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	02/05/2026

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on staff and family council president interview, and review of family council minutes, the facility failed to provide and support a private meeting space for family council meetings in 1 out of 12 months in the year 2025. Corrective measures were implemented prior to the survey and compliance was determined to be met on 4/29/25. The census was 66. The findings were:1. Interview with the family council president on 2/4/26 at 12:19 PM revealed the facility canceled the family council meeting and did not provide a meeting space for the month of March 2025. She further revealed there was a sign posted on the community board on 3/4/2025 that stated Family council meeting for March will be canceled. Look forward to seeing you in April, contact social services with any questions. S/he was then told by the former activity director that there wouldn't be a meeting in March and there might not be one in April because they were trouble makers. 2. Review of the family council meetings confirmed no meeting occurred in March 2025.3. Review of Family Council meeting minutes provided by the council president verified meetings were being held during the 3rd or 4th week of the month. Further review confirmed the issue had been resolved and monthly meetings had resumed since 4/29/25. 4. Interview with the NHA on 2/5/26 at 1:57 PM verified the facility had implemented corrective action and has provided space for family council meetings since 4/29/25.

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

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	02/05/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and resident and resident representative interview, the facility failed to provide a safe, clean, comfortable and homelike environment for 3 of 4 (Secure unit, 100, 400 halls) units reviewed. The findings were:1. Regarding homelike environment:a. Observation throughout the days on 2/4/26 and 2/5/26 showed no washcloths, bath towels. or hand towels in resident rooms on 3 of 4 units. b. Interview with resident representative for resident #1 on 2/5/26 at 10:20 AM revealed there was never any linen in the resident's room to assist with bathing when she visited. c. Interview with the director of housekeeping 2/5/26 at 11:30 AM revealed that clean linen was available in the clean supply storage for staff to stock rooms.d. Interview with RN # 1 on 2/5/26 at 11:45 AM revealed that staff will supply residents with hand towels and clean linen from the clean supply room when needed.e. Interview with the DON on 2/5/26 at 11:15 AM revealed staff were expected to stock resident rooms with washcloths and clean linen as required.f. Interview with the resident representative for resident #1 on 2/5/26 at 9:02 AM the resident resided in room [ROOM NUMBER] [in the secure unit] and during the resident's stay, there was no bathroom door in place. Review of the medical record showed the resident was at the facility for approximately 6 weeks from June 2025 to August 2025. Observation on 24/26 at 6 PM showed there was no resident residing in room [ROOM NUMBER]; however, there was still no bathroom door in place.2. Regarding safe, and clean environment:a. Observation on 2/4/26 at 10:33 AM showed broken tiles under both toilet riser legs in room [ROOM NUMBER] which appeared dirty and had a urine odor.b. Interview with resident # 2 on 2/4/26 at 4:35 PM revealed s/he reported the broken tile to maintenance over two months ago and was told the facility was waiting to repair the tile because they planned to remodel.3. Interview with housekeeper # 1 on 2/5/26 at 8:59 AM revealed maintenance would have been notified if there were objects requiring repair, which included doors. 4. Interview with housekeeper # 2 on 2/5/26 at 9:02 AM revealed maintenance and supervisory staff would be notified if items were in need of repair.5. Interview with the maintenance director on 2/5/26 at 11:18 AM confirmed he was aware of the broken tiles and revealed the repair was pending a remodel of the unit which was planned to start in March. Further interview revealed the bathroom door had been on order for a couple months.

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	02/05/2026

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 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 staff interview, medical record review and policy review, the facility failed to ensure residents received adequate supervision to prevent accidents for 1 of 4 residents (#3) reviewed for accident hazards. The findings were:1. Review of the 1/2/26 quarterly MDS assessment for resident #3 showed s/he was admitted to the facility on [DATE], had a BIMS score of 11 out of 15, which indicated moderate cognitive impairment, and diagnoses which included Alzheimer's disease, Non-Alzheimer's dementia, and cancer. Further review showed the resident's mood interview revealed the resident had reported feeling down, depressed or hopeless for 12 to 14 days of the 14-day look-back period. The resident was coded as receiving an antipsychotic medication. Review of the resident's progress notes showed the resident reported s/he was going to leave the building. The following concerns were identified: a. Review of the medical record showed the resident's 8/11/25 elopement evaluation score was 0. b. Review of a progress note dated 11/6/25 and timed 1:06 PM showed the resident informed the SSD that s/he was going to leave the facility. The SSD called the Ombudsman and left a message, and the social services assistant called the Department of Family Services (DFS). The SSD advised the resident that if s/he left the building, she would call the police because s/he was not safe to leave. She left a message for the resident's power of attorney (POA) and spoke to the resident's son, who stated he could not take the resident and advised the resident to stay at the facility. c. Review of a progress note dated 11/6/25 and timed 2:02 PM showed the resident's POA told the resident she could not take him/her, and s/he needed to stay at the facility. The resident became angry and said s/he was leaving the facility. The resident returned to the television room. Further review showed the nursing staff would inform the SSD if the resident left. d. Review of a progress note dated 11/6/25 and timed 5:05 showed the resident declined his/her evening medications, and wanted to leave the facility. The nurse on duty, DON and SSD spoke with the resident. e. Review of a progress note dated 11/6/25 and timed 5:11 PM showed the nurse encouraged the resident not to pull out his/her foley catheter, and the resident was ranting about leaving and having his/her family member pick him/her up that night. The resident went into his/her room and shut the door. The nurse notified the DON who went to talk to the resident. f. Review of a progress note dated 11/6/25 and timed 5:15 PM showed the resident left his/her room with 2 bags of clothing, walked towards the lobby, and stated s/he was going home with family. The DON arrived to talk to the resident at that time. g. Review of a progress note dated 11/6/25 and timed 6:53 PM showed the SSD called the resident's POA to inform her that the resident had calmed down and was watching television when she left the office. During the phone call, the POA informed the SSD that the resident was at her home. The SSD called the DON to check if the staff had called the police. h. Review of a progress note dated 11/6/25 and timed 7:43 PM showed the SSD called the police department at 7 PM to inform them of the resident's situation and the address s/he could be located. i. Review of a progress note dated 11/6/25 and timed 8:40 PM showed at approximately 6:30 PM the staff had been unable to locate the resident, and elopement protocol was initiated within the facility immediately. The staff conducted a search of the facility and had been unable to locate the resident within the facility. Law enforcement had been notified by the SSD. The DON met with law enforcement and notified the NHA. The DON and law enforcement traveled to the reported location where the resident had been reported, and the resident was found with no visible injuries, and denied suicidal ideation. The resident initially refused to return to the facility. After approximately 30 minutes of conversation the resident agreed to return to the facility with the DON. Nursing staff were advised to initiate 15-minute checks, the DON verified all door alarms were on, and sat with (continued on next page)

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	02/05/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident for approximately 60 minutes. Staff were to monitor the resident closely and report any behavioral changes. 2. Review of the resident's care plan initiated on 11/7/25 showed the resident was an elopement risk related to adjustment to the nursing home, impaired safety awareness, history of elopement attempts and leaving against medical advice (AMA). Interventions were to assess for fall risk, offer emotional and psychological support, orient resident to the environment, and reorient/validate and redirect the resident as needed.3. Review of the medical record showed no evidence additional supervision was implemented after the resident made statements regarding a desire to leave.4. Interview with the SSD on 2/5/26 at 2:05 PM revealed the resident had told the staff he wanted to leave, and the staff attempted to calm him/her down. She reported after she left for the evening, the resident showed up at his/her POA's home, and the DON was able to talk the resident into returning. She stated the resident signed against medical advice (AMA) papers the following day, and was picked up and taken to the hospital by the police. Further interview revealed the resident had apologized and was aware s/he had made a bad decision.5. Interview with the DON on 2/5/26 at 2:19 PM revealed the facility staff had made multiple attempts to contact the residents POA and family, both were verbal about their desire to not be involved in the resident's decision to leave the facility, and the resident's family informed the resident s/he was unable to return home. Following the elopement, the resident's POA rescinded their POA. The DON reported she had stayed with the resident for part of the evening prior to his elopement. Further interview revealed she was unsure if the resident had a wanderguard. 6. Review of the policy titled Elopements, undated, and provided by the NHA on 2/5/26 showed .This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.1. The facility is equipped with door locks/alarms to be used as necessary to help avoid elopements. 2. Staff are to be vigilant in responding to alarms in a timely manner. A. Monitoring and Managing Residents at Risk for Elopement Residents will be assessed for risk of elopement upon admission and throughout their stay by the interdisciplinary care plan team .c. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly.

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	02/05/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, review of manufacturer's instructions, and facility policy review, the facility failed to ensure a sanitary environment in 1 of 1 kitchen. The findings were: 1. Regarding unsanitary items in the kitchen preparation area: a. Observation on 2/4/26 beginning at 9:15 AM showed the Traulsen refrigerator had visible grime and dried food particles on the surface, and a sticky handle when touched to open. The soap dispenser at the handwashing sink had a dark, reddish build-up on the pump. The ice machine scoop was placed on top of the machine next to packaged hair nets. 2. Regarding food safety: a. Observation on 2/4/26 beginning at 9:15 AM showed undated, unlabeled package of ham was found inside the Traulson refrigerator. The walk-in refrigerator did not show a temperature on the thermostat. A partially uncovered, undated bowl of crushed vanilla wafers was found on a bottom shelf of the walk-in pantry. There were no logs visible for the walk-in refrigerator and freezer. 3. Regarding monitoring dish machine temperature requirements: a. There were no temperature logs available for the Ecolab XL dishwashing machine.4. Interview with the assistant dietary manager on 2/4/26 at 10:15 AM confirmed there were no logs for dish machine temperatures. Further interview revealed the ice scoop was washed after each use and placed on top of the dish machine. He confirmed the ham was undated, and should have been labeled with the name of the food and date it was opened. He did not know what the spot on the soap dispenser was. He reported the temperature on the walk-in refrigerator should have been at 20 to 30 degrees, and he thought the dietary manager kept logs on the walk-in refrigerator and freezer. 5. Interview with the director of maintenance on 2/4/26 at 12:11 PM confirmed there were no temperature logs for the walk-in refrigerator or freezer, and the outside temperature of the refrigerator was incorrect. He reported he placed a thermometer in the walk-in and ordered a new thermostat. 6. Review of the [NAME] dish machine manufacturer's instructions provided by the NHA on 2/5/25 showed the minimum operating temperatures should be 150 degrees for wash and 180 degrees for sanitizing rinse.7. Review of the facility policy titled Monitoring of Cooler/Freezer Temperature, undated, and provided by the NHA on 2/5/26 showed .1. Logs for recording temperatures for each refrigerator or freezer will be posted in a visible location outside the freezer or refrigerator unit. A. Temperatures will be checked and logged daily by designated personnel. B. Logs will be changed out and filed each month. 2. All refrigerated storage must be maintained at or below 41 degrees F [Fahrenheit], unless otherwise specified by law. 3. All frozen storage must be maintained at or -4 degrees F, unless specified by law.9 Refrigerated food shall be labeled, dated, and monitored so that it is used by the use by date, frozen, or discarded, whichever is applicable.8. Review of the facility policy titled Sanitation Inspection, undated, and provided by the NHA on 2/5/26 showed .1. All food areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies and other insects. 2. The department shall establish a sanitation program for food services based on applicable state and federal requirements.4. Sanitation inspections will be conducted in the following manner: a. Daily: Food service staff shall inspect refrigerators/coolers, freezers, storage area temperatures, and dishwasher temperatures daily.

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	02/05/2026

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 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on staff interview, the facility failed to ensure social services were provided to residents by a qualified social worker. The findings were:1.Interview with the SSD on 2/4/26 at 4:40 PM revealed she started the job in October 2025. Further interview confirmed her bachelor's degree was in criminal justice. She reported she reached out to the social worker in another facility if she had any questions, but did not have any regular scheduled meetings with her.2.Interview with the NHA on 2/5/26 at 1:55 PM revealed he assumed the SSD had someone she consulted with between her date of hire and now. Further interview revealed he did not have a facility policy on the required qualifications.