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	05/07/2026

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

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. Based on medical record review, staff interview, and policy review, the facility failed to ensure residents' right to secure and confidential personal and medical records. The census was 73. The findings were: 1. Review of the medical record for resident #26 showed the resident received hospice facility's beginning on 1/2/26. Further review showed the hospice provided documented notes directly into the electronic medical record system. 2. Review of the medical record for resident #83 showed the resident received hospice facility's beginning on 1/21/26. Further review showed the hospice provided documented notes directly into the electronic medical record system. 3. Review of the medical record for resident #84 showed the resident received hospice facility's beginning on 2/5/26. Further review showed the hospice provided documented notes directly into the electronic medical record system. 4. Interview with the regional clinical director on 5/6/26 at 12:44 PM revealed the only hospice used prior to a change in operator, was given full access to the electronic medical record for all residents. 5. Review of the policy titled Resident Rights last revised on 6/10/25 showed .7. Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records .b. The resident has a right to secure and confidential personal and medical records. i. The resident has the right to refuse the release of personal and medical records except as provided at S483.70 (i) (2) or other applicable federal or state laws .

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on medical record review, staff interview, and policy review, the facility failed to ensure residents' right to choose health care and providers of healthcare for 3 of 12 sample residents (#26, #83, #84) reviewed for hospice services. The findings were:1. Review of the medical record for resident #26 showed the resident received hospice services beginning on 1/2/26. Further review showed no evidence the resident was offered a choice in hospice provider. 2. Review of the medical record for resident #83 showed the resident received hospice services beginning on 1/21/26. Further review showed no evidence the resident was offered a choice in hospice provider. 3. Review of the medical record for resident #84 showed the resident received hospice services beginning on 2/5/26. Further review showed no evidence the resident was offered a choice in hospice provider. 4. Interview with the regional clinical director on 5/6/26 at 12:44 PM confirmed prior to the operator transition, residents on hospice were not given a choice for hospice provider. 5. Review of the policy titled Resident Rights last revised on 6/10/25 showed .5. Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: a. The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, medical record review, staff and family interview, and policy review, the facility failed to implement interventions and treatment for 4 of 4 sample residents (#1, #6, #69, #81) reviewed for a change in condition. 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 metabolic encephalopathy, coronary artery disease, pulmonary hypertension, peripheral vascular disease, pneumonia, hyponatremia, and chronic respiratory failure. Review of the care plan last revised 4/30/26 showed a focus on safety with tobacco use, ADLs, nutrition related to esophageal obstruction and antidepressant medications. The following concerns were identified:a. Review of a progress note dated 2/1/26 and timed 6:45 AM showed the resident had an unwitnessed fall in his/her bathroom. Vital signs included with the note dated 2/1/26 and timed 6:35 AM were blood pressure (BP) of 150/90, heart rate (HR) of 81, respiratory rate (RR) of 22, temperature of 98.4 degrees Fahrenheit (F) and an oxygen saturation of 88% on 3 lpm via nasal cannula (NC). There was no evidence of a follow up assessment.b. Review of a progress note dated 2/1/26 and timed 7:09 PM showed the resident reported s/he had a fall but was in bed at the time the call light had been answered. The vital signs included with the note were a BP of 126/88, HR of 78, RR of 22, temperature of 98.4 degrees F and an oxygen saturation of 90% on 2 LPM via nasal cannula. Review of the vital signs record showed the recorded vital signs were dated 2/1/26 and timed 2:44 PM, and did not reflect the resident's status at time of the fall. There was no evidence the resident had been assessed following the fall.c. Review of a progress note dated 2/3/26 and timed 2:33 PM showed 3X [3 times] res to request staff to check [his/her] O2. 3 times [his/her] cannula was in [his/her] nares upside down or completely off. Nurse to place cannula in the correct position and requested res to breath deep with [his/her] nose, and out mouth. O2 was back to baseline in less than 10min. Res without respiratory distress. No cough. Res educated on position of cannula in nares. There was no evidence the resident's vital signs were taken or lungs were assessed.d. Review of a progress note dated 2/4/26 and timed 10:59 AM showed the resident refused his/her shower due to not feeling well. There was no evidence the resident had been assessed.e. Review of a progress note dated 2/4/26 and timed 12:48 showed floor nurse alerted this nurse resident not looking well, the resident could not respond verbally and had been on 3 lpm oxygen via NC. The resident's oxygen had been turned up to 5 lpm and was recorded at 88%. The resident had used accessory muscles with dyspnea, and lungs were auscultated as clear but diminished in bases bilaterally. Further review showed the resident was sent by ambulance for assessment and treatment following the assessment. f. Review of the Discharge summary dated [DATE] showed a transfer on 2/4/26 where the resident had been taken to the emergency department due to respiratory failure with oxygen saturations in the 50 % range, requiring oxygen at 10 liters per minute (lpm). Further review showed the additional oxygenation needs escalated to BiPAP assistance for respiratory failure, left lower lobe pneumonia, acute heart failure, and dry gangrene. The resident was treated with antibiotics, thoracentesis for a pleural effusion and diuretics.g. Review of a progress note dated 3/5/26 and timed 11:10 AM showed the resident was lethargic during medication pass. There was no evidence of vital signs or assessment.h. Review of a progress note dated 3/5/26 and timed 12:06 PM showed the resident was sent to the emergency room for lethargy, confusion and abnormal sodium level. There was no evidence of assessment or vital signs.i. Review of a late entry progress note titled progress note*NEW* dated 3/5/26 at 9 AM contained resident assessment and vital signs. Review of the progress notes showed a Late entry note for the incident dated 3/5/26 and timed 9 AM was added on 5/6/26, 62 days after the incident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	j. Review of the hospital admission progress note dated 3/10/26 showed the resident had been admitted on [DATE] for hyponatremia with decreased serum osmolality, metabolic encephalopathy, and pulmonary edema. The resident required fluid restriction, diuresis, and a PICC line placement.k. Review of the late entry progress note titled progress note*NEW* dated 4/27/26 at 5:40 PM showed the resident had been found by a dietary aid unresponsive and an ambulance had been called. There was no evidence of an assessment or vital signs.l. Review of the hospital admission note dated 4/30/26 showed resident was admitted on [DATE] after s/he had an episode of unresponsiveness for 20 minutes with hypoxia. The admission diagnoses were encephalopathy, critical hypokalemia, hypomagnesemia, hyponatremia, new onset atrial fibrillation with RVR, and acute kidney injury. 2. Review of the quarterly MDS assessment dated [DATE] showed resident #69 had a BIMS score of 14 out of 15, which indicated minimal to no cognitive dysfunction with diagnoses of chronic myeloid leukemia, coronary artery disease, seizure disorder, traumatic brain injury, and chronic obstructive pulmonary disease. Review of the care plan dated 2/3/26 indicated staff would evaluate his/her respiratory rate and effort, skin color, temperature and characteristics related to risk of impaired gas exchange. The following concerns were identified:a. Observation on 5/4/26 at 4:10 PM showed the resident was on the edge of his/her bed and had his/her hands on his/her knees leaned forward. The resident's respiratory rate was 30-40 times a minute and s/he had a grey pallor. Further observation showed the resident did not have oxygen on.b. Interview with medication assistant-certified (MA-C) #1 on 5/5/26 at 8:26 AM revealed the resident had been sent to the hospital due to respiratory failure.c. Review of the progress notes on 5/5/26 showed no evidence of documentation related to the transfer.d. Review of a progress note provided by the facility dated 5/6/26 and timed 5:14 PM showed LPN #1 documented for 5/4/26 at 11 PM the nurse went to check on the resident to get obtain vital signs and s/he had an oxygenation of 60% on 4 lpm NC with difficulty breathing. The nurse administered a breathing treatment when the resident became lethargic and would not respond to verbal stimuli. The note showed the nurse placed a call to on call and gathered transfer paperwork. Further review showed the nurse attempted to call his/her guardian but it was after hours. e. Interview with LPN #1 on 5/7/26 at 12 PM revealed on the afternoon of 5/4/26 the resident had been reported as unsteady on his/her feet which prompted her to assess the resident. She had him/her sit down and checked his/her oxygen and it was a little low. She checked on the resident a little later and she found him/her on the floor with an elevated temperature and an oxygen saturation in the 50-60's. The LPN revealed she provided the resident with a nebulizer treatment, and tried to contact the administrator, but was unsuccessfully. The LPN revealed she rechecked the resident's oxygen, which was 70%, and she then made the decision to send him/her to the emergency department. The LPN revealed she was the only one working on the unit at the time and was unable to notify the guardian and reported that at shift change to the next nurse. Further interview revealed she was asked by administration to come in on her day off to document the assessment and transfer. 3. Review of the admission MDS assessment dated [DATE] showed resident #81 had a BIMS score of 5 out of 15, which indicated severe cognitive impairment, and had diagnoses which included cervical spondylolysis, atrial fibrillation, coronary artery disease, diabetes, non-Alzheimer's dementia, and chronic obstructive pulmonary disease. Further review showed the resident was at risk for falls and had two or more falls since admission. The following concerns were identified:a. Review of the fall risk assessment dated [DATE] at 2:59PM showed a fall risk score of 12 which indicated the resident was at medium risk for falls.b. Review of a progress note dated 4/20/26 and timed 11:45 PM showed the resident had fallen and vital signs had been obtained. Further review showed the area of the template for resident assessment had been left blank.c. Review of the document titled N-Adv skilled evaluation created on 5/5/26 at 3:54 PM and dated for 4/23/26 at 3:35 PM showed an assessment that identified the resident had pain, confusion and unsteadiness on standing and no risks for safety (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concerns.d. Review of a progress note dated 4/25/26 and timed 1:24 PM showed housekeeping reported the resident was on the floor in the reception area. The resident's vital signs were taken, the resident assessment was within normal limits, and staff did not know if the resident hit his/her head. Further review showed no evidence follow up assessments were performed.e. Review of a progress note dated 4/30/26 and timed 5:16 AM showed the resident had been found on the floor outside his/her door with his/her back against the wall after staff had heard a loud crash. The resident had been found with hands on his/her head and complained of pain.f. Review of the interdisciplinary team event review meeting on 4/30/26 at 10:07 AM showed a review of the fall. The root cause had been identified as impaired cognition, weakness and self-transfers. The immediate intervention had been to perform a head-to-toe assessment where a new skin tear had been identified. g. Interview with the resident's representative #2 5/7/26 at 12:58 PM revealed for the 10 days the resident at the facility, she had checked on him/her daily and watched him/her decline. She revealed when she arrived on 4/30/26 the resident appeared to be in a high level of pain, which appeared to affect his/her cognition, and the resident was not acting at his/her baseline. The representative revealed the resident had been visibly disheveled, his/her brief was saturated, and the room smelled of urine. She revealed she observed swelling in his/her neck and the resident did not have his/her pain patch on. The representative revealed the facility stated they were going to run tests for him/her and nothing happened. The representative revealed she decided to call the ambulance for the safety of the resident and to get his/her pain addressed, however; the facility staff said they would call for her. She revealed she followed the resident to the hospital and reported s/he returned to his/her baseline after the pain was under control and the swelling in his/her neck went down. Further interview revealed she reported no vital signs had been taken or an assessment performed from the time she arrived at the facility until the time the resident was sent to the hospital. 4. Review of the quarterly MDS assessment dated [DATE] showed resident #6 had a BIMS assessment of 12/15 which indicated moderate cognitive impairment, and diagnoses which included cancer, coronary artery disease, heart failure, renal insufficiency, renal failure, or end-stage renal disease, obstructive uropathy, Alzheimer's disease, and non-Alzheimer's dementia. Review of the medical record showed the resident received a diagnosis of severe sepsis with septic shock on 12/1/25. The resident had an indwelling catheter. Review of the care plan last revised on 12/8/25 showed the resident had a risk of UTIs related to the foley catheter, urinary retention, and prostate cancer. Interventions in place were to monitor and record output, changes in amount, color, or odor of urine. The following concerns were identified: a. Review of a practitioner note dated 12/22/25 and timed 10:57 PM showed .This is a 81 y/o [identifier] being seen [sic] follow-up visit at Big Horn rehab. [S/he] returned to the facility yesterday after a hospitalization over the weekend for acute sepsis related to [his/her] UTI/prostate cancer. [S/he] has completed [his/her] vancomycin treatment at this time[sic] [Name] is pleasant siting up in [his/her] recliner and denies needs. [S/he} denies pain. Nursing denies acute mentation change. Trending vital signs stable. No fever night sweats or chills. Unfortunately, labs were not obtained .Urinary tract infection, site not specified, Sepsis, unspecified organism. No acute concern for systemic infection, cardiac or respiratorydistress[sic].b. Review of a progress note dated 12/26/25 and timed 5:46 AM showed thick cloudy output in Cath drainage bag. c. Review of a progress note dated 12/27/25 and timed 4:51 AM showed .This resident was complaining of pain and has had no output from [his/her] catheter since the previous shift had changed the urine bag [sic] The family had called several times to tell us we need to send [him/her] to the ER. I spoke with the ER nurse who stated she had spoken with the same family member and the ER nurse told the family we are capable of changing the catheter without a trip to the ER. I changed the foley catheter using sterol technic [sic]. The foley was draining well but had some (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bloody urine output. The resident complained of pain but the source of the pain appeared to be in his stomach area not [his/her] bladder.d. Review of the treatment administration record (TAR) for December 2025 showed on 12/24/25 the resident's output was 300 milliliters (mL) between 6 AM to 6 PM and 250 mL between 6 PM and 6 AM. On 12/25/25 the resident's output was 600 mL between 6 AM and 6 PM, 50 mL between 6 PM and 6 AM and 250 mL between 6 PM and 6 AM. On 12/26/25 the resident's output was 50 mL between 6 AM and 6 PM, and 120 mL between 6 PM and 6 AM. On 12/27/25 the resident's output was 550 mL between 6 AM and 6 PM, and 550 mL between 6 PM and 6 AM.e. Review of a progress note dated 12/28/25 and timed 9:58 AM showed .Resident did not get up for breakfast., Nurse did get [him/her] to take [his/her] meds. Received phone call from [name] who wanted us to send [him/her] to the hospital. Resident said [s/he] didn't want to go to hospital. Nurse called [name] and reported [his/her] response. V/s [vital signs] 98.2 = t [temperature] rsp [respirations] 24 bpm [beats per minute] pulse 82 ; 140/85; 02 [oxygen] 92% Nurse has called NOC [nurse on call] and reported Action. f. Review of a progress note dated 12/28/25 and timed 10:46 AM showed .Resident able to sit up 2 assist. washed face, changed shirt, drank 120 cc [cubic centimeters] fluid. with cuing. Nurse held glass, Assist of two to transfer to wheelchair, and then to recliner. Urine in cath bag cloudy grayish yellow, Noc [nurse on call] notified that resident will go to the hospital, Said [s/he] be right in. [name] notified of action . g. Review of a progress note dated 12/28/25 and timed 11:43 showed the resident was transferred to the ED at 12:45 PM. Further review showed no evidence of the resident's catheter output. h. Review of the emergency room (ER) final report dated 12/28/26 and timed 1:09 PM showed .Reportedly care team at BHR changed his/her foley yesterday but unfortunately caused traumatic injury and hematuria d/t inflating the balloon in the prostatic urethra. It has since been repositioned and is draining purulent urine .recently admitted [DATE] to 12/1/25 for sepsis d/t UTI .[S/he] is also found to have AKI [Acute Kidney Injury] with creatinine of 2.55 with baseline approximately 1.25 . h. Interview with the DON on 5/7/26 at 12:50 PM revealed the staff watched the resident's output for 1 shift, changed the resident's catheter, and initiated vitals. She confirmed the nurses did not always follow through with her expectations for assessments. Further interview confirmed only vitals were completed, and from 12/26/25 until the resident was sent to the hospital on [DATE], the ongoing assessment was not completed as expected. 5. Interview with the DON on 5/7/26 at 9:40 AM revealed she expected documentation for resident transfers to include a discharge note with the resident condition, vital signs, family notification, physician notification, nurse management notification, and a report to the facility and ambulance services. She revealed the documentation should be done immediately or within 24 hours. She revealed she expected vital signs to be performed when concerns for change of condition had occurred and the nurses had discretion on the appropriate clinical response after they assessed residents.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, review of manufacturer's instructions, and policy and procedure review, the facility failed to label medications with the date medications were opened and/or expired in 2 of 2 medication fridges. The findings were:1. Observation on [DATE] at 10:48 AM in the Rock Creek medication fridge showed an Ozempic 8mg/3ml pen with no opened on or discard on date.2. Interview with medication assistant-certified (MA-C) #1 on [DATE] at 10:49 AM confirmed the Ozempic pen was opened and used the day before and there was no opened on or discard on date written on it.3. Observation on [DATE] at 12:12 PM in the secure unit fridge, showed an opened Tubersol with no opened on or discard on date. Further observation showed an opened Ativan oral solution 2mg/ml with no opened on or discard on date.4. Interview with LPN #2 on [DATE] at 12:13 PM confirmed the Tubersol and Ativan were in use and there was no opened on or discard on dates on either. 5. Interview with the DON on [DATE] at 12:34 PM confirmed she expected an opened on or discard by date written on in-use multi dose vials. 6. Review of the manufacturer's medication guide, page 29, for Ozempic date last revised 1/2025 showed After first use of the OZEMPIC pen, the pen can be stored for 56 days at controlled room temperature 59 F to 86 F (15 C to 30 C) or in a refrigerator 36 F to 46 F (2 C to 8 C).7. Review of manufacturer's medication guide, page 2, for oral liquid Lorazepam showed Discard opened bottle after 90 days.8. Review of manufacturer's package insert, page 10, for Tubersol date last revised [DATE] showed A vial of TUBERSOL which has been entered and in use for 30 days should be discarded.9. Review of the facility policy titled Labeling of Medications and Biologicals dated [DATE] showed .8. Labels for multi-use vials must include: a. The date the vial was initially opened or accessed (needle-punctured); b. All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on medical record review and staff interview, the facility failed to ensure hospice services met professional standards for 3 of 12 sample residents (#7, #83, #84) reviewed for hospice services. The findings were:1. Review of the medical record for resident #7 showed the resident received hospice services beginning on 3/31/26. Further review showed no evidence the resident had a physician order for a hospice referral or evaluation. 2. Review of the medical record for resident #83 showed the resident received hospice services beginning on 1/21/26. Further review showed no evidence the resident had a physician order for a hospice referral or evaluation. 3. Review of the medical record for resident #84 showed the resident received hospice services beginning on 2/5/26. Further review showed no evidence the resident had a physician order for a hospice referral or evaluation. 4. Interview with the regional clinical director on 5/6/26 at 12:44 PM confirmed residents who were placed on hospice did not receive a physician order for eval and the hospice used at that time was given access to the medical record for all residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, staff interview, and policy review, the facility failed to ensure infection prevention and control standards were implemented for 3 of 8 sample residents (#66, #69, #71) reviewed for resident care. In addition, the facility failed to implement infection prevention and control in 1 of 3 dining areas (main dining room) reviewed for meal service. The census was 73. The findings were:Related to Dining: 1. Observation on 5/4/26 beginning at 5:02 PM showed CNA #3 touched his hair then began handling the resident meal tickets. The CNA grabbed a bag of chips from a box on the tray cart and placed the bag of chips on top of a residents hamburger patty and top half of the hamburger bun. The CNA covered the plate with a cover an took it to resident #67 who was seated at a dining table. The CNA removed the cover and the resident removed the bag of chips from on top of his/her hamburger. Then with his exposed hand, the CNA grabbed the top of the resident's hamburger bun and applied jelly to the bun. The CNA placed the top of the bun on the burger and the resident ate the burger. No hand hygiene was performed until after the meal tray was delivered. After performing hand hygiene, the CNA pulled up his pants by touching the outside fabric and then began passing additional meal trays. At 5:11 PM the CNA touched his hair while applying a hairnet, then obtained a drink cup, holding it by the rim, and delivered the drink to a resident at a table. Without performing hand hygiene, the CNA returned to the steam table and continued passing meal trays. The CNA was observed adjusting his pants 3 times while passing 2 meal trays in which he touched the eating surface of each plate, before performing hand hygiene. At 5:15 PM, the CNA was observed placing another bag of chips on top of a burger patty and top bun, prior to delivering it to a resident. At 5:18 PM the CNA was observed touching his hair, and without performing hand hygiene, he obtained a coffee cup by grabbing the rim of the cup. The CNA filled the cup with coffee and delivered it to resident #55. At 5:23 PM the CNA was observed readjusting his pants and at 5:27 PM he was observed touching the back of his hair, and without per then obtained 3 drinking cups by touching the rims of each glass, filled the cups from a carafe near the coffee, and took them to the meal cart. The CNA obtained 3 plastic lids, touching each side of the lid, and placed the lids on the glasses. 2. Interview with the infection preventionist and DON on 5/7/26 at 9:27 AM revealed they would expect staff to perform hand hygiene after touching anything that would cause contamination, such as hair, skin, or clothing. Further they confirmed the CNA should not have touched resident meal items without performing hand hygiene. Related to soiled linens: 1. Observation on 5/4/26 at 2:49 PM showed resident #69 had linen with visible bowel movement incontinence. Continued observation showed: a. At 2:56 PM the resident's top blanket was pulled up over sheets by staff. b. At 3:10 PM the resident was on the bed resting which had pulled down the top blanket and soiled linen was visible. c. At 3:39 PM the resident laid on top of his/her oxygen cannula that was on top of his/her soiled sheets. d. At 4:17 PM the resident was sat on the edge of his/her bed, the nasal cannula had fallen on floor (continued on next page)

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	535026	A. Building B. Wing	05/07/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and housekeeping had picked it up off the floor and placed it on the resident. Related to oxygen cannulas 1. Observation on 5/5/26 starting at 8:25 AM showed resident #71's nasal cannula had fallen on the floor and was dated 4/19/26. The medication assistant-certified (MA-C) #1 entered the resident's room and did not pick up the cannula. CNA #4 entered the resident's room, removed the meal tray, and did not pick up the cannula. MA-C #1 entered the resident's room and administered the resident his/her inhaler, and tried to put the oxygen back on the resident after she picked it up off the floor and the resident declined. Continued observation showed: a. Observation on 5/6/26 at 9:11 AM showed the resident wore the oxygen tubing dated 4/19/26. b. Observation on 5/7/26 at 10:42 AM showed the oxygen tubing was dated 4/19/26 and the tubing was on the ground. 2. Observation on 5/5/26 at 2:52 PM showed resident #66's nasal cannula connected to oxygen concentrator was on the floor and was not dated. Continued observation showed: a. On 5/6/26 at 9:22 AM the resident's tubing to the concentrator was labeled 5/3/26 and was on the floor. b. Observation on 5/6/26 at 9:22 AM the resident's portable oxygen tubing was unlabeled. c. Observation on 5/7/26 at 10:50 AM the resident was wearing the oxygen tubing on the concentrator labeled 5/3/26. 3. Interview with the IP on 5/7/26 at 9:27 AM confirmed oxygen tubing should be changed and labeled weekly and as needed, or when visibly soiled. He stated staff who observed oxygen cannulas on the floor should not use them on residents, and were expected to replace the cannulas. Further interview confirmed soiled linens should be changed immediately. 4. Review of facility policy titled Oxygen Concentrator, last revised on 5/1/25 showed .5.c. Nurse responsibilities: i. change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of CDC recommendations, the facility failed to ensure the residents were immunized for pneumococcal disease in 5 of 5 sample residents (#66, #69, #1, #33, #4) reviewed for current vaccination status. The findings were:1. Review of medical records for residents' #66, #69, #1, #33 and #4 showed no pneumococcal conjugate vaccine had been assessed or offered.2. Interview with the IP on 5/7/26 at 12:32 PM confirmed there was no evidence of pneumococcal vaccination status.3. Interview with the IP on 5/7/26 at 9:27 AM revealed the facility process for immunizations immunizations were assessed and tracked on admission. The facility offered annual covid and influenza vaccines and documented results. He reported the facility had been delayed in an audit of pneumococcal vaccines due to the inability to access records.4. Review of the Center for Disease Control Recommended Adult Immunization Schedule for ages 19 years or older, last revised 2025 showed for routine adult vaccination age [AGE] years or older who have not previously received a dose of PCV13, PCV15, PCV20, or PCV21 or whose previous vaccination history is unknown should receive 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on grievance review, resident, volunteer, and staff interview, state survey agency incident database review, and policy and procedure review, the facility failed to ensure allegations of abuse were reported timely for 1 of 3 sample residents (#55) reviewed for abuse allegations. The findings were: 1. Review of a Complaint/Grievance Report Form dated 2/26/26 showed the volunteer reported Verbal Abuse to residents during activity by activities employee [activities staff member #1] on 2/14/26. The grievance showed resident #55 called out bingo at which point [activity staff member #1] proceeded to yell at [him/her] and told [him/her] to stop interrupting her while she was talking. It continued for a couple of minutes at which time I stepped over and told [activities staff member #1] to stop yelling at [resident #55] as [s/he] was playing the game and telling her [s/he] has a bingo. She then started yelling at me telling me I was talking over her. I told her I was in fact talking over her to prevent her from yelling at residents. Further review showed the volunteer said 2 residents, resident #55 and resident #66, reported the activities staff member yells at them all the time and speaks to them the same way every time they play bingo. The following concerns were identified:a. Interview with resident #55 on 5/5/26 at 2:17 PM revealed s/he had an issue with activities staff member #1 in BINGO when she was rude to resident #55. The resident revealed s/he had complained about something in BINGO and the activities staff member was upset, then stormed out. The resident revealed activities staff member #1 in a smart-ass way said weren't you paying attention? The resident revealed the statement made him/her angry and s/he called the staff member names. Further interview revealed the staff member was terminated following the incident.b. Interview with facility volunteer #3 on 5/6/26 at 12:15 PM revealed on the day of the incident, she was at the facility with other resident family members, sorting cookies and balloons inside the doorway by the Rock Creek dining room and activities staff member #1 was calling Bingo in the Rock Creek dining room. She revealed she heard resident #55 call out Bingo and heard activities staff member #1 saying the resident was interrupting her. She revealed the activities staff member was speaking to the resident very loudly and rudely, and told the resident to stop interrupting her. She revealed she went around the corner and told the activities staff member to stop talking to the resident in that way and the activities staff member said [s/he] doesn't have a right to interrupt and then yelled at the volunteer. She revealed following the interaction, the activities staff member stormed off.c. Review of the state survey agency incident database showed no evidence the allegation was reported. 2. Interview with the regional clinical director on 5/6/26 at 4:36 PM confirmed the facility did not have evidence the allegation of verbal abuse was reported. She revealed the former employee filed a grievance regarding the incident and while looking into the incident, they learned about the allegation of verbal abuse toward the resident. She confirmed the incident should have been reported and revealed she was unsure why the incident was not reported. 3. Review of the policy titled Abuse, Neglect and Exploitation dated 7/25/25 showed .VII. Reporting/Response A. The facility will have written procedure that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on grievance review, resident, volunteer, and staff interview, and policy and procedure review, the facility failed to ensure allegations of abuse were thoroughly investigated for 1 of 3 sample residents (#55) reviewed for abuse. The findings were:1. Review of a Complaint/Grievance Report Form dated 2/26/26 showed the volunteer reported Verbal Abuse to residents during activity by activities employee [activities staff member #1] on 2/14/26. The grievance showed resident #55 called out bingo at which point [activity staff member #1] proceeded to yell at [him/her] and told [him/her] to stop interrupting her while she was talking. It continued for a couple of minutes at which time I stepped over and told [activities staff member #1] to stop yelling at [resident #55] as [s/he] was playing the game and telling her [s/he] has a bingo. She then started yelling at me telling me I was talking over her. I told her I was in fact talking over her to prevent her from yelling at residents. Further review showed the volunteer said 2 residents, resident #55 and resident #66, reported the activities staff member yells at them all the time and speaks to them the same way every time they play bingo. The following concerns were identified:a. Interview with resident #55 on 5/5/26 at 2:17 PM revealed s/he had an issue with activities staff member #1 in BINGO when she was rude to resident #55. The resident revealed s/he had complained about something in BINGO and the activities staff member was upset, then stormed out. The resident revealed activities staff member #1 in a smart-ass way said weren't you paying attention? The resident revealed the statement made him/her angry and s/he called the staff member names. Further interview revealed the staff member was terminated following the incident.b. Interview with facility volunteer #3 on 5/6/26 at 12:15 PM revealed on the day of the incident, she was at the facility with other resident family members, sorting cookies and balloons inside the doorway by the Rock Creek dining room and activities staff member #1 was calling Bingo in the Rock Creek dining room. She revealed she heard resident #55 call out Bingo and heard activities staff member #1 saying the resident was interrupting her. She revealed the activities staff member was speaking to the resident very loudly and rudely, and told the resident to stop interrupting her. She revealed she went around the corner and told the activities staff member to stop talking to the resident in that way and the activities staff member said [s/he] doesn't have a right to interrupt and then yelled at the volunteer. She revealed following the interaction, the activities staff member stormed off.c. Review of the state survey agency incident database showed no evidence an investigation of the incident was reported. 2. Interview with the regional clinical director on 5/6/26 at 4:36 PM confirmed the facility did not have evidence the allegation of verbal abuse was investigated. She revealed the former employee filed a grievance regarding the incident and while looking into the incident, they learned about the allegation of verbal abuse toward the resident. She confirmed the incident should have been investigated and revealed she was unsure why the incident was not reported and investigated. 3. Review of the policy titled Abuse, Neglect and Exploitation dated 7/25/25 showed .V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warrented when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect, or exploitation occur .

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure residents were allowed to return following acute hospitalization for 1 of 4 sample residents (#82) reviewed for transfer and discharge. The findings were:1. Review of a progress note dated 3/11/26 and timed 8:33 PM showed resident #82 was transferred to the hospital emergency room due to altered mental status/increased confusion. The following concerns were identified:a. Review of the medical record showed no evidence a transfer/discharge notice was provided at the time of transfer.b. Review of a discharge MDS assessment dated [DATE] showed the resident's return to the facility was anticipated and the discharge was unplanned. Further review showed the discharge status was Short-Term General Hospital (acute hospital, IPPS).c. Interview with the DON on 5/7/26 at 9:45 AM revealed the resident did not return following the hospital transfer and the decision to not allow the return was financial. Further interview confirmed a discharge notice was not provided after transfer and revealed the facility did not assist in finding alternate placement.d. Interview with the business office manager on 5/7/26 at 10:54 AM confirmed the resident was not allowed to return to the facility following the hospital transfer; however, he revealed he thought the reason was due to insufficient staffing. 2. Review of the policy titled Transfer and Discharge (including AMA) last revised on 6/10/25 showed .10. Emergency Transfers to Acute Care .i. The resident will be permitted to return to the facility upon discharge from the acute care setting. j. Not permitting a resident to return following hospitalization constitutes a discharge. In situations where the facility has decided to discharge the resident while the resident is still hospitalized , the facility will send a notice of discharge to the resident and resident representative before the discharge, and must also send a copy of the discharge notice to the Office of State Long-Term Care Ombudsmen. Notice to the Ombudsman will occur at the same time the notice to discharge is provided to the resident and resident representative, even though, at the time of the initial emergency transfer, only needed to occur as soon as practicable .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and guardian interview, the facility failed to provide a notice of transfer/discharge prior to a facility-initiated hospital transfer for 3 of 6 sample residents (#6, #69, #77) and failed to provide written information on the bed-hold policy to the resident or the resident's representative for 1 of 6 sample residents (#77) reviewed for facility-initiated transfers. In addition, the facility failed to send a copy of the transfer/discharge notice to a representative of the Office of the State Long-Term Care Ombudsman. The findings were: 1. Review of the medical record showed resident #6 was transferred to the hospital on [DATE]. Further review showed no evidence the facility had issued a written transfer/discharge notice to the resident and/or the resident representative. There was no evidence a representative of the Office of the State Long-Term Care Ombudsman was notified of the transfer. a. Interview with the Regional Clinical Director on 5/7/26 at 11:45 AM confirmed there was no evidence a transfer/discharge notice had been provided to resident #6. 2. Review of the medical record showed resident #69 was transferred to the hospital on 5/4/26. Further review showed no evidence the facility had issued a written transfer/discharge notice to the resident and/or the resident representative. a. Interview with LPN #1 on 5/7/26 at 12 PM revealed she did not notify the resident's guardian because she had been the only nurse on the unit and she did not have time. She stated she had reported to the next shift that the resident's guardian had not been notified. b. Interview with the resident's guardian on 5/7/26 at 3:11PM confirmed she had not been notified the resident was transferred to the hospital. 3. Review of the medical record showed resident #77 was transferred to the hospital on 3/4/26. Further review showed no evidence the facility had issued a written transfer/discharge notice and written information on the bed-hold policy to the resident and/or the resident representative. There was no evidence a representative of the Office of the State Long-Term Care Ombudsman was notified of the transfer. a. Interview with the Regional Clinical Director on 5/7/26 at 11:45 AM confirmed there was no evidence the bed-hold and transfer/discharge notices were provided to resident #77.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, medical record review, resident representative and staff interview, and policy review, the facility failed to ensure individual activities of preference were provided to 1 of 3 sample residents (#80) reviewed. The findings were:1. Review of resident #80's care plan initiated on 4/24/26 showed s/he had a diagnosis of Alzheimer's disease, and was at risk for depression and impaired social interaction. Further review showed the resident will participate in social situations, activities of choice . The following concerns were identified: a. Interview with the resident's representative on 5/5/26 at 9:46 AM revealed the resident had not received activities at the facility. She reported the resident needed to stay busy, and s/he was unable to focus due to his/her diagnosis of dementia. She reported when she attempted to talk to activity staff about appropriate activities for the resident, they were always on their way to somewhere else. b. Observations throughout the survey showed the resident wandered in the halls and sat in the front lobby. The resident was not observed participating in facility activities. c. Interview with the DON on 5/7/26 at 1:12 PM revealed there was no record of activity participation for the resident. d. Interview with activity staff member #2 on 5/7/26 at 1:17 PM revealed she sat and talked to the resident once in a while, but she was the only person on the activity staff and did not have time.2. Review of the policy titled Activities dated 6/5/25 showed .9. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, and medical record review, the facility failed to ensure that residents received care that accounted for resident preferences that mitigated triggers for past trauma for 1 of 8 sample residents (#66) reviewed for trauma informed care. The findings were:1.Review of the quarterly MDS assessment dated [DATE] showed the resident had a BIMS score of 13 out of 15 which indicated little to no cognitive impairment, and had diagnoses which included schizophrenia, anxiety, and post-traumatic stress disorder (PTSD).a. Interview with the resident on 5/4/26 at 3:21 PM revealed the s/he had requested to not have men bathe her/him due to PTSD from sexual assault in the past, and s/he has had to remind staff weekly of his/her preference.b. Review of the care plan dated 1/23/26 showed no identification of the resident's preference for female staff only to assist in the areas of personalized care, ADL's and bathing, and mood and behavior, and no identification of triggers for PTSD or the resident's preference of only having females assist with bathing.c. Interview with CNA #2 on 5/7/26 at 10:37 AM confirmed the resident preferred female staff due to past trauma.

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. Based on resident and staff interview, the facility failed to ensure the activities program was directed by a qualified professional. The census was 73. The findings were: 1. Interview with resident #55 on 5/5/26 at 2:17 PM revealed the facility did not have an activity director and had been without for about a month. 2. Interview with the administrator and regional clinical director on 5/6/26 at 11:45 AM confirmed the facility did not have a qualified activity professional at that time; however, they revealed a new activity professional had been hired. They revealed the new director who would be starting was not qualified either and the program would be overseen by occupational therapy until qualification was met. 3. Interview with the regional clinical director on 5/7/26 at 12:32 PM revealed the activity program was not being overseen by a qualified person and the previous activity director left on 3/18/26.