

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 10/23/2025	
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 survey was conducted by Healthcare Licensing and Surveys from 10/21/25 through 10/23/25. The survey was prompted by complaint intakes 2637136, 2641349, 2645356, and 2650728. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant ER: Emergency Room LPN: Licensed Practical Nurse MDS: Minimum Data Set NHA: Nursing Home Administrator RA: Resident Assistant RN: Registered Nurse UTI: Urinary Tract Infection Less commonly used abbreviations will be annotated in each deficiency.		F0000			11/05/2025	
F0658 SS = G	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, facility incident review, and staff interview, the facility failed to		F0658	1. Corrective Action for Residents Affected Resident #1 was discharged on 9/23/25. Resident #7 was discharged on 9/19/2025. The findings from the facility's internal investigation conducted into resident # 1 fall, immediately after the incidents differed significantly from statements later provided by staff to surveyors during the State Survey, including statements that management discouraged staff from utilizing EDS services and that nursing or other notes created by staff "disappeared" from the facility's medical record system. The facility has		11/21/2025	

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
---	-------	-----------

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 10/23/2025	
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	
F0658 SS = G	Continued from page 1 ensure that services provided met professional standards for 2 of 4 sampled residents (#1, #7) reviewed for quality of care. This failure resulted in actual harm to resident #1 and #7. The findings were: 1. Review of the admission MDS assessment dated 9/15/25 showed resident #1 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included cancer, diabetes mellitus, hypertension, and arthritis. Review of the facility incident report dated 9/23/25 showed the resident had been found on the floor following a fall in his/her room and had been assisted to a wheelchair by staff. The resident complained of nausea and numbness to the arms. The resident was transported to the ER in the facility van, accompanied by CNA #1 and the activities director, where s/he was diagnosed with cervical spine fractures of the 5th and 6th vertebrae. The following concerns were identified: a. Interview with RA #1 on 10/22/25 at 10:32 AM revealed he found the resident on the floor in his/her room, unable to move his/her arms or legs, and he observed a small amount of blood behind his/her head. After alerting LPN #2 and the former DON, he was instructed to assist them in lifting the resident off the floor and into his/her wheelchair where s/he would be transported to the ER in the facility van. Further interview revealed emergency medical services were not notified. b. Interview with LPN #1 on 10/22/25 at 6:15 PM revealed she observed the resident on the floor, the resident had a small amount of blood at the back of his/her head, s/he complained of not being able to feel [his/her] arms while lying on the floor, and was not able to sit up without staff assistance. The resident was assisted to a wheelchair and driven to the ER in the facility van. She felt the resident was unstable in the wheelchair riding in the van. c. Interview with LPN #2 on 10/23/25 at 2 PM confirmed the resident was found on the floor with a small amount of blood behind his/her head. He observed LPN #1 had assessed the resident's arm movements and lifted his/her head onto a pillow. He stated the resident was not able to sit up without staff assistance and was transferred to a wheelchair by staff. Further interview revealed the former DON told staff the resident had a head injury and was then transported to the ER in the facility van. d. Interview with CNA #2 on 10/23/25 at 11:12 AM revealed she was called into the resident's room and		F0658	Continued from page 1 initiated an additional investigation to reconcile those discrepancies in staff statements and ensure appropriate follow-up. Additionally, several members of the facility management team in place at the time of the incident and responsible for the initial investigation have now separated from employment. 2. Identification of Other Residents at Risk The DON or designee reviewed all resident falls from the previous 30 days to ensure appropriate emergency response, assessment, and provider notification occurred. The DON or designee reviewed all urinalysis (UA) orders from the previous 30 days to ensure samples were obtained timely and results reported to the provider. Any concerns identified were corrected, and care plans were updated as needed. 3. Systemic Changes to Prevent Recurrence The DON or designee educated nursing staff (RAs, CNAs, Medication Aides, LPNs, RNs) on facility emergency response expectations, including when EMS must be called rather than using facility transport. Training included recognition of conditions requiring EMS activation, such as suspected spinal injury, neurological deficits, inability to move extremities, or altered consciousness. The DON or designee educated licensed nurses (LPN, RN) on provider notification requirements, change-of-condition procedures, and appropriate steps for transferring a resident to the hospital. 4. Monitoring and Quality Assurance The DON or designee will conduct weekly audits of five (5) residents with falls for four (4) weeks, then monthly for two (2) months, to ensure proper fall response, including: Immediate assessment Timely and complete documentation			

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 10/23/2025	
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	
F0658 SS = G	Continued from page 2 observed him/her on the floor. She assisted RA #1, LPN #2, and the former DON to lift the resident off the floor and into a wheelchair. She stated, "It took all of us to lift [him/her] off the floor and into the chair because [his/her] legs weren't working, they were limp." She confirmed the former DON had the resident transported to the ER via facility van and did not call 911 because the ambulance was too expensive. e. Interview with the activities director on 10/23/25 at 11:20 AM revealed the former DON asked her to transport the resident to the ER following the fall because it was faster and easier than calling an ambulance. She revealed the resident had nausea and vomiting, was not alert, and had abnormal movements of his/her hands and feet. She confirmed she and CNA #1 transported him/her to the hospital, and the resident had leaned on CNA #1 during the van ride. f. Interview with CNA #1 on 10/23/25 at 11:57 revealed she had been asked by the former DON to accompany the resident to the ER in the facility van following a fall due to the expense of calling the ambulance. She observed the resident leaning forward in his/her wheelchair and talking with staff. She confirmed the resident leaned on her during the van ride and did not maintain his/her upper body balance. g. Review of the facility document titled "Resident Abuse and/or neglect", dated 9/23/25, showed the NP was notified the date of the fall. 2. Interview with the facility NP on 10/23/25 at 1:11 PM revealed she had had not been notified of the fall or a need to transport to the hospital. 3. Interview with the NHA on 10/23/25 at 11:20 AM revealed he had been informed the resident was found on the floor with blood coming from his/her head and was transported to the ER one hour following the fall via facility van. Further interview confirmed that staff were expected to call 911 when resident's required higher level of care. 4. Review of the discharge MDS assessment dated 9/19/25 showed resident #7 had modified independence which indicated difficulty in new situations only for cognitive skills for daily decision making, and diagnoses which included malnutrition, anxiety disorder, fracture of the upper end of the right humerus, fracture of the left ilium, chronic	F0658	Continued from page 2 Provider and representative notification Care plan updates The DON or designee will conduct a weekly audit of five (5) residents who required mechanical lift transfers for four (4) weeks, then monthly for two (2) months, to ensure sling placement, safe transfer technique, and timely documentation. Results of audits will be reviewed in QAPI for three (3) months and until substantial compliance is achieved. 5. Date of Compliance November 21, 2025				

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 10/23/2025	
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	
F0658 SS = G	Continued from page 3 respiratory failure, muscle wasting and atrophy, major depressive disorder, and altered mental status. Further review showed the resident was dependent on staff for toileting hygiene, personal hygiene, to roll left and right, to sit from lying, and to reposition from lying to sitting on the side of bed. Further review showed the resident had a urinary catheter, and was always incontinent of bowel. Review of the care plan last revised on 8/27/25 showed the resident was dependent for transfers and required at least 5 people to assist to turn and reposition in bed, and maximum assistance by 5 to 8 staff for toileting and check and change. Further review of the care plan showed "...Monitor/record/report to MD for s/sx [signs and symptoms] UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening or urine color, increased pulse, increased temp, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns..." The following concerns were identified: a. Review of a progress note dated 9/9/25 at 12:20 AM by the NP showed "...Clinical picture is inconsistent at this time. [S/He] has not had labs since early August. New orders: CBC, BMP, ESR and CRP. Exchange Foley and obtain urine specimen for urinalysis. Follow-up tomorrow for further evaluation. The patient is in no acute respiratory or cardiac distress at this time..." b. Review of a progress note dated 9/10/25 at 12:13 AM by the NP showed "...[S/He] reports [s/he] has had good appetite but has had a feeling of fever and chills. Trending vital signs stable. [S/He] does have a Foley catheter in place. CBC and CMP available for review. Urinalysis not obtained... [Resident #7] is resting quietly in bed and stable in no acute distress today...Follow-up tomorrow for urinalysis results. Nursing encouraged to obtain sample and sent [sic] to lab..." c. Review of a progress note dated 9/10/25 at 12:55 PM by the NP showed "... [Resident #7] is resting quietly in bed and stable in no acute distress today...Follow-up tomorrow for urinalysis results. Nursing encouraged to obtain sample and sent to lab. 9/11..." d. Review of a progress note dated 9/19/25 at 1:38 PM by RN #2 showed "extremely drowsy, slurred speech. normally able to awaken easily from sleep during day but abnormally drowsy since this nurse arrived on shift at 0600. Confusion unchanged, speech unclear. Vitals WNL [within normal limits]: blood pressure 85/58 manual, oxygen 94% 4L [liters] NC [nasal cannula], pulse 62, temp 98.4, RR [respiration rate] 18 even and		F0658				

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 10/23/2025	
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	
F0658 SS = G	Continued from page 4 unlabored. Resident repositioned, provider notified, will continue to monitor." e. Interview with RN #2 on 10/22/25 at 2:08 PM revealed she had written several days of documentation on the resident that were no longer in the resident's chart. She revealed the resident had not had very much urinary output during the last 5 days of his/her stay and RN #2 had been concerned about the resident's decline. She revealed LPN/staff development coordinator had decided to replace the foley catheter, which did help with output briefly. She revealed when she came on shift on 9/19/25, she had received a report that the resident did not have much urinary output and had been tired all night. She revealed during her shift on 9/19/25, the resident slept all day, had low urinary output, and mumbled but did not open his/her eyes when s/he was turned in bed. She revealed around 3 PM she called LPN/staff development coordinator to report the resident's change in condition and deterioration, and he told her to hold off until the night nurse came on shift to confirm her opinion because it would be an "extreme transfer" due to his/her size, and no large things were jumping out at the LPN/staff development coordinator. She revealed she reported to LPN/staff development coordinator she did not want to hold off on the transfer, and she was told not to contact the provider. She revealed her capacity to make a decision to send the resident to the hospital was limited by management, and decisions had to come from the provider. Further interview revealed when the night nurse, LPN #3, came on shift, he agreed with her assessment of the resident, and in 5 minutes a non-emergent transfer was called to transport the resident to the ER. f. Interview with the staff development coordinator on 10/22/25 at 3:26 PM revealed his opinion was that the resident was going septic because s/he had a permanent catheter and a positive UTI. Further interview revealed the resident had been at the point where s/he did not always answer questions and displayed mental changes, and did not have a temperature but did have a drop in his/her intellectual functioning. Further interview revealed when this behavior had been seen before, the first thing the facility checked for was a UTI. g. Interview with LPN #3 on 10/23/25 at 8:23 AM revealed he had come on shift the night the resident was transferred, and RN #2 had tried all day to get the resident sent to the hospital. He revealed administration staff wanted to wait until he arrived to send resident #7 to the hospital. Further interview revealed the resident was gray and ashen, and LPN #3	F0658					

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 10/23/2025	
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	
F0658 SS = G	Continued from page 5 could not obtain a blood pressure from the resident before s/he was sent to the hospital. h. Interview with the NP on 10/23/25 at 1:04 PM revealed the resident had been treated for a UTI in August and she had ordered a UA on 9/9/25, which was not obtained. Further interview revealed she had not been alerted by nursing about the resident's change in condition on 9/19/25, prior to the resident being sent to the hospital. i. Interview with the staff development coordinator on 10/23/25 at 2:22 PM revealed he noticed the resident's catheter had leaked and his/her urine "didn't look too good." He revealed the night nurse gave the recommendation after he noticed the resident's change of condition, and the resident was sent to the hospital. He confirmed he waited for LPN #3's opinion before sending the resident to the hospital because he did not see the resident enough to notice a change in behavior. Further he revealed he was not sure who obtained a UA on the resident. j. Interview with the DON on 10/23/25 at 10:48 AM confirmed the resident did not have a UA until he arrived at the hospital. k. Interview with the NHA on 10/23/25 at 11:45 AM confirmed that RNs have the autonomy to make a clinical judgment to send a resident to the hospital. 3. Review of the policy titled "Fall Prevention Policy" showed "...9. When any resident experiences a fall, the facility will...d. notify the physician and family..." 4. Review of the facility policy titled "Notification of Changes" showed "...2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-threatening conditions, or b. Clinical complication. 3. Circumstances that require a need to alter treatment. This may include: New treatment. B. Discontinuation of current treatment due to: i. Adverse consequences. ii. Acute condition. iii. Exacerbation of a chronic condition..."		F0658				
F0677 SS = E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and		F0677	1. Corrective Action for Residents Affected Residents #2, #3, and #4 were interviewed regarding bathing frequency and preferences. Each was offered a shower immediately per their preferences.		11/21/2025	

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 10/23/2025	
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	
F0677 SS = E	Continued from page 6 personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interview, medical record review, and facility policy and procedure review, the facility failed to ensure bathing was performed per residents' preference for 3 of 4 sample residents (#2, #3, #4) reviewed for bathing. The findings were: 1. Review of resident #2's "...ADL self-care performance..." care plan last revised 10/21/25 showed the resident required 1 person assist for showers. The following concerns were identified: a. Review of the bathing record between 9/29/25 and 10/20/25 showed the resident received showers on 9/29/25 and 10/10/25 and was documented as refused on 10/6/25, 10/13/25 and 10/20/25. The record showed a shower was to be offered on an alternative day/time on 10/3/25, and 10/17/25; however, there was no evidence the bathing was offered, accepted, or refused. b. Interview with the resident on 10/23/25 at 9:55 AM revealed the s/he received a shower every 2 weeks, because "that's how they have it set up." Further interview revealed s/he would prefer more showers if there was enough help. 2. Review of resident #3's "...ADL self-care performance..." care plan last revised 8/17/25 showed the resident required the assistance of 2 staff members for showers. The following concerns were identified: a. Review of the bathing record between 9/24/25 and 10/22/25 showed the resident received showers on 9/24/25 and 10/1/25. Showers were to be offered on alternate days/times on 10/5/25, 10/9/25, and 10/22/25; however, there was no evidence the showers were offered. Further review showed no evidence the resident was offered, accepted, or refused bathing for 22 days following the 10/1/25 shower. b. Interview with the resident on 10/23/25 at 9:55 AM revealed "I'm supposed to get 2 showers a week but so far I only get 1 shower a week. It could happen a little more frequently." 3. Review of resident #4's "...ADL self-care performance..." care plan last revised 4/1/24 showed "...I prefer showers three days a week and prefers [sic] a female care giver..." The following concerns were identified:		F0677	Continued from page 6 Care plans for these residents were reviewed and updated to ensure bathing schedules, preferences, and instructions are clearly documented and current. 2. Identification of Other Residents at Risk The DON or designee reviewed bathing records for all residents scheduled for showers over the past two weeks to ensure showers were offered and documented per resident preferences. Any identified concerns were corrected, and care plans updated as needed. 3. Systemic Changes to Prevent Recurrence The Staff Development Coordinator or designee educated nursing staff (CNAs, RAs, Med Aides, LPNs, RNs) on: Bathing expectations per resident preferences Offering bathing on scheduled days Documenting in PCC (Point of Care) Communicating to the Nurse Supervisor when a resident refuses or is unable to complete a scheduled bath Training included how to document bathing in PCC, including use of Quick Entry, refusal documentation, and selecting the correct options (completed/offered/refused). Administrator, DON, and Scheduler will review staffing during daily stand-up to ensure sufficient staff are available to meet bathing needs. 4. Monitoring and Quality Assurance The DON or designee will perform a weekly audit of five (5) residents scheduled for showers for four (4) weeks, then monthly for two (2) months to ensure: The bath was offered per resident preference Documentation in PCC is complete and accurate			

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 10/23/2025	
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
F0677 SS = E	Continued from page 7 a. Review of the bathing record between 9/24/25 and 10/22/25 showed the resident received showers one to two times per week on 9/24/25, 10/1/25, 10/3/25, 10/8/25, 10/13/25, and 10/17/25. A shower was to be offered as an alternate day/time on 10/6/25; however, there was no evidence the resident was offered, accepted, or refused bathing at that time. Further review showed the resident refused one shower on 10/22/25. b. Interview with the resident on 10/23/25 at 10:02 AM revealed the s/he had not received a shower for a week, and s/he was supposed to have showers on Mondays, Wednesdays, and Saturdays. Further interview revealed the resident had frequent diarrhea and that was why s/he needed 3 showers per week. 4. Interview with CNA #3 on 10/22/25 at 3:10 PM revealed showers were not getting done at night because there were often only 2 CNAs and they could not provide the necessary care to the residents and provide them with showers when there were only 2 staff who worked on the hall. 5. Interview with CNA #4 on 10/23/25 at 10:05 AM revealed some days there were not enough CNAs to provide showers for the residents. Further interview revealed on a normal day the staff should be able to complete 4 to 5 showers, but there were days where they could only give 1 resident a shower because they had to prioritize answering call lights over showers. 6. Interview with the DON on 10/23/25 at 2:38 PM revealed the expectation was that showers were provided on the scheduled day, and if they were unable to be provided they would roll over to the next day. Further interview revealed some residents had staff preference which turned into a missed opportunity to receive a shower, and this had been addressed with residents. 7. Review of the policy titled "Resident Showers" showed "...Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety..."			F0677	Continued from page 7 Results of these audits will be reviewed in QAPI for three (3) months and until substantial compliance is achieved. 5. Date of Compliance November 21, 2025		
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a			F0684	1. Corrective Action for Residents Affected Resident #1 was discharged on 9/23/25. The findings from the facility's internal investigation conducted into resident # 1 fall, immediately after the incidents differed significantly from statements later provided by staff to surveyors during the State Survey,		11/21/2025

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 10/23/2025	
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	
F0684 SS = G	Continued from page 8 resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, facility incident review, and policy review, the facility failed to implement interventions and treatment to prevent a decline in condition for 1 of 4 sampled residents (#1) reviewed for quality of care. This failure resulted in actual harm to residents #1. The findings were: 1. Review of the admission MDS assessment dated 9/15/25 showed resident #1 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included cancer, diabetes mellitus, hypertension and arthritis. The following concerns were identified: a. Review of the facility incident report dated 9/23/25 showed the resident had been found on the floor following a fall in his/her room and had been assisted to a wheelchair by staff. The resident complained of nausea and numbness to the arms. The resident was transported to the ER in the facility van, accompanied by CNA #1 and the activities director, where s/he was diagnosed with cervical spine fractures of the 5th and 6th vertebrae. b. Interview with RA #1 on 10/22/25 at 10:32 AM revealed he found the resident on the floor in his/her room, unable to move his/her arms or legs, and he observed a small amount of blood behind his/her head. After alerting LPN #2 and the former DON, he was instructed to assist them in lifting the resident off the floor and into his/her wheelchair where s/he would be transported to the ER in the facility van. Further interview revealed emergency medical services were not notified. c. Interview with LPN #1 on 10/22/25 at 6:15 PM revealed she observed the resident on the floor, and s/he had a small amount of blood at the back of his/her head and complained of not being able to feel [his/her] arms while lying on the floor, and was not able to sit up without staff assistance. The resident was assisted to a wheelchair and driven to the ER in the facility van. She felt the resident was unstable in the wheelchair while riding in the van. d. Interview with LPN #2 on 10/23/25 at 2 PM confirmed		F0684	Continued from page 8 including statements that management discouraged staff from utilizing EDS services and that nursing or other notes created by staff "disappeared" from the facility's medical record system. The facility has initiated an additional investigation to reconcile those discrepancies in staff statements and ensure appropriate follow-up. Additionally, several members of the facility management team in place at the time of the incident and responsible for the initial investigation have now separated from employment. 2. Identification of Other Residents at Risk The DON or designee reviewed all residents with falls in the past 30 days to ensure appropriate assessment, documentation, provider notification, and EMS activation occurred as required. Any care plan updates needed were completed promptly. 3. Systemic Changes to Prevent Recurrence The DON or designee educated nursing staff (LPNs, RNs) on emergency response procedures, including when EMS activation is mandatory. Education included identifying symptoms such as suspected spinal injury, neurological deficits, inability to move extremities, or altered mental status. Licensed nurses (LPN, RN) were educated on change-of-condition assessment, timely provider notification, and hospital transfer procedures. Staff were reminded that residents must never be transported via facility vehicle when EMS-level support is required. 4. Monitoring and Quality Assurance The DON or designee will complete weekly audits of five (5) residents with falls for four (4) weeks, then monthly for two (2) months, to ensure: Proper assessment was completed Provider notification occurred			

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 10/23/2025	
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	
F0684 SS = G	Continued from page 9 the resident was found on the floor with a small amount of blood behind his/her head. He observed LPN #1 had assessed the resident's arm movements and lifted his/her head onto a pillow. He stated the resident was not able to sit up without staff assistance and was transferred to a wheelchair by staff. Further interview revealed the former DON told staff the resident had a head injury and was then transported to the ER in the facility van. e. Interview with CNA #2 on 10/23/25 at 11:12 AM revealed she was called into the resident's room and observed him/her on the floor. She assisted RA #1, LPN #2 and the former DON to lift the resident off the floor and into a wheelchair. She stated, "It took all of us to lift [him/her] off the floor and into the chair because [his/her] legs weren't working, they were limp." She confirmed the former DON had the resident transported to the ER via facility van and did not call 911 because the ambulance was too expensive. f. Interview with the activities director on 10/23/25 at 11:20 AM revealed the former DON asked her to transport the resident to the ER following the fall because it was faster and easier than calling an ambulance. She revealed the resident had nausea and vomiting, was not alert, and had abnormal movements of his/her hands and feet. She confirmed she and CNA #1 transported him/her to the hospital, and the resident had leaned on CNA #1 during the van ride. g. Interview with CNA #1 on 10/23/25 at 11:57 revealed she had been asked by the former DON to accompany the resident to the ER in the facility van following a fall due to the expense of calling the ambulance. She observed the resident leaning forward in his/her wheelchair and talking with staff. She confirmed the resident leaned on her during the van ride and did not maintain his/her upper body balance. h. Review of the facility document titled "Resident Abuse and/or neglect", dated 9/23/25, showed the NP was notified the date of the fall. 2. Interview with the facility NP on 10/23/25 at 1:11 PM revealed she had not been notified of the fall or a need to transport to the hospital. 3. Interview with the NHA on 10/23/25 at 11:20 AM revealed he had been informed the resident was found on the floor with blood coming from his/her head and was transported to the ER one hour following the fall via facility van. Further interview confirmed that staff were expected to call 911 when resident's required		F0684	Continued from page 9 EMS was called appropriately Documentation is timely and complete Results of audits will be reviewed in QAPI for three (3) months and until substantial compliance is achieved. 5. Date of Compliance November 21, 2025			

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 10/23/2025	
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	
F0684 SS = G	Continued from page 10 higher level of care.	F0684					
F0689 SS = D	4. Review of the policy titled "Fall Prevention Policy" showed "...9. When any resident experiences a fall, the facility will...d. notify the physician and family..." Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on resident representative and staff interview, medical record review, and policy review, the facility failed to ensure the environment was free of accident hazards for 1 of 3 sample residents (#5) reviewed for falls. The findings were: 1. Review of the admission MDS dated 8/28/25 showed resident #5 had a BIMS score of 11/15 which indicated moderate cognitive impairment, and diagnoses which included diabetes mellitus, unspecified congestive heart failure, and morbid obesity. The resident was dependent for transfers and self cares, and was incontinent of bowel and bladder. Review of the care plan initiated on 7/30/25 showed the resident was at risk for falls, and had interventions which included "If a fall occurs, alert provider" and "If a fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol." The following concerns were identified: a. Interview with the resident's representative on 10/22/25 at 11:30 AM revealed she received a phone call from the resident's nurse on 9/9/25 at 2:03 PM and was told the resident had fallen during a mechanical lift transfer from the wheelchair to the bed. The representative was told the resident slipped through the hoist lift sling and landed on the floor next to the bed because his/her brief was wet. The representative revealed she had asked for an incident report and had been told it could not be found. Further	F0689	1. Corrective Action for Residents Affected Resident #5 has been discharged from the facility. 2. Identification of Other Residents at Risk The DON or designee reviewed all residents with falls in the past 30 days to ensure proper documentation, incident reporting, provider and representative notification, and care plan updates were completed. 3. Systemic Changes to Prevent Recurrence Nursing staff (RAs, CNAs, Medication Aides, LPNs, RNs) were educated by the DON or designee on: Proper mechanical lift use Correct sling placement Fall response requirements Immediate provider and family notification Required documentation following a fall Staff were educated that facility-level employees cannot delete documentation from the electronic health record and that the audit trails for the facility's EHR record all modifications and deletions of documentation. Education included proper correction of documentation errors, including striking through erroneous entries and writing a new note with the correct information. 4. Monitoring and Quality Assurance Audit #1 – Mechanical Lift Transfers:			11/21/2025	

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 10/23/2025	
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
F0689 SS = D	Continued from page 11 interview revealed the resident had been discharged to a different facility. b. Interview with RN #2 on 10/22/25 at 2:08 PM revealed she had been the nurse on duty with resident #5 the day after the fall, and was not aware of the fall until the resident's representative called and asked how the resident was doing, because there had not been any notes about the fall in the record. She revealed she documented on the resident's behavior after the incident because the resident had been upset, and her documentation had been deleted. c. Interview with the current DON on 10/22/25 at 2:59 PM revealed on 9/9/25 a CNA reported to her when she was RN on duty that resident #5 had fallen from the mechanical lift to the floor while being transferred from his/her wheelchair to the bed for a "check and change." She revealed the resident had slipped out of the bottom of the sling and it was determined the sling had been placed appropriately; however, the resident's wet brief had caused the resident to slip out of the sling and onto the floor. She revealed she had completed a risk management note, progress note, and notified the family; however, she was unable to find the documentation in the medical record. Further interview confirmed there was no documentation in the resident's medical record about the fall, and there had been no follow up with risk management. d. Interview with RA #1 on 10/23/25 at 10:31 AM revealed he controlled the mechanical lift during resident #5's transfer after a CNA placed the sling. He revealed the resident fell to the floor, and he immediately alerted RN #1 about the fall. Further interview revealed he did not position the sling under the resident, he ran the controls of the lift. e. Interview with the NP on 10/23/25 at 1:04 PM revealed she had not been notified about the resident's fall. f. Review of the resident's medical record showed there was no documentation on the fall and the care plan had not been updated after the fall. 2. Review of facility policy titled "Fall Prevention Policy" showed "...9. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury..."			F0689	Continued from page 11 The DON or designee will conduct a weekly audit of five (5) residents requiring mechanical lift transfers for four (4) weeks, then monthly for two (2) months, to ensure: Sling placement was appropriate Transfers were completed safely Documentation is complete Audit #2 – Fall Response Review: The DON or designee will conduct a weekly audit of five (5) residents with falls for four (4) weeks, then monthly for two (2) months, to ensure: Documentation is complete Provider and representative notification occurred Care plan updates were completed Results from both audits will be reviewed in QAPI for three (3) months and until substantial compliance is achieved. 5. Date of Compliance November 21, 2025		

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 10/23/2025
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
F0689 58725 SS = E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interview and medical record review, the facility failed to ensure there was sufficient nursing staff for 1 of 4 resident care units (Chapel) reviewed for sufficient staffing. The facility census was 77 and the Chapel unit census was 17. The findings were: 1. Review of resident #2's "...ADL self-care performance..." care plan last revised 10/21/25 showed the resident required 1 person assist for showers. The following concerns were identified: a. Review of the bathing record between 9/29/25 and 10/20/25 showed the resident received showers on 9/29/25 and 10/10/25 and was documented as refused on	F0689 F0725	1. Corrective Action for Residents Affected Resident #2, #3, and #4 were interviewed regarding bathing preferences and frequency. Each resident was immediately offered a shower in accordance with their documented preferences. Care plans for these residents were reviewed and updated to ensure bathing preferences are clearly documented and current. 2. Identification of Other Residents at Risk The DON or designee reviewed residents scheduled for showers over the past 30 days to ensure documentation reflected whether bathing was provided according to resident preference and schedule. Any resident identified as having missed showers without proper documentation was offered a shower, and care plans were reviewed and updated where needed. 3. Systemic Changes to Prevent Recurrence Nursing staff (CNA, RA, Medication Aide, LPNs, RNs) were educated on: • Offering bathing per resident preference and documented schedule • Proper documentation of bathing in the Point of Care (POC) Charting system • Communicating to the nurse supervisor when bathing is refused or unable to be completed Administrator, DON, and Scheduler will review facility staffing during the daily stand-up meeting to ensure sufficient staffing levels to meet resident care needs, including bathing. 4. Monitoring and Quality Assurance The DON or designee will conduct a weekly audit of five (5) residents scheduled for showers for four (4) weeks, then monthly for two (2) months, to ensure bathing was offered per resident preference and that documentation in POC is complete and accurate. Audit results will be reviewed in QAPI for three (3) months and until substantial compliance is achieved. 5. Date of Compliance		11/21/2025

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 10/23/2025	
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	
F0725 SS = E	Continued from page 13 10/6/25, 10/13/25 and 10/20/25. The record showed a shower was to be offered on an alternative day/time on 10/3/25, and 10/17/25; however, there was no evidence the bathing was offered, accepted, or refused. b. Interview with the resident on 10/23/25 at 9:55 AM revealed the s/he received a shower every 2 weeks, because "that's how they have it set up." Further interview revealed s/he would prefer more showers if there was enough help. 2. Review of resident #3's "...ADL self-care performance..." care plan last revised 8/17/25 showed the resident required the assistance of 2 staff members for showers. The following concerns were identified: a. Review of the bathing record between 9/24/25 and 10/22/25 showed the resident received showers on 9/24/25 and 10/1/25. Showers were to be offered on alternate days/times on 10/5/25, 10/9/25, and 10/22/25; however, there was no evidence the showers were offered, accepted, or refused. Further review showed no evidence the resident was offered, accepted, or refused bathing for 22 days following the 10/1/25 shower. b. Interview with the resident on 10/23/25 at 9:55 AM revealed "I'm supposed to get 2 showers a week but so far I only get 1 shower a week. It could happen a little more frequently." 3. Review of resident #4's "...ADL self-care performance..." care plan last revised 4/1/24 showed "...I prefer showers three days a week and prefers [sic] a female care giver..." The following concerns were identified: a. Review of the bathing record between 9/24/25 and 10/22/25 showed the resident received showers one to two times per week on 9/24/25, 10/1/25, 10/3/25, 10/8/25, 10/13/25, and 10/17/25. A shower was to be offered on as an alternate days/time on 10/6/25; however, there was no evidence the resident was offered, accepted, or refused bathing at that time. Further review showed the resident refused one shower on 10/22/25. b. Interview with the resident on 10/23/25 at 10:02 AM revealed the s/he had not received a shower for a week, and s/he was supposed to have showers on Mondays, Wednesdays, and Saturdays. Further interview revealed the resident had frequent diarrhea and that was why s/he needed 3 showers per week. 4. Interview with CNA #3 on 10/22/25 at 3:10 PM		F0725	Continued from page 13 November 21, 2025			

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 10/23/2025	
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	
F0725 SS = E	Continued from page 14 revealed showers were not getting done at night because there were often only 2 CNAs and they could not provide the necessary care to the residents and provide them with showers when there were only 2 staff who worked on the hall. 5. Interview with CNA #4 on 10/23/25 at 10:05 AM revealed some days there were not enough CNAs to provide showers for the residents. Further interview revealed on a normal day the staff should be able to complete 4 to 5 showers, but there were days where they could only give 1 resident a shower because they had to prioritize answering call lights over showers. 6. Interview with the DON on 10/22/25 at 2:59 PM revealed she had brought someone new into the position of scheduler, and was trying to get staff on a set rotation because she did not want a varied and chaotic schedule, but wanted a routine schedule for the staff. 7. Interview with the DON on 10/23/25 at 2:38 PM revealed her expectation was for showers to be provided on the scheduled day, and if they were unable to be provided, they would roll over to the next day. Further interview revealed some residents had staff preference which turned into a missed opportunity to receive a shower, and this had been addressed with residents.	F0725					
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F0842	1. Corrective Action for Residents Affected Resident #5 has been discharged from the facility. Resident #1 was discharged on 9/23/25. 2. Identification of Other Residents at Risk The DON or designee reviewed all residents with falls in the past 30 days to ensure documentation is present and complete for each incident, including assessments, notifications, and care plan updates. Any resident lacking appropriate fall documentation had records corrected promptly, and care plans were updated as needed. 3. Systemic Changes to Prevent Recurrence Licensed Nursing staff (LPN, RNS) were educated on: • Fall documentation requirements • Completing incident reports, provider notifications, family notifications, and post-fall assessments			11/21/2025	

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 10/23/2025	
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	
F0842 SS = D	Continued from page 15 (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;		F0842	Continued from page 15 • Requirements for updating the care plan following a fall Staff were educated that facility staff cannot delete documentation from the medical record. Staff were instructed that a progress note is not part of the permanent medical record until it is saved and signed, and any erroneous documentation must be struck through, remain visible, and be corrected with a new progress note. 4. Monitoring and Quality Assurance The DON or designee will conduct a weekly audit of five (5) residents with falls for four (4) weeks, then monthly for two (2) months, to ensure all required fall documentation is completed, provider and family notifications occur, post-fall assessments are documented, and care plan updates are completed as required. Audit findings will be reviewed in QAPI for three (3) months and until substantial compliance is achieved. 5. Date of Compliance November 21, 2025			

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 10/23/2025	
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	
F0842 SS = D	Continued from page 16 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, medical record review, and policy review, the facility failed to maintain accurately documented medical records for 2 of 3 sample residents (#1, #5) reviewed for falls. The findings were: . 1. Review of the admission MDS dated 8/28/25 showed resident #5 had a BIMS score of 11/15 which indicated moderate cognitive impairment, and diagnoses which included diabetes mellitus, unspecified congestive heart failure, and morbid obesity. The resident was dependent for transfers and self cares, and was incontinent of bowel and bladder. Review of the care plan initiated on 7/30/25 showed the resident was at a risk for falls, and "If a fall occurs, alert provider" and "If a fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol." The following concerns were identified: a. Interview with the resident's representative on 10/22/25 at 11:30 AM revealed she received a phone call from the resident's nurse, RN #1, on 9/9/25 at 2:03 PM and was told the resident had fallen during a mechanical lift transfer from the wheelchair to the bed. The representative was told the resident slipped through the hoist lift sling and landed on the floor next to the bed because his/her brief was wet. Further, the representative was told she had asked for an incident report and had been told it could not be found. The representative stated the resident had been discharged to a different facility. b. Interview with RN #2 on 10/22/25 at 2:08 PM revealed she had been the nurse on duty with resident #5 the day after the fall, and was not aware of the fall until the resident's representative called and asked how the resident was doing, because there had no been any notes about the fall the record. She reported she documented on the resident's behavior after the incident because	F0842					

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 10/23/2025	
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	
F0842 SS = D	Continued from page 17 the resident had been upset, and her documentation had been deleted. c. Interview with the current DON on 10/22/25 at 2:59 PM revealed on 9/9/25 a CNA reported to her when she was RN on duty that resident #5 had fallen from the mechanical lift to the floor while being transferred from his/her wheelchair to the bed for a "check and change." She reported the resident had slipped out of the bottom of the sling. She had determined the sling had been placed appropriately, however the wet brief had caused the resident to slip out of the sling and onto the floor. She reported she completed a risk management note, progress note, and notified the family, however she was unable to find this documentation in the medical record. Further interview confirmed there was no documentation in the resident's medical record about the fall, and there had been no follow up with risk management. d. Interview with LPN #3 on 10/23/25 at 8:23 AM revealed he had written notes on residents that were deleted from the medical records. e. Interview with the NP on 10/23/25 at 1:04 PM revealed she had not been notified about the resident's fall. f. Review of the resident's medical record showed there was no documentation on the fall and the care plan had not been updated after the fall. 2. Review of the admission MDS assessment dated 9/15/25 showed resident #1 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included cancer, diabetes mellitus, hypertension, and arthritis. Review of the facility incident report dated 9/23/25 showed the resident had been found on the floor following a fall in his/her room and had been assisted to a wheelchair by staff. The resident complained of nausea and numbness to the arms. The resident was transported to the ER in the facility van, accompanied by CNA #1 and the activities director, where s/he was diagnosed with cervical spine fractures of the 5th and 6th vertebrae. The following concerns were identified: a. Review of the facility document titled "Resident Abuse and/or neglect", dated 9/23/25, showed the NP was notified the date of the fall. b. Interview with the facility NP on 10/23/25 at 1:11 PM revealed she had had not been notified of the resident's fall or a need to transport to the hospital.		F0842				

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 10/23/2025	
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	
F0842 SS = D	Continued from page 18 3. Review of facility policy titled "Fall Prevention Policy" showed "...9. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury..."		F0842				