported by the facility as of 9/26/25.2. Review of a FRI dated 8/21/25 showed an incident of abuse between resident #8 and resident #9 had occurred on 8/21/25 at 9:45 AM. Staff was aware of the incident at 9:45 AM, the administrator was made aware at 10:05 AM, and the initial incident report was sent to [NAME] at 12:01 PM. Further review showed no investigation was completed or reported by the facility as of 9/26/25. 3. Review of a FRI dated 8/28/25 showed an incident of abuse between resident #10 toward LPN #1 had occurred on 8/28/25 at 2:57 PM. Staff was aware of the incident at 3:00 PM, the administrator was made aware of the incident at 12:00 AM, and the initial incident report was sent to [NAME] at 4:21 PM. Further review showed no investigation was completed or reported by the facility as of 9/26/25.4. Interview with the NHA on 10/1/25 at 11:36 AM revealed the investigations were not in the facility.5. Interview with the regional nurse on 10/1/25 at 12:30 PM revealed the reportable investigations binder had been in the facility 3 weeks ago, was not in the facility at that time, and the administration had called the police to report it was missing. 6. Interview with the DON on 10/1/25 at 2:45 PM confirmed investigations should have been submitted by the former SSD but were not. Further interview revealed the DON did not have access to submit investigations.7. Review of the facility policy titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation dated 2025 showed .Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation: .2. The Administrator or designee will: a. Notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than 2 hours after discovery or forming the suspicion. b. Obtain statements from direct care staff. C. Suspend the accused employee pending completion of the investigation. d. Follow up with appropriate agencies, during business hours, to confirm the report was received. E. Report to the state nurse aide registry or nursing board any knowledge of any actions which would indicate an employee is unfit for service. F. Within 5 working days of the incident, report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and resident representative and staff interview, the facility failed to provide services to prevent a decrease in mobility for 1 of 3 sample residents (#1) with limited mobility. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #1 had a BIMS score of 15 out of 15 which indicated intact cognition, and diagnoses which included coronary artery disease (CAD), heart failure, hypertension, and acute systolic (congestive) heart failure. Further review showed the resident had a colostomy, a need for assistance with personal care, and the ability to walk 150 feet independently. Review of the medical record showed the resident was discharged to the hospital on 9/25/25. The following concerns were identified:a. Interview with the resident's representative on 10/1/25 at 10:06 AM revealed the resident had been able to walk with a walker when s/he admitted to the facility in January, but was discharged from therapy in March; and was now unable to walk. Further interview revealed the resident could receive therapy only if s/he paid privately, and s/he would not receive restorative services until s/he had Medicaid. She reported the resident's payor source changed to Medicaid the other day. b. Interview with RN #1 on 10/2/25 at 8:40 AM revealed the resident could transfer from his/her wheelchair, stand at the sink, and completed all mobility with a wheelchair. c. Interview with the DON on 10/2/25 at 9:00 AM revealed there had been a restorative aide (RNA) to provide maintenance when residents were discharged from skilled therapy, however the RNA had been scheduled to work the floor for staffing reasons. She revealed the resident used to walk around her room before September, but had not walked since then. Further interview revealed the DON was waiting for handbooks to get the restorative program up and running, and resident #1 did not receive restorative services. d. Review of a physical therapy (PT) screening log provided by the NHA on 10/2/25 at 2:27 PM showed the resident was on the in-process list for a screen due on 10/23/25, and a screen would be completed 10/6/25 by PT.