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	10/23/2025

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

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 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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 0658 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, facility incident review, and staff interview, the facility failed to ensure that services provided met professional standards for 2 of 4 sampled residents (#1, #7) reviewed for quality of care. This failure resulted in actual harm to resident #1 and #7. The findings were: 1. Review of the admission MDS assessment dated [DATE] showed resident #1 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included cancer, diabetes mellitus, hypertension, and arthritis. Review of the facility incident report dated 9/23/25 showed the resident had been found on the floor following a fall in his/her room and had been assisted to a wheelchair by staff. The resident complained of nausea and numbness to the arms. The resident was transported to the ER in the facility van, accompanied by CNA #1 and the activities director, where s/he was diagnosed with cervical spine fractures of the 5th and 6th vertebrae. The following concerns were identified:a. Interview with RA #1 on 10/22/25 at 10:32 AM revealed he found the resident on the floor in his/her room, unable to move his/her arms or legs, and he observed a small amount of blood behind his/her head. After alerting LPN #2 and the former DON, he was instructed to assist them in lifting the resident off the floor and into his/her wheelchair where s/he would be transported to the ER in the facility van. Further interview revealed emergency medical services were not notified.b. Interview with LPN #1 on 10/22/25 at 6:15 PM revealed she observed the resident on the floor, the resident had a small amount of blood at the back of his/her head, s/he complained of not being able to feel [his/her] arms while lying on the floor, and was not able to sit up without staff assistance. The resident was assisted to a wheelchair and driven to the ER in the facility van. She felt the resident was unstable in the wheelchair riding in the van.c. Interview with LPN #2 on 10/23/25 at 2 PM confirmed the resident was found on the floor with a small amount of blood behind his/her head. He observed LPN #1 had assessed the resident's arm movements and lifted his/her head onto a pillow. He stated the resident was not able to sit up without staff assistance and was transferred to a wheelchair by staff. Further interview revealed the former DON told staff the resident had a head injury and was then transported to the ER in the facility van.d. Interview with CNA #2 on 10/23/25 at 11:12 AM revealed she was called into the resident's room and observed him/her on the floor. She assisted RA #1, LPN #2, and the former DON to lift the resident off the floor and into a wheelchair. She stated, It took all of us to lift [him/her] off the floor and into the chair because [his/her] legs weren't working, they were limp. She confirmed the former DON had the resident transported to the ER via facility van and did not call 911 because the ambulance was too expensive. e. Interview with the activities director on 10/23/25 at 11:20 AM revealed the former DON asked her to transport the resident to the ER following the fall because it was faster and easier than calling an ambulance. She revealed the resident had nausea and vomiting, was not alert, and had abnormal movements of his/her hands and feet. She confirmed she and CNA #1 transported him/her to the hospital, and the resident had leaned on CNA #1 during the van ride.f. Interview with CNA #1 on 10/23/25 at 11:57 revealed she had been asked by the former DON to accompany the resident to the ER in the facility van following a fall due to the expense of calling the ambulance. She observed the resident leaning forward in his/her wheelchair and talking with staff. She confirmed the resident leaned on her during the van ride and did not maintain his/her upper body balance. g. Review of the facility document titled Resident Abuse and/or neglect, dated 9/23/25, showed the NP was notified the date of the fall. 2. Interview with the facility NP on 10/23/25 at 1:11 PM revealed she had had not been notified of the fall or a need to transport to the hospital. 3. Interview with the NHA on 10/23/25 at 11:20 AM revealed he had been informed the resident was found on the floor with blood coming from his/her head and was transported to the ER on e hour following the fall via facility van. Further interview confirmed that staff were expected to call 911 when resident's required higher level of care. 4. Review of the discharge MDS assessment dated [DATE] showed resident #7 had modified independence which indicated difficulty in new situations only for cognitive skills for daily decision making, and diagnoses which included malnutrition, anxiety disorder, fracture of the upper end of the right humerus, fracture of the left ilium, chronic respiratory failure, muscle wasting and atrophy, major depressive disorder, and altered mental status. Further review showed the resident was dependent on staff for toileting hygiene, personal hygiene, to roll left and right, to sit from lying, and to reposition from lying to sitting on the side of bed. Further review showed the resident had a urinary catheter, and was always incontinent of bowel. Review of the care plan last revised on 8/27/25 showed the resident was dependent for transfers and required at least 5 people to assist

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on resident and staff interview, medical record review, and facility policy and procedure review, the facility failed to ensure bathing was performed per residents' preference for 3 of 4 sample residents (#2, #3, #4) reviewed for bathing. The findings were: 1. Review of resident #2's .ADL self-care performance . care plan last revised 10/21/25 showed the resident required 1 person assist for showers. The following concerns were identified:a. Review of the bathing record between 9/29/25 and 10/20/25 showed the resident received showers on 9/29/25 and 10/10/25 and was documented as refused on 10/6/25, 10/13/25 and 10/20/25. The record showed a shower was to be offered on an alternative day/time on 10/3/25, and 10/17/25; however, there was no evidence the bathing was offered, accepted, or refused.b. Interview with the resident on 10/23/25 at 9:55 AM revealed the s/he received a shower every 2 weeks, because that's how they have it set up. Further interview revealed s/he would prefer more showers if there was enough help.2. Review of resident #3's .ADL self-care performance . care plan last revised 8/17/25 showed the resident required the assistance of 2 staff members for showers. The following concerns were identified:a. Review of the bathing record between 9/24/25 and 10/22/25 showed the resident received showers on 9/24/25 and 10/1/25. Showers were to be offered on alternate days/times on 10/5/25, 10/9/25, and 10/22/25; however, there was no evidence the showers were offered. Further review showed no evidence the resident was offered, accepted, or refused bathing for 22 days following the 10/1/25 shower.b. Interview with the resident on 10/23/25 at 9:55 AM revealed I'm supposed to get 2 showers a week but so far I only get 1 shower a week. It could happen a little more frequently. 3. Review of resident #4's .ADL self-care performance . care plan last revised 4/1/24 showed .I prefer showers three days a week and prefers [sic] a female care giver . The following concerns were identified: a. Review of the bathing record between 9/24/25 and 10/22/25 showed the resident received showers one to two times per week on 9/24/25, 10/1/25, 10/3/25, 10/8/25, 10/13/25, and 10/17/25. A shower was to be offered as an alternate day/time on 10/6/25; however, there was no evidence the resident was offered, accepted, or refused bathing at that time. Further review showed the resident refused one shower on 10/22/25.b. Interview with the resident on 10/23/25 at 10:02 AM revealed the s/he had not received a shower for a week, and s/he was supposed to have showers on Mondays, Wednesdays, and Saturdays. Further interview revealed the resident had frequent diarrhea and that was why s/he needed 3 showers per week. 4. Interview with CNA #3 on 10/22/25 at 3:10 PM revealed showers were not getting done at night because there were often only 2 CNAs and they could not provide the necessary care to the residents and provide them with showers when there were only 2 staff who worked on the hall. 5. Interview with CNA #4 on 10/23/25 at 10:05 AM revealed some days there were not enough CNAs to provide showers for the residents. Further interview revealed on a normal day the staff should be able to complete 4 to 5 showers, but there were days where they could only give 1 resident a shower because they had to prioritize answering call lights over showers. 6. Interview with the DON on 10/23/25 at 2:38 PM revealed the expectation was that showers were provided on the scheduled day, and if they were unable to be provided they would roll over to the next day. Further interview revealed some residents had staff preference which turned into a missed opportunity to receive a shower, and this had been addressed with residents. 7. Review of the policy titled Resident Showers showed .Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety .

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, facility incident review, and policy review, the facility failed to implement interventions and treatment to prevent a decline in condition for 1 of 4 sampled residents (#1) reviewed for quality of care. This failure resulted in actual harm to residents #1. The findings were:1. Review of the admission MDS assessment dated [DATE] showed resident #1 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included cancer, diabetes mellitus, hypertension and arthritis. The following concerns were identified: a. Review of the facility incident report dated 9/23/25 showed the resident had been found on the floor following a fall in his/her room and had been assisted to a wheelchair by staff. The resident complained of nausea and numbness to the arms. The resident was transported to the ER in the facility van, accompanied by CNA #1 and the activities director, where s/he was diagnosed with cervical spine fractures of the 5th and 6th vertebrae. b. Interview with RA #1 on 10/22/25 at 10:32 AM revealed he found the resident on the floor in his/her room, unable to move his/her arms or legs, and he observed a small amount of blood behind his/her head. After alerting LPN #2 and the former DON, he was instructed to assist them in lifting the resident off the floor and into his/her wheelchair where s/he would be transported to the ER in the facility van. Further interview revealed emergency medical services were not notified. c. Interview with LPN #1 on 10/22/25 at 6:15 PM revealed she observed the resident on the floor, and s/he had a small amount of blood at the back of his/her head and complained of not being able to feel [his/her] arms while lying on the floor, and was not able to sit up without staff assistance. The resident was assisted to a wheelchair and driven to the ER in the facility van. She felt the resident was unstable in the wheelchair while riding in the van. d. Interview with LPN #2 on 10/23/25 at 2 PM confirmed the resident was found on the floor with a small amount of blood behind his/her head. He observed LPN #1 had assessed the resident's arm movements and lifted his/her head onto a pillow. He stated the resident was not able to sit up without staff assistance and was transferred to a wheelchair by staff. Further interview revealed the former DON told staff the resident had a head injury and was then transported to the ER in the facility van. e. Interview with CNA #2 on 10/23/25 at 11:12 AM revealed she was called into the resident's room and observed him/her on the floor. She assisted RA #1, LPN #2 and the former DON to lift the resident off the floor and into a wheelchair. She stated, It took all of us to lift [him/her] off the floor and into the chair because [his/her] legs weren't working, they were limp. She confirmed the former DON had the resident transported to the ER via facility van and did not call 911 because the ambulance was too expensive. f. Interview with the activities director on 10/23/25 at 11:20 AM revealed the former DON asked her to transport the resident to the ER following the fall because it was faster and easier than calling an ambulance. She revealed the resident had nausea and vomiting, was not alert, and had abnormal movements of his/her hands and feet. She confirmed she and CNA #1 transported him/her to the hospital, and the resident had leaned on CNA #1 during the van ride. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	g. Interview with CNA #1 on 10/23/25 at 11:57 revealed she had been asked by the former DON to accompany the resident to the ER in the facility van following a fall due to the expense of calling the ambulance. She observed the resident leaning forward in his/her wheelchair and talking with staff. She confirmed the resident leaned on her during the van ride and did not maintain his/her upper body balance. h. Review of the facility document titled Resident Abuse and/or neglect, dated 9/23/25, showed the NP was notified the date of the fall. 2. Interview with the facility NP on 10/23/25 at 1:11 PM revealed she had not been notified of the fall or a need to transport to the hospital. 3. Interview with the NHA on 10/23/25 at 11:20 AM revealed he had been informed the resident was found on the floor with blood coming from his/her head and was transported to the ER on e hour following the fall via facility van. Further interview confirmed that staff were expected to call 911 when resident's required higher level of care. 4. Review of the policy titled Fall Prevention Policy showed .9. When any resident experiences a fall, the facility will .d. notify the physician and family .

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident representative and staff interview, medical record review, and policy review, the facility failed to ensure the environment was free of accident hazards for 1 of 3 sample residents (#5) reviewed for falls. The findings were: 1. Review of the admission MDS dated [DATE] showed resident #5 had a BIMS score of 11/15 which indicated moderate cognitive impairment, and diagnoses which included diabetes mellitus, unspecified congestive heart failure, and morbid obesity. The resident was dependent for transfers and self cares, and was incontinent of bowel and bladder. Review of the care plan initiated on 7/30/25 showed the resident was at risk for falls, and had interventions which included If a fall occurs, alert provider and If a fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol. The following concerns were identified:a. Interview with the resident's representative on 10/22/25 at 11:30 AM revealed she received a phone call from the resident's nurse on 9/9/25 at 2:03 PM and was told the resident had fallen during a mechanical lift transfer from the wheelchair to the bed. The representative was told the resident slipped through the hoyer lift sling and landed on the floor next to the bed because his/her brief was wet. The representative revealed she had asked for an incident report and had been told it could not be found. Further interview revealed the resident had been discharged to a different facility.b. Interview with RN #2 on 10/22/25 at 2:08 PM revealed she had been the nurse on duty with resident #5 the day after the fall, and was not aware of the fall until the resident's representative called and asked how the resident was doing, because there had not been any notes about the fall in the record. She revealed she documented on the resident's behavior after the incident because the resident had been upset, and her documentation had been deleted.c. Interview with the current DON on 10/22/25 at 2:59 PM revealed on 9/9/25 a CNA reported to her when she was RN on duty that resident #5 had fallen from the mechanical lift to the floor while being transferred from his/her wheelchair to the bed for a check and change. She revealed the resident had slipped out of the bottom of the sling and it was determined the sling had been placed appropriately; however, the resident's wet brief had caused the resident to slip out of the sling and onto the floor. She revealed she had completed a risk management note, progress note, and notified the family; however, she was unable to find the documentation in the medical record. Further interview confirmed there was no documentation in the resident's medical record about the fall, and there had been no follow up with risk management.d. Interview with RA #1 on 10/23/25 at 10:31 AM revealed he controlled the mechanical lift during resident #5's transfer after a CNA placed the sling. He revealed the resident fell to the floor, and he immediately alerted RN #1 about the fall. Further interview revealed he did not position the sling under the resident, he ran the controls of the lift. e. Interview with the NP on 10/23/25 at 1:04 PM revealed she had not been notified about the resident's fall.f. Review of the resident's medical record showed there was no documentation on the fall and the care plan had not been updated after the fall.2. Review of facility policy titled Fall Prevention Policy showed .9. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on resident and staff interview and medical record review, the facility failed to ensure there was sufficient nursing staff for 1 of 4 resident care units (Chapel) reviewed for sufficient staffing. The facility census was 77 and the Chapel unit census was 17. The findings were: 1. Review of resident #2's .ADL self-care performance . care plan last revised 10/21/25 showed the resident required 1 person assist for showers. The following concerns were identified:a. Review of the bathing record between 9/29/25 and 10/20/25 showed the resident received showers on 9/29/25 and 10/10/25 and was documented as refused on 10/6/25, 10/13/25 and 10/20/25. The record showed a shower was to be offered on an alternative day/time on 10/3/25, and 10/17/25; however, there was no evidence the bathing was offered, accepted, or refused.b. Interview with the resident on 10/23/25 at 9:55 AM revealed the s/he received a shower every 2 weeks, because that's how they have it set up. Further interview revealed s/he would prefer more showers if there was enough help.2. Review of resident #3's .ADL self-care performance . care plan last revised 8/17/25 showed the resident required the assistance of 2 staff members for showers. The following concerns were identified:a. Review of the bathing record between 9/24/25 and 10/22/25 showed the resident received showers on 9/24/25 and 10/1/25. Showers were to be offered on alternate days/times on 10/5/25, 10/9/25, and 10/22/25; however, there was no evidence the showers were offered, accepted, or refused. Further review showed no evidence the resident was offered, accepted, or refused bathing for 22 days following the 10/1/25 shower.b. Interview with the resident on 10/23/25 at 9:55 AM revealed I'm supposed to get 2 showers a week but so far I only get 1 shower a week. It could happen a little more frequently. 3. Review of resident #4's .ADL self-care performance . care plan last revised 4/1/24 showed .I prefer showers three days a week and prefers [sic] a female care giver . The following concerns were identified: a. Review of the bathing record between 9/24/25 and 10/22/25 showed the resident received showers one to two times per week on 9/24/25, 10/1/25, 10/3/25, 10/8/25, 10/13/25, and 10/17/25. A shower was to be offered on as an alternate days/time on 10/6/25; however, there was no evidence the resident was offered, accepted, or refused bathing at that time. Further review showed the resident refused one shower on 10/22/25.b. Interview with the resident on 10/23/25 at 10:02 AM revealed the s/he had not received a shower for a week, and s/he was supposed to have showers on Mondays, Wednesdays, and Saturdays. Further interview revealed the resident had frequent diarrhea and that was why s/he needed 3 showers per week. 4. Interview with CNA #3 on 10/22/25 at 3:10 PM revealed showers were not getting done at night because there were often only 2 CNAs and they could not provide the necessary care to the residents and provide them with showers when there were only 2 staff who worked on the hall. 5. Interview with CNA #4 on 10/23/25 at 10:05 AM revealed some days there were not enough CNAs to provide showers for the residents. Further interview revealed on a normal day the staff should be able to complete 4 to 5 showers, but there were days where they could only give 1 resident a shower because they had to prioritize answering call lights over showers. 6. Interview with the DON on 10/22/25 at 2:59 PM revealed she had brought someone new into the position of scheduler, and was trying to get staff on a set rotation because she did not want a varied and chaotic schedule, but wanted a routine schedule for the staff. 7. Interview with the DON on 10/23/25 at 2:38 PM revealed her expectation was for showers to be provided on the scheduled day, and if they were unable to be provided, they would roll over to the next day. Further interview revealed some residents had staff preference which turned into a missed opportunity to receive a shower, and this had been addressed with residents.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, medical record review, and policy review, the facility failed to maintain accurately documented medical records for 2 of 3 sample residents (#1, #5) reviewed for falls. The findings were: . 1. Review of the admission MDS dated [DATE] showed resident #5 had a BIMS score of 11/15 which indicated moderate cognitive impairment, and diagnoses which included diabetes mellitus, unspecified congestive heart failure, and morbid obesity. The resident was dependent for transfers and self cares, and was incontinent of bowel and bladder. Review of the care plan initiated on 7/30/25 showed the resident was at a risk for falls, and If a fall occurs, alert provider and If a fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol. The following concerns were identified:a. Interview with the resident's representative on 10/22/25 at 11:30 AM revealed she received a phone call from the resident's nurse, RN #1, on 9/9/25 at 2:03 PM and was told the resident had fallen during a mechanical lift transfer from the wheelchair to the bed. The representative was told the resident slipped through the hoyer lift sling and landed on the floor next to the bed because his/her brief was wet. Further, the representative was told she had asked for an incident report and had been told it could not be found. The representative stated the resident had been discharged to a different facility.b. Interview with RN #2 on 10/22/25 at 2:08 PM revealed she had been the nurse on duty with resident #5 the day after the fall, and was not aware of the fall until the resident's representative called and asked how the resident was doing, because there had no been any notes about the fall the record. She reported she documented on the resident's behavior after the incident because the resident had been upset, and her documentation had been deleted.c. Interview with the current DON on 10/22/25 at 2:59 PM revealed on 9/9/25 a CNA reported to her when she was RN on duty that resident #5 had fallen from the mechanical lift to the floor while being transferred from his/her wheelchair to the bed for a check and change. She reported the resident had slipped out of the bottom of the sling. She had determined the sling had been placed appropriately, however the wet brief had caused the resident to slip out of the sling and onto the floor. She reported she completed a risk management note, progress note, and notified the family, however she was unable to find this documentation in the medical record. Further interview confirmed there was no documentation in the resident's medical record about the fall, and there had been no follow up with risk management.d. Interview with LPN #3 on 10/23/25 at 8:23 AM revealed he had written notes on residents that were deleted from the medical records. e. Interview with the NP on 10/23/25 at 1:04 PM revealed she had not been notified about the resident's fall.f. Review of the resident's medical record showed there was no documentation on the fall and the care plan had not been updated after the fall.2. Review of the admission MDS assessment dated [DATE] showed resident #1 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included cancer, diabetes mellitus, hypertension, and arthritis. Review of the facility incident report dated 9/23/25 showed the resident had been found on the floor following a fall in his/her room and had been assisted to a wheelchair by staff. The resident complained of nausea and numbness to the arms. The resident was transported to the ER in the facility van, accompanied by CNA #1 and the activities director, where s/he was diagnosed with cervical spine fractures of the 5th and 6th vertebrae. The following concerns were identified:a. Review of the facility document titled Resident Abuse and/or neglect, dated 9/23/25, showed the NP was notified the date of the fall.b. Interview with the facility NP on 10/23/25 at 1:11 PM revealed she had had not been notified of the resident's fall or a need to transport to the hospital.3. Review of facility policy titled Fall Prevention Policy showed .9. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury.