

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/08/2025	
NAME OF PROVIDER OR SUPPLIER Big Horn Rehabilitation and Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1851 Big Horn Ave , Sheridan, Wyoming, 82801			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0000	INITIAL COMMENTS A complaint investigation was conducted on 9/30/25 to 10/8/25. The survey was prompted by complaints WY00004231, WY00004394, WY00004462, WY00004470, 2580962, 2588461, 2588793, 2629350, 2631681, 2629382, and 2629397. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing ED: Emergency Department LPN: Licensed Practical Nurse MDS: Minimum Data Set NHA: Nursing Home Administrator OHLS: Office of Healthcare Licensing and Surveys RN: Registered Nurse SSD: Social Services Director Less commonly used abbreviations will be annotated in each deficiency.		F0000			10/30/2025	
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in		F0580	**Plan of Correction for F0580 – Notification of Changes (SS=D)** **Corrective Action for Affected Resident** Resident #1 discharged on 9/25/2025 **Identification of Other Residents Potentially Affected** As of October 30, 2025, the DON or designee completed an audit of resident transfers to the hospital over the		10/30/2025	

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 reverse for further 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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F0580 SS = D	Continued from page 1 injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on resident representative, and staff interview,	F0580	Continued from page 1 past 30 days, to verify that resident representatives were notified of the change of condition and hospital transfer. If there was a missed notification, family representatives were called to provide updates on resident conditions. **Systemic Changes** As of October 30, 2025, Administrator or designee educated licensed nursing staff and inter-disciplinary team on: - Facility *Notification of Changes* policy regarding timely notification of resident representatives. - Documentation standards for notification of events. **Monitoring and Quality Assurance** The DON or designee will conduct audits of 5 resident charts after a resident change of condition and hospital transfers to ensure compliance with notification procedures. Audits will be completed weekly x 4 weeks then monthly x 2 months. The results of the audit will be reviewed by the Quality Assurance and Performance Improvement committee and provide recommendations until substantial compliance is achieved. **Completion Date** All corrective actions will be completed by October 30, 2025.				

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F0580 SS = D	Continued from page 2 medical record review, and policy and procedure review, the facility failed to ensure resident representatives were notified of a change in condition for 1 of 3 sample residents (#1) who were transferred to the hospital. The census was 79. The findings were: 1. Review of the quarterly MDS assessment dated 7/23/25 showed resident #1 had a BIMS score of 15 out of 15 which indicated intact cognition, and diagnoses which included coronary artery disease (CAD), heart failure, hypertension. Further review showed the resident had acute systolic (congestive) heart failure, need for assistance with personal care, and a colostomy. The following concerns were identified: a. Review of a progress note dated 9/25/25 showed "...Resident presented with diaphoresis, pallor, c/o chest pain, constant coughing with bloody sputum, wheezes, course lung sounds, shortness of breath, and weakness. Vital signs: 145/82 manual, oxygen 97% 4L[liters] NC [nasal cannula], HR [heart rate] 79, RR 24 even and labored, temp 99.3. Physician on call notified, recommended to present to ED for further evaluation. 0708- Admin on call notified, told to continue to monitor, transfer to ED when driver became available through facility at 0800. 0815- Driver available, resident sent to ED by wheelchair." b. Review of a transfer notice dated 9/25/25 showed the notice was not signed by the resident, and the resident's representative "will get copy when she comes to p/u [resident's] kindle." c. Interview with the resident's representative on 10/1/25 at 10:06 AM revealed she was not notified of the resident's transfer to the ED. Further interview revealed she went to the facility that morning to visit the resident, and was told by the nurse the resident had been sent to the hospital. She reported she had not received a phone call from the facility regarding the transfer, and had not received any paperwork from the facility regarding the transfer. d. Interview with the DON on 10/2/25 at 1:25 PM confirmed the resident's representative had not been called about the resident's transfer to the ED. e. Review of the policy titled "Notification of Changes" and dated 2025 showed "...The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification...Circumstances requiring notification include: ...2. Significant change in the resident's		F0580				

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F0580 SS = D	Continued from page 3 physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status...4. A transfer or discharge of the resident from the facility..."	F0580					
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, facility investigation review, and policy and procedure review, the facility failed to ensure residents were free from abuse from staff for 1 of 11 sample residents (#4) reviewed for allegations of abuse. The findings were: 1. Review of the quarterly MDS assessment dated 6/28/25 showed resident #4 had a BIMS score of 3/15 which indicated severely impaired cognition, and diagnoses which included non-traumatic brain dysfunction, renal insufficiency, Alzheimer's disease, non-Alzheimer's dementia, anxiety, and depression. In addition, the resident had behaviors which included physical and verbal behavioral symptoms directed toward others that occurred 1 to 3 days in the look-back period, and other behavioral symptoms not directed toward others that occurred daily in the look-back period. Further review showed the resident was dependent on toileting hygiene and required partial/moderate assistance for toilet transfers. 2. Review of an incident dated 8/5/25 showed the SSD was contacted by a family member of a resident who saw a video on social media on 7/21/25 that CNA #1 had posted of herself in resident #4's bathroom. Resident	F0600	**Plan of Correction for F0600 – Freedom from Abuse and Neglect (483.12(a)(1))** **Corrective Actions Taken for the Affected Resident (#4):** 1. **Resident Monitoring:** Resident #4 was monitored after the event for 72 hours by nursing staff for signs of distress. None was identified. 2) **Immediate Protection:** CNA #1 was suspended on 8/5/25 and subsequently terminated on 8/7/25. **Identification of Other Residents Potentially Affected:** All current residents residing in the facility have the potential to be affected Resident and Family Awareness:** Residents and families were educated on types of abuse including social media posting of residents that are demeaning or humiliating in nature, in resident and family council. Educated on what to do if they have concerns about abuse while residing in the facility. **Systemic Changes** As of October 30, 2025, Administrator or designee educated staff on the Abuse, Neglect, and Exploitation policy, including specific training on social media posting of residents that are demeaning or humiliating in nature, regardless of the residents cognitive status as well as focus on reporting any suspicious social media activity to Abuse Coordinator. **Monitoring and Quality Assurance** The Social Services Director or designee will perform 10 random resident interviews (sample will be from all residents regardless of resident's cognitive status) weekly x4 then monthly x 2 to ensure they have no concerns about social media posting that is demeaning or humiliating in nature, and that they feel safe in the facility. The results of the audit will be reviewed by the Quality Assurance and Performance Improvement committee			10/30/2025	

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F0600 SS = D	Continued from page 4 #4 could be heard on the video saying "please let me out of here" and CNA #1 responded "you've pooped your pants 4 times today you have to try to use the bathroom." This was repeated back and forth several times before resident #4 responded to the CNA "I don't know how." Further review showed the SSD contacted the administrator immediately, and suspended CNA #1 on 8/5/25 at 7:04 PM. The SSD spoke with CNA #1 on 8/6/25 and she stated, "I think I know what this is about" and disclosed that she had taken video of herself in resident #4's bathroom, confirmed all of the details given by the reporter, and did not understand what she had done "that was so wrong." CNA #1 was terminated on 8/7/25. Two attempts to contact CNA #1 were unsuccessful. 3. Interview with the DON on 10/2/25 at 1:25 PM revealed CNA #1 had been terminated, the resident had been monitored by nursing, and the staff had been given education on abuse and neglect, but no further action had been taken to assure it would not happen again. She confirmed the incident was not reviewed in Quality Assurance and Performance Improvement (QAPI). Further interview revealed the SSD had "walked out three weeks ago" and was unavailable for interview. 4. Review of the policy titled "Abuse, Neglect and Exploitation" dated 2025 showed "...IV. Identification of Abuse, Neglect and Exploitation...B. Possible indicators of abuse include, but are not limited to: ...9. Evidence of photographs or videos of a resident that are demeaning or humiliating in nature, regardless of whether the resident provided consent and regardless of the resident's cognitive status..." Further review showed "...VII. Coordination with QAPI...1. Cases of physical or sexual abuse, for example by facility staff or other residents, will be reviewed for and receive corrective action and tracking by the QAA committee. This coordinated effort results in the QAA Committee determining: a. If a thorough investigation is conducted; b. Whether the resident is protected; c. Whether an analysis was conducted as to why the situation occurred; d. Risk factors that contributed to the abuse 9e.g., history of aggressive behaviors, environmental factors); and e. Whether there is further need for systemic action such as: i. Insight on needed revisions to the policies and procedures that prohibit and prevent abuse/neglect/misappropriation/exploitation, ii. Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about, iii. Efforts to educate residents and their families about how to report any alleged violations without fear of repercussions, iv.		F0600	Continued from page 4 and provide recommendations until substantial compliance is achieved. **Completion Date:** All corrective actions will be completed by October 30, 2025			

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F0600 SS = D	Continued from page 5 Measures to verify the implementation of corrective actions and timeframes, and v. Tracking patterns of similar occurrences."	F0600					
F0609 SS = E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported 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, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, facility investigation review, Office of Healthcare Licensing and Surveys (OHLS) incident report log review, and policy and procedure review, the facility failed to report the results of abuse investigations within 5 working days to the State Agency for 4 of 11 sample residents (#7, #8, #9, and #10) reviewed for allegations of abuse. The findings were: 1. Review of a facility reported incident (FRI) dated 7/28/25 showed an allegation of verbal abuse between resident #7 and a staff member had occurred on 7/20/25 at 2:30 PM. The incident had been reported to the SSD on 7/28/25 at 12:00 PM and the administrator was made	F0609	**Plan of Correction for F0609 – Reporting of Alleged Violations (SS = E)** **Corrective Action Taken for Affected Residents (#7, #8, #9, #10):** As of October 30, 2025, the administrator completed and submitted the previously missing investigations for residents #7, #8, #9, and #10 to the State Survey Agency. **Identification of Other Residents Potentially Affected:** As of October 30, 2025, an audit of the OHLS incident report log for the past 6 months completed to identify any other uninvestigated or unreported allegations. All investigations have been submitted. **Systemic Changes:** An Investigation Binder has been implemented for abuse/neglect/exploitation investigations to be maintained in the administrator's office. As of October 30, 2025, the administrator or designee trained the facility staff on reporting incidents timely in the chain of command, investigations and the facility policy, including completing investigations and reporting findings within 5 working days to the state agency. **Monitoring and Quality Assurance:** The administrator or designee will audit weekly x 4 then monthly x 2 to ensure investigations have been conducted and reported to the State Survey Agency by facility policy and within 5 working days. The results of the audit will be reviewed by the Quality Assurance and Performance Improvement committee and provide recommendations until substantial compliance is achieved. **Completion Date:** All corrective actions will be completed by October 30, 2025.			10/30/2025	

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F0609 SS = E	Continued from page 6 aware at 1:00 PM. The initial incident report was sent to OHLS at 2:35 PM, and an investigation was begun. On 9/12/25 at 10:23 AM the OHLS requested the investigation for the incident to be submitted. Further review showed no investigation was completed or reported by the facility as of 9/26/25. 2. Review of a FRI dated 8/21/25 showed an incident of abuse between resident #8 and resident #9 had occurred on 8/21/25 at 9:45 AM. Staff was aware of the incident at 9:45 AM, the administrator was made aware at 10:05 AM, and the initial incident report was sent to OHLS at 12:01 PM. Further review showed no investigation was completed or reported by the facility as of 9/26/25. 3. Review of a FRI dated 8/28/25 showed an incident of abuse between resident #10 toward LPN #1 had occurred on 8/28/25 at 2:57 PM. Staff was aware of the incident at 3:00 PM, the administrator was made aware of the incident at 12:00 AM, and the initial incident report was sent to OHLS at 4:21 PM. Further review showed no investigation was completed or reported by the facility as of 9/26/25. 4. Interview with the NHA on 10/1/25 at 11:36 AM revealed the investigations were not in the facility. 5. Interview with the regional nurse on 10/1/25 at 12:30 PM revealed the reportable investigations binder had been in the facility 3 weeks ago, was not in the facility at that time, and the administration had called the police to report it was missing. 6. Interview with the DON on 10/1/25 at 2:45 PM confirmed investigations should have been submitted by the former SSD but were not. Further interview revealed the DON did not have access to submit investigations. 7. Review of the facility policy titled "Compliance with Reporting Allegations of Abuse/Neglect/Exploitation" dated 2025 showed "...Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation: ...2. The Administrator or designee will: a. Notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than 2 hours after discovery or forming the suspicion. b. Obtain statements from direct care staff. C. Suspend the accused employee pending completion of the investigation. d. Follow up with appropriate agencies, during business hours, to confirm the report was received. E. Report to the state nurse aide registry or nursing board any knowledge of any actions which would		F0609				

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F0609 SS = E	Continued from page 7 indicate an employee is unfit for service. F. Within 5 working days of the incident, report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified..."	F0609					
F0610 SS = E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, facility investigation review, OHLS incident report log review, policy and procedure review, the facility failed to ensure a thorough investigation was completed and failed to report the results of the investigation to the State Agency for 4 of 11 sample residents (#7, #8, #9, and #10) reviewed for allegations of abuse. The findings were: 1. Review of a facility reported incident (FRI) dated 7/28/25 showed an allegation of verbal abuse between resident #7 and a staff member had occurred on 7/20/25 at 2:30 PM. The incident had been reported to the SSD on 7/28/25 at 12:00 PM and the administrator was made aware at 1:00 PM. The initial incident report was sent to OHLS at 2:35 PM, and an investigation was begun. On 9/12/25 at 10:23 AM the OHLS requested the investigation for the incident to be submitted. Further review showed no investigation was completed or reported by the facility as of 9/26/25.	F0610	**Plan of Correction for F0610 (SS=E)** **Corrective Action for Affected Residents (#7, #8, #9, #10):** As of October 30, 2025, the facility completed and submitted investigations for incidents involving residents #7, #8, #9, and #10 to the State Survey Agency. **Identification of Other Residents Potentially Affected:** As of October 30, 2025, an audit of the OHLS incident report log for the past 6 months completed to identify any other uninvestigated or unreported allegations. All investigations have been submitted. **Systemic Changes:** The DON was given access to the OHLS reporting system to ensure continuity of reporting if the administrator is not available. An Investigation Binder has been implemented for abuse/neglect/exploitation investigations to be maintained in the administrator's office. As of October 30, 2025, the administrator or designee trained the facility staff on reporting incidents timely in the chain of command, investigations and the facility policy, including completing investigations and reporting findings within 5 working days to the state agency. **Monitoring and Quality Assurance:** The administrator or designee will audit weekly x 4 then monthly x 2 to ensure investigations have been conducted and reported to the State Survey Agency by facility policy and within 5 working days. The results of the audit will be reviewed by the Quality Assurance and Performance Improvement committee and provide recommendations until substantial compliance is achieved. **Completion Date:**			10/30/2025	

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F0610 SS = E	Continued from page 8 2. Review of a FRI dated 8/21/25 showed an incident of abuse between resident #8 and resident #9 had occurred on 8/21/25 at 9:45 AM. Staff was aware of the incident at 9:45 AM, the administrator was made aware at 10:05 AM, and the initial incident report was sent to OHLS at 12:01 PM. Further review showed no investigation was completed or reported by the facility as of 9/26/25. 3. Review of a FRI dated 8/28/25 showed an incident of abuse between resident #10 toward LPN #1 had occurred on 8/28/25 at 2:57 PM. Staff was aware of the incident at 3:00 PM, the administrator was made aware of the incident at 12:00 AM, and the initial incident report was sent to OHLS at 4:21 PM. Further review showed no investigation was completed or reported by the facility as of 9/26/25. 4. Interview with the NHA on 10/1/25 at 11:36 AM revealed the investigations were not in the facility. 5. Interview with the regional nurse on 10/1/25 at 12:30 PM revealed the reportable investigations binder had been in the facility 3 weeks ago, was not in the facility at that time, and the administration had called the police to report it was missing. 6. Interview with the DON on 10/1/25 at 2:45 PM confirmed investigations should have been submitted by the former SSD but were not. Further interview revealed the DON did not have access to submit investigations. 7. Review of the facility policy titled "Compliance with Reporting Allegations of Abuse/Neglect/Exploitation" dated 2025 showed "...Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation: ...2. The Administrator or designee will: a. Notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than 2 hours after discovery or forming the suspicion. b. Obtain statements from direct care staff. C. Suspend the accused employee pending completion of the investigation. d. Follow up with appropriate agencies, during business hours, to confirm the report was received. E. Report to the state nurse aide registry or nursing board any knowledge of any actions which would indicate an employee is unfit for service. F. Within 5 working days of the incident, report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified..."		F0610	Continued from page 8 All corrective actions will be completed by October 30, 2025.			
F0688	Increase/Prevent Decrease in ROM/Mobility		F0688	**Plan of Correction for F0688 – Mobility and Range of		10/30/2025	

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NAME OF PROVIDER OR SUPPLIER Big Horn Rehabilitation and Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1851 Big Horn Ave , Sheridan, Wyoming, 82801			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0688 SS = D	Continued from page 9 CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, and resident representative and staff interview, the facility failed to provide services to prevent a decrease in mobility for 1 of 3 sample residents (#1) with limited mobility. The findings were: 1. Review of the quarterly MDS assessment dated 7/23/25 showed resident #1 had a BIMS score of 15 out of 15 which indicated intact cognition, and diagnoses which included coronary artery disease (CAD), heart failure, hypertension, and acute systolic (congestive) heart failure. Further review showed the resident had a colostomy, a need for assistance with personal care, and the ability to walk 150 feet independently. Review of the medical record showed the resident was discharged to the hospital on 9/25/25. The following concerns were identified: a. Interview with the resident's representative on 10/1/25 at 10:06 AM revealed the resident had been able to walk with a walker when s/he admitted to the facility in January, but was discharged from therapy in March; and was now unable to walk. Further interview revealed the resident could receive therapy only if s/he paid privately, and s/he would not receive restorative services until s/he had Medicaid. She reported the resident's payor source changed to Medicaid "the other day."		F0688	Continued from page 9 Motion** **Corrective Action for Resident #1** Resident #1 discharged on 9/25/2025 **Identification of Other Residents Potentially Affected** As of October 30,2025, DON completed an audit of all residents to determine any residents who have had a decline in ADLs. Any residents identified during the audit will be referred to PT/OT **Systemic Changes** Facility implemented a weekly GG meeting to identify residents that have had a decline in ADL function. Individualized interventions will be implemented for any residents that are found to have a decline. Interventions may include PT/OT/ST evaluation and treatment orders. Implementation of Nursing staff interventions such as ambulation or individualized exercise program. Facility implementing an exercise group with emphasis on ROM of upper and lower extremities. As of October 30, 2025, DON or designee educated nursing staff on maintaining resident mobility and process for reporting changes in resident mobility to nurse leadership. **Monitoring and Quality Assurance** As of October 30, 2025, the DON or designee will audit 5 resident charts weekly x4 four and then monthly x2 to ensure that any residents that had a decline in mobility had interventions initiated. The results of the audit will be reviewed by the Quality Assurance and Performance Improvement committee and provide recommendations until substantial compliance is achieved. **Completion Date:** All corrective actions will be completed by October 30, 2025.			

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F0688 SS = D	Continued from page 10 b. Interview with RN #1 on 10/2/25 at 8:40 AM revealed the resident could transfer from his/her wheelchair, stand at the sink, and completed all mobility with a wheelchair. c. Interview with the DON on 10/2/25 at 9:00 AM revealed there had been a restorative aide (RNA) to provide maintenance when residents were discharged from skilled therapy, however the RNA had been scheduled to work the floor for staffing reasons. She revealed the resident used to walk around her room "before September, but had not walked since then." Further interview revealed the DON was waiting for handbooks to get the restorative program up and running, and resident #1 did not receive restorative services. d. Review of a physical therapy (PT) screening log provided by the NHA on 10/2/25 at 2:27 PM showed the resident was on the in-process list for a screen due on 10/23/25, and a screen would be completed 10/6/25 by PT.		F0688				