

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Big Horn Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>50485</p> <p>Based on observation and resident and staff interview, the facility failed to ensure mail was delivered and unopened, including on Saturday. The census was 78. The findings were:</p> <ol style="list-style-type: none"> 1. Interview with 5 residents during a group interview on 9/11/24 at 2 PM revealed the mail was locked up and the facility did not deliver mail on Saturdays. Further, the residents revealed mail was sometimes opened by the business office prior to delivery. 2. Interview with the activities director on 9/13/24 at 9:02 AM revealed she sorted through the mail and if it was not postcards or junk mail, she took it to the business office to open. Further, she revealed that mail was not delivered on Saturdays as the business office was closed. 3. Interview with business office manager on 9/13/24 at 10:20 AM revealed she was new to the facility and still learning what to do with the mail. She revealed she opened the mail to decide where it should go as some would be scanned into the computer for the resident's file and bills for the residents were paid out of their account. She revealed If it's personal mail it's opened here. Sometimes they get stressed over bills and they don't know what to do with them so we do that here. 4. Observation on 9/13/24 at 10:20 AM showed a stack of residents' mail on the desk in the business office.

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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081</p> <p>Based on medical record review and staff interview, the facility failed to ensure residents choice for advance directive for 1 of 18 sample residents (#50). The findings were:</p> <ol style="list-style-type: none"> 1. Review of the electronic medical record (EHR) Clinical Resident Profile for resident #50 on [DATE] at 8:02 AM showed Code Status: (Advance Directives) ADC: Full Code. 2. Review of a physician's note for resident #50 dated [DATE] and timed 7:16 AM showed .Code Status: ADC FULL CODE . 3. Review of the physician orders for resident #50 showed an order for ADC: Full Code which was active with a start date of [DATE]. 4. Review of the [DATE] WyoPOLST-Providers Orders for Life Sustaining Treatment signed by resident #50 showed Cardiopulmonary Resuscitation (CPR) was marked DNR/Do Not Attempt Resuscitation (Allow Natural Death). 5. Interview with the DON on [DATE] at 9 AM confirmed resident #50 had elected a code status of DNR and the EHR indicated Full code. Further interview revealed the facility should follow the resident's code status election.

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081</p> <p>Based on medical record review and staff interview, the facility failed to ensure preadmission screening was performed and was accurate for 2 of 18 sample residents (#8, #59) with qualifying diagnoses. The findings were:</p> <ol style="list-style-type: none"> 1. Review of the quarterly MDS assessment dated [DATE] showed resident #8 had diagnoses which included depression and bipolar disease. Review of the resident's active diagnosis report showed the resident had diagnoses which included mood disorder due to known physiological condition with mixed features and did not have a primary diagnosis of dementia. The following concerns were identified: <ul style="list-style-type: none"> a. Review of the PASARR Level I assessment completed on 3/8/23 showed the resident had a qualifying diagnosis of mood disorder due to known physiological condition with mixed features and was marked no for all mental illness screening questions. Further review showed the PASARR Level I screening summary indicated no evidence of mental illness or intellectual disability. A PASARR level II was not triggered or performed. 2. Review of the admission MDS assessment dated [DATE] showed resident #59 had diagnoses which included depression and bipolar disease. The following concerns were identified: <ul style="list-style-type: none"> a. Review of a PASARR level I completed on 5/23/24 showed the resident had diagnoses which included bipolar disorder and depression and the mental illness screening indicated the resident had a major mental illness. Further review showed the PASARR level I screening summary indicated a categorical 6 determination and the resident was appropriate for convalescent care after acute hospital stay, not to exceed 120 days. Additional information showed .An individualized level II determination will be required on the 120th day if client stay will be extended, please plan accordingly. b. Review of a PASARR Level I completed on 7/3/24 showed the resident had diagnoses which included bipolar disorder and depression and was marked no for all mental illness screening questions. Further review showed the PASARR Level I screening Summary showed No evidence of Mental Illness or Intellectual disability. 3. Interview with the administrator on 9/12/24 at 9:02 AM revealed the facility identified issues with duties performed by social services and the social services director was terminated. Further interview revealed PASARR completion was one of the duties assigned to the social services director. 4. Interview with the administrator on 9/12/24 at 10:58 AM revealed a plan to correct issues with PASARR completion was created; however, she confirmed it had not been implemented at that time. Further interview confirmed the most recent PASARR level I for resident #8 and resident #59 was not completed accurately. 		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50485</p> <p>Based on observation, resident, resident representative, and staff interview, and medical record review, the facility failed to ensure residents received services to maintain good personal hygiene for 3 of 5 sample residents (#8, #25, #53) reviewed for activities of daily living. The findings were:</p> <p>1. Review of the quarterly MDS assessment dated [DATE] showed resident #8 had a brief interview for mental status score of 15 out of 15, which indicated no cognitive impairment, and diagnoses which included polyneuropathy, cervicalgia or neck pain, osteoarthritis, and muscle wasting and atrophy. Further review showed the resident required substantial/maximal assistance with bathing. Review of the ADL (activities of daily living) care plan last revised on 4/8/24 showed I have told staff I prefer to have my showers, but I often may refuse my showers and only get 1 a week. If staff if [sic] making up my shower it may not be on the day or time I originally chose, but I am ok with that .BATHING/SHOWERING: I need 1 staff to provide weight-bearing assistance for my shower activities. Encourage me to perform any part of showering I am able . The following concerns were identified:</p> <p>a. Interview with the resident on 9/11/24 at 11:07 AM revealed s/he did not receive showers routinely and s/he felt it was due to the facility not having enough staff.</p> <p>b. Review of the resident's bathing record from 6/29/24 through 9/12/24 showed the resident went without bathing for 6 days between 7/1/24 and 7/9/24, 14 days (including 3 documented refusals) between 7/9/24 and 7/24/24, 9 days between 7/29/24 and 8/8/24, 6 days between 8/12/24 and 8/19/24, 7 days between 8/23/24 and 8/29/24, and 14 days between 8/29/24 and 9/12/24.</p> <p>2. Review of the quarterly MDS assessment dated [DATE] showed resident #25 had a BIMS score of 13 out of 15, which indicated the resident was cognitively intact. Review of the care plan last revised on 6/22/24 showed the resident preferred to shower once a week in the morning. The following concerns were identified:</p> <p>a. Interview with the resident on 9/11/24 at 8:55 AM revealed I'm supposed to get showers once a week. Yesterday was my two weeks and I didn't get any.</p> <p>b. Review of the 30-day look-back for the showers tasks showed the resident went 21 days without a shower from 8/6/24 to 8/27/24, and 15 days without a shower from 8/27/24 through 9/11/24.</p> <p>3. Review of the quarterly MDS assessment dated [DATE] showed resident #53 had a BIMS score of 11 out of 15, which indicated the resident's cognition was moderately impaired. Review of the care plan last revised on 7/31/24 showed the resident preferred to take a shower two times a week during the day. The following concerns were identified:</p> <p>a. Interview with the resident on 9/10/24 at 3:36 PM revealed s/he was supposed to get two showers a week and almost never did. I hear lots of excuses.</p> <p>b. Observation of the resident on 9/10/24 at 3:36 PM showed the resident was wheelchair bound and dependent on others for bathing. The resident's hair was greasy and nails were long.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. Review of the 30-day look back for the showers task showed the resident went 6 days without a shower from 9/5/24 to 9/11/24.</p> <p>4. Interview with the resident representative for resident #47 on 9/11/24 at 4:15 PM revealed she had concerns about the amount of care residents received and stated the facility was short-handed.</p> <p>5. Interview with CNA #1 on 9/12/24 at 2:04 PM revealed the staffing levels were not sufficient enough to get resident care done. The CNA revealed she was expected to get showers done; however, she was unable to perform the showers. The CNA revealed showers were completed for residents when staff identified the residents had body odor and really need a shower. Further interview revealed staff had voiced concerns to the leadership team and they were told we are trying; however, felt it was impossible to get all tasks done daily.</p> <p>6. Interview with CNA #2 on 9/12/24 at 2:07 PM revealed getting normal care done was possible; however, she was not able to get showers completed. Further interview revealed sometimes they had a shower aide; however, she wasn't at the facility daily and only worked 4 hours per day.</p> <p>7. Interview with CNA #3 on 9/12/24 at 2:19 PM revealed there were not enough CNAs to ensure resident care was performed and CNAs were expected to provide ADL care including showers and making beds, taking meal orders, and picking up and passing room trays for meals. The CNA revealed showers were not completed often, beds are were not made, and linens were not changed as expected.</p> <p>8. Interview with the DON and director of clinical operations on 9/12/24 at 1:17 PM revealed the facility identified concerns related to bathing and completed an ad hoc meeting on 9/3/24. The leadership team was to audit showers daily on the night shift, discuss the audit results in stand up, and clinical management was to follow up the next day. Further interview confirmed there were residents, including resident #8, who had not received showers prior to or following the ad hoc meeting.</p> <p>35081</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>50665</p> <p>Based on observation, resident, resident representative, and staff interviews, facility staff posting review, and facility assessment review, the facility failed to ensure sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident on 3 of 4 resident care units (Deer, Chapel, Courtyard). The census was 78. The findings were:</p> <ol style="list-style-type: none"> 1. Observation on the Courtyard Hall (secure unit) on 9/10/24 at 5:10 PM showed MA-C #1 assisted resident #68 who stood up from a recliner and walked across the room. The MA-C attempted to get the resident to sit in his/her wheelchair; however, she was only able to sit the resident sideways in the seat and was unable to reposition the resident safely in the wheelchair. The MA-C required assistance from a second person, and attempted to call 5 people for assistance, which were not answered. Interview with the MA-C revealed this is how it always is. Continued observation showed at 5:16 PM an unidentified non-clinical staff member opened the secure unit door and the MA-C asked them to get some help now! At 5:17 PM (seven minutes later) a CNA arrived to assist and the staff member repositioned the resident in the wheelchair. 2. Observation of the Deer Hall on 9/12/24 at 8:54 AM showed resident #50 yelled from the bathroom No one's coming in here! I've been waiting half an hour! Review of the MDS assessment showed the resident's brief interview for mental status score was 15 out of 15 which indicated no cognitive impairment. 3. Interview with resident #8, who resided on the Chapel Hall, on 9/11/24 at 11:07 AM revealed s/he did not receive showers routinely and s/he felt it was due to the facility not having enough staff. Review of the resident's bathing record from 6/29/24 through 9/12/24 showed the resident went without bathing for 6 days between 7/1/24 and 7/9/24, 14 days (including 3 documented refusals) between 7/9/24 and 7/24/24, 9 days between 7/29/24 and 8/8/24, 6 days between 8/12/24 and 8/19/24, 7 days between 8/23/24 and 8/29/24, and 14 days between 8/29/24 and 9/12/24. 4. Interview with resident #25, who resided on the Deer Hall, on 9/11/24 at 8:55 AM revealed s/he was supposed to get showers once a week, and yesterday was my two weeks and I didn't get any. Review of the 30-day look-back for the showers tasks showed the resident went 21 days without a shower from 8/6/24 through 8/27/24, and 15 days without a shower from 8/27/24 through 9/11/24. 5. Interview with resident #53, who resided on the Deer Hall, on 9/10/24 at 3:36 PM revealed s/he did not receive two showers per week because of staffing. Observation of the resident at that time showed the resident's hair was greasy and his/her nails were long. Review of the 30-day look back for the showers task showed the resident went 6 days without a shower from 9/5/24 through 9/11/24. 6. Interview with the resident representative for resident #10, who resided on the Deer Hall, on 9/11/24 at 11:55 AM revealed when the representative was there to visit there were not a lot of staff to help and the representative had assisted the resident with meals. The representative reported it could be several hours before the resident received assistance. <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7. Interview with resident #23, who resided on the Deer Hall, on 9/11/24 at 2 PM revealed that the facility had lost a lot of staff recently. Further interview revealed nothing is getting done after losing administrative staff. The resident also reported to have waited 30 minutes for call lights to be answered, and s/he missed a doctor's appointment as there was no van driver available.</p> <p>8. Interview with the resident representative for resident #47, who resided on the Chapel Hall, on 9/11/24 at 4:15 PM revealed she had concerns about the amount of care residents received and stated the facility was short-handed.</p> <p>9. Interview with CNA #4, who worked on the Rock Creek Hall, on 9/12/24 at 1:57 PM revealed the facility continued admitting residents even though they didn't have sufficient staff to take care of the residents already in the facility. The CNA revealed if there were more staff, they could better watch over residents who need closer observation.</p> <p>10. Interview with CNA #1, who worked on the Deer Hall, on 9/12/24 at 2:04 PM revealed the staffing levels were not sufficient enough to get resident care done. The CNA revealed she was expected to get showers done; however, she was unable to perform the showers. The CNA revealed showers were completed for residents when staff identified the residents had body odor and really need a shower. Further interview revealed staff had voiced concerns to the leadership team and they were told we are trying; however, felt it was impossible to get all tasks done daily.</p> <p>11. Interview with CNA #2, who worked on the Deer Hall, on 9/12/24 at 2:07 PM revealed getting normal care done was possible; however, she was not able to get showers completed. Further interview revealed sometimes they had a shower aide; however, she wasn't at the facility daily and only worked 4 hours per day.</p> <p>12. Interview with CNA #3, who worked on the Chapel Hall, on 9/12/24 at 2:19 PM revealed there were not enough CNAs to ensure resident care was performed and CNAs were expected to provide ADL care including showers and making beds, taking meal orders, and picking up and passing room trays for meals. The CNA revealed showers were not completed often, beds are were not made, and linens were not changed as expected.</p> <p>13. Review of facility staff posting on 9/12/24 at 11 AM showed resident assistant (RA) hours were included in daily staffing hours. Review of the RA job description dated 1/20/23 showed .the resident assistant/CNA trainee provides basic personal service to residents/patients under the direction and supervision of RN, LPN or LVN. Interview with staff scheduler on 9/13/24 at 9:39 AM revealed she was not sure if RA hours could be included in the daily staff hours, but she had included them.</p> <p>14. Review of the revised facility assessment tool dated 8/6/24 showed the minimum hours per resident days (HPRD) for RN's/LPN's was 0.6 for both day and night shifts, CNAs on day shift was 1.0 and night shift was 0.9. HPRD for a total 2.0 HPRD.</p> <p>15. Review of the July 2024 nursing schedule showed the facility failed to ensure the minimum staffing requirement identified on the facility assessment was met on 3 days, 7/22, 7/23, and 7/28.</p> <p>16. Review of the August 2024 nursing schedule showed the facility failed to ensure the minimum staffing requirement identified on the facility assessment on 15 days, 8/1, 8/2, 8/3, 8/9, 8/10, 8/11, 8/12, 8/20, 8/21, 8/22, 8/23, 8/28, 8/29, 8/30, and 8/31.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>17. Review of the September 2024 nursing schedule, from 9/1/24 through 9/12/24, showed the facility failed to ensure the minimum staffing requirement identified on the facility assessment was met on 5 days, 9/1, 9/2, 9/5, 9/8, and 9/9.</p> <p>18. Interview with the administrator, DON, and staff scheduler on 9/13/24 at 9:39 AM confirmed the facility was aware of staffing concerns and revealed they recently had a lot of staff return to school or leave during a recent leadership turnover. The staff scheduler revealed she usually attempted to stick to 2.75 and 2.92 combined HPRD total CNA's and RN/LPN's. They revealed they attempted to staff 24 hours per day for nurses and between 75 and 80 hours on day shift and 34 and 46 hours on night shift for CNAs. They revealed the current open positions included 2 full time day shift and 2 full time night shift nurses and 2 full time day shift and 4 or 5 full time night shift CNAs. Further interview revealed a lot of nurse positions were being covered by MA-Cs who help CNAs; however, they were not assigned to resident care and the MA-C hours were counted in the CNA hours on staff postings.</p> <p>50485</p> <p>35081</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50665</p> <p>Based on observation, staff interview, and policy review, the facility failed to ensure medications available for resident use were labeled appropriately in 2 of 5 medication storage areas (Rock Creek Hall medication cart, Deer Hall medication cart). The findings were:</p> <ol style="list-style-type: none"> 1. Observation of Rock Creek Hall medication administration cart on 9/10/24 at 4:16 PM showed a Novolog insulin pen which was opened and undated. In the top-drawer of the cart, yellow stickers were available for medication labeling. 2. Observation of the Rock Creek Hall medication cart on 9/11/24 at 10 AM showed a Lantus SoloStar insulin pen and Toujeo SoloStar multidose insulin pen which were opened and undated. In the top-drawer of the cart, yellow stickers were available for medication labeling. 3. Observation of the Deer hall medication cart on 9/11/24 at 09:55 AM showed a Basaglar insulin pen which was opened and undated. In the top-drawer of the cart, yellow stickers were available for medication labeling. 4. Interview with the LPN #1 on 9/10/24 at 4:16 PM revealed she did not open the insulin pen and a yellow sticker should have been placed to indicate when the medication was opened, when it would expire, and who opened it. 5. Interview with LPN #2 on 9/11/24 at 10 AM revealed all insulin pens should be labeled with a yellow sticker, dated with an open date and expiration date, and initialed. Further she revealed all insulin pens should be discarded after 28 days from the open date. 6. Interview with the DON on 9/13/24 at 8:23 AM revealed all nurses were responsible for labeling and dating multidose vials of medication upon opening. Further he revealed the nurses were also responsible for indicating the 28-day expiration date on the yellow labels, along with their initials. 7. Review of the policy titled Labeling of Medications and Biologicals dated 4/16/24 showed .Labels for multidose vials must include: the date the vial was initially opened or accessed (needle-punctured) . 		