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 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Horn Rehabilitation and Care Center	**1851 Big Horn Ave , Sheridan, 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 2/4/26 through 2/5/26. The survey was prompted by complaint intakes 1901481, 1901484, 1901485, 1901481, 1901477, 1901487, 2605104, 2641357, 2646703, 2661024, 2673749, 2696928, 2697004, 2699020, 2710101, and 2710132. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse SSD: Social Services Director Less commonly used abbreviations will be annotated in each deficiency.	F0000		02/20/2026
F0565 SS = D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group	F0565	"Past Noncompliance - no plan of correction required"	02/27/2026

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 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Horn Rehabilitation and Care Center	**1851 Big Horn Ave , Sheridan, 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
F0565 SS = D	Continued from page 1 and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on staff and family council president interview, and review of family council minutes, the facility failed to provide and support a private meeting space for family council meetings in 1 out of 12 months in the year 2025. Corrective measures were implemented prior to the survey and compliance was determined to be met on 4/29/25. The census was 66. The findings were: 1. Interview with the family council president on 2/4/26 at 12:19 PM revealed the facility canceled the family council meeting and did not provide a meeting space for the month of March 2025. She further revealed there was a sign posted on the community board on 3/4/2025 that stated “Family council meeting for March will be canceled. Look forward to seeing you in April, contact social services with any questions”. S/he was then told by the former activity director that there wouldn’t be a meeting in March and there might not be one in April because they were "trouble makers". 2. Review of the family council meetings confirmed no meeting occurred in March 2025. 3. Review of Family Council meeting minutes provided by the council president verified meetings were being held	F0565		

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 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Horn Rehabilitation and Care Center	**1851 Big Horn Ave , Sheridan, 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
F0565 SS = D	Continued from page 2 during the 3rd or 4th week of the month. Further review confirmed the issue had been resolved and monthly meetings had resumed since 4/29/25. 4. Interview with the NHA on 2/5/26 at 1:57 PM verified the facility had implemented corrective action and has provided space for family council meetings since 4/29/25.	F0565		
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F0584	F0584 – Safe/Clean/Comfortable/Homelike Environment 1. Corrective Action for Affected Areas: All resident rooms were stocked with washcloths, towels, and linens 2/7/2026 Broken tiles in Room 415 were repaired. 2/6/2026 Bathroom door for Room 305 was installed. 2/6/2026 2. Identification of Other Residents Potentially Affected: Maintenance Director or designee will audit resident rooms, and common areas for environmental, maintenance, and linen concerns on or by 3/10/2026 3. Systemic Changes: Maintenance log system was revised to track repairs with completion timelines. Facility staff were re-educated on expectations for maintaining a homelike environment. DON or designee will administer education on or before 3/10/2026 Weekly environmental rounds implemented by Administration and Maintenance. 4. Monitoring: Maintenance or designee to complete weekly environmental audits on 5 resident rooms and 1 common area to include checking for homelike environment, stocked linen and for needed repairs, such as broken tile will be conducted weekly x4, and then monthly x2 for a total of 3 months. Results of audit will be reviewed at QAPI until substantial compliance is achieved.	03/10/2026

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 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Horn Rehabilitation and Care Center	**1851 Big Horn Ave , Sheridan, 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
F0584 SS = E	Continued from page 3 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and resident and resident representative interview, the facility failed to provide a safe, clean, comfortable and homelike environment for 3 of 4 (Secure unit, 100, 400 halls) units reviewed. The findings were: 1. Regarding homelike environment: a. Observation throughout the days on 2/4/26 and 2/5/26 showed no washcloths, bath towels. or hand towels in resident rooms on 3 of 4 units. b. Interview with resident representative for resident #1 on 2/5/26 at 10:20 AM revealed there was never any linen in the resident's room to assist with bathing when she visited. c. Interview with the director of housekeeping 2/5/26 at 11:30 AM revealed that clean linen was available in the clean supply storage for staff to stock rooms. d. Interview with RN # 1 on 2/5/26 at 11:45 AM revealed that staff will supply residents with hand towels and clean linen from the clean supply room when needed. e. Interview with the DON on 2/5/26 at 11:15 AM revealed staff were expected to stock resident rooms with washcloths and clean linen as required. f. Interview with the resident representative for resident #1 on 2/5/26 at 9:02 AM the resident resided in room #305 [in the secure unit] and during the resident's stay, there was no bathroom door in place. Review of the medical record showed the resident was at the facility for approximately 6 weeks from June 2025 to August 2025. Observation on 24/26 at 6 PM showed there was no resident residing in room #305; however, there was still no bathroom door in place. 2. Regarding safe, and clean environment: a. Observation on 2/4/26 at 10:33 AM showed broken tiles under both toilet riser legs in room 415 which	F0584	Continued from page 3 5. Completion Date: 3/10/2026	

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 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Horn Rehabilitation and Care Center	**1851 Big Horn Ave , Sheridan, 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
F0584 SS = E	Continued from page 4 appeared dirty and had a urine odor. b. Interview with resident # 2 on 2/4/26 at 4:35 PM revealed s/he reported the broken tile to maintenance over two months ago and was told the facility was waiting to repair the tile because they planned to remodel. 3. Interview with housekeeper # 1 on 2/5/26 at 8:59 AM revealed maintenance would have been notified if there were objects requiring repair, which included doors. 4. Interview with housekeeper # 2 on 2/5/26 at 9:02 AM revealed maintenance and supervisory staff would be notified if items were in need of repair. 5. Interview with the maintenance director on 2/5/26 at 11:18 AM confirmed he was aware of the broken tiles and revealed the repair was pending a remodel of the unit which was planned to start in March. Further interview revealed the bathroom door had been on order for a couple months.	F0584		
F0689 SS = D	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 staff interview, medical record review and policy review, the facility failed to ensure residents received adequate supervision to prevent accidents for 1 of 4 residents (#3) reviewed for accident hazards. The findings were: 1. Review of the 1/2/26 quarterly MDS assessment for resident #3 showed s/he was admitted to the facility on 8/11/25, had a BIMS score of 11 out of 15, which indicated moderate cognitive impairment, and diagnoses which included Alzheimer's disease, Non-Alzheimer's dementia, and cancer. Further review showed the resident's mood interview revealed the resident had	F0689	F0689 – Free of Accident Hazards/Supervision/Devices Corrective Action for Resident #3: Resident #3 discharged AMA on 11/7/2025 Resident readmitted on 11/14/2025, reassessed for elopement risk. Care plan was updated to include specific supervision interventions. 2. Identification of Other Residents Potentially Affected: DON reviewed all recent elopement assessments and care plans included appropriate interventions on 2/27/2026 Systemic Changes: Don or designee to educate facility staff on elopement policy and supervision expectations including what to do if a resident verbalizes wanting to leave the building on or before 3/10/2026. Elopement drill conducted by DON on 2/27/2026. 4. Monitoring: DON or designee will audit 5 resident elopement risk assessments and care plans for appropriate interventions weekly x 4 weeks, then monthly x 2 months. Results of audit will be reviewed at QAPI until substantial compliance is achieved.	03/10/2026

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 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Horn Rehabilitation and Care Center	**1851 Big Horn Ave , Sheridan, 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 5 reported feeling down, depressed or hopeless for 12 to 14 days of the 14-day look-back period. The resident was coded as receiving an antipsychotic medication. Review of the resident's progress notes showed the resident reported s/he was going to leave the building. The following concerns were identified: a. Review of the medical record showed the resident's 8/11/25 elopement evaluation score was 0. b. Review of a progress note dated 11/6/25 and timed 1:06 PM showed the resident informed the SSD that s/he was going to leave the facility. The SSD called the Ombudsman and left a message, and the social services assistant called the Department of Family Services (DFS). The SSD advised the resident that if s/he left the building, she would call the police because s/he was not safe to leave. She left a message for the resident's power of attorney (POA) and spoke to the resident's son, who stated he could not take the resident and advised the resident to stay at the facility. c. Review of a progress note dated 11/6/25 and timed 2:02 PM showed the resident's POA told the resident she could not take him/her, and s/he needed to stay at the facility. The resident became angry and said s/he was leaving the facility. The resident returned to the television room. Further review showed the nursing staff would inform the SSD if the resident left. d. Review of a progress note dated 11/6/25 and timed 5:05 showed the resident declined his/her evening medications, and wanted to leave the facility. The nurse on duty, DON and SSD spoke with the resident. e. Review of a progress note dated 11/6/25 and timed 5:11 PM showed the nurse encouraged the resident not to pull out his/her foley catheter, and the resident "was ranting about leaving" and having his/her family member pick him/her up that night. The resident went into his/her room and shut the door. The nurse notified the DON who went to talk to the resident. f. Review of a progress note dated 11/6/25 and timed 5:15 PM showed the resident left his/her room with 2 bags of clothing, walked towards the lobby, and stated s/he was going home with family. The DON arrived to talk to the resident at that time. g. Review of a progress note dated 11/6/25 and timed 6:53 PM showed the SSD called the resident's POA to inform her that the resident had calmed down and was watching television when she left the office. During	F0689	Continued from page 5 5. Completion Date: 3/10/2026	

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 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Horn Rehabilitation and Care Center	**1851 Big Horn Ave , Sheridan, 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 6 the phone call, the POA informed the SSD that the resident was at her home. The SSD called the DON to check if the staff had called the police. h. Review of a progress note dated 11/6/25 and timed 7:43 PM showed the SSD called the police department at 7 PM to inform them of the resident's situation and the address s/he could be located. i. Review of a progress note dated 11/6/25 and timed 8:40 PM showed at approximately 6:30 PM the staff had been unable to locate the resident, and elopement protocol was initiated within the facility immediately. The staff conducted a search of the facility and had been unable to locate the resident within the facility. Law enforcement had been notified by the SSD. The DON met with law enforcement and notified the NHA. The DON and law enforcement traveled to the reported location where the resident had been reported, and the resident was found with no visible injuries, and denied suicidal ideation. The resident initially refused to return to the facility. After approximately 30 minutes of conversation the resident agreed to return to the facility with the DON. Nursing staff were advised to initiate 15-minute checks, the DON verified all door alarms were on, and sat with the resident for approximately 60 minutes. Staff were to monitor the resident closely and report any behavioral changes. 2. Review of the resident's care plan initiated on 11/7/25 showed the resident was an elopement risk related to adjustment to the nursing home, impaired safety awareness, history of elopement attempts and leaving against medical advice (AMA). Interventions were to assess for fall risk, offer emotional and psychological support, orient resident to the environment, and reorient/validate and redirect the resident as needed. 3. Review of the medical record showed no evidence additional supervision was implemented after the resident made statements regarding a desire to leave. 4. Interview with the SSD on 2/5/26 at 2:05 PM revealed the resident had told the staff he wanted to leave, and the staff attempted to calm him/her down. She reported after she left for the evening, the resident showed up at his/her POA's home, and the DON was able to talk the resident into returning. She stated the resident signed against medical advice (AMA) papers the following day, and was picked up and taken to the hospital by the police. Further interview revealed the resident had apologized and was aware s/he had made a bad decision.	F0689		

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 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Horn Rehabilitation and Care Center	**1851 Big Horn Ave , Sheridan, 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 7 5. Interview with the DON on 2/5/26 at 2:19 PM revealed the facility staff had made multiple attempts to contact the residents POA and family, both were verbal about their desire to not be involved in the resident's decision to leave the facility, and the resident's family informed the resident s/he was unable to return home. Following the elopement, the resident's POA rescinded their POA. The DON reported she had stayed with the resident for part of the evening prior to his elopement. Further interview revealed she was unsure if the resident had a wanderguard. 6. Review of the policy titled "Elopements," undated, and provided by the NHA on 2/5/26 showed "…This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk…1. The facility is equipped with door locks/alarms to be used as necessary to help avoid elopements. 2. Staff are to be vigilant in responding to alarms in a timely manner. A. Monitoring and Managing Residents at Risk for Elopement Residents will be assessed for risk of elopement upon admission and throughout their stay by the interdisciplinary care plan team...c. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly…"	F0689		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F0812	F0812 – Food Procurement/Store/Prepare/Serve – Sanitary 1. Corrective Action: Kitchen surfaces, refrigerator, soap dispenser, and ice machine were immediately cleaned and sanitized on 2/5/2026 Undated food items were discarded on 2/6/2026 Temperature logs were implemented for walk-in refrigerator, freezer, and dish machine on 2/5/2026 Thermometer placed in walk-in unit on 2/5/2026. 2. Identification of Other Areas Potentially Affected: All residents have potential to be at risk for alleged deficient practices. 3. Systemic Changes:	03/10/2026

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 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Horn Rehabilitation and Care Center	**1851 Big Horn Ave , Sheridan, 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
F0812 SS = F	Continued from page 8 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, review of manufacturer's instructions, and facility policy review, the facility failed to ensure a sanitary environment in 1 of 1 kitchen. The findings were: 1. Regarding unsanitary items in the kitchen preparation area: a. Observation on 2/4/26 beginning at 9:15 AM showed the Traulsen refrigerator had visible grime and dried food particles on the surface, and a sticky handle when touched to open. The soap dispenser at the handwashing sink had a dark, reddish build-up on the pump. The ice machine scoop was placed on top of the machine next to packaged hair nets. 2. Regarding food safety: a. Observation on 2/4/26 beginning at 9:15 AM showed undated, unlabeled package of ham was found inside the Traulson refrigerator. The walk-in refrigerator did not show a temperature on the thermostat. A partially uncovered, undated bowl of crushed vanilla wafers was found on a bottom shelf of the walk-in pantry. There were no logs visible for the walk-in refrigerator and freezer. 3. Regarding monitoring dish machine temperature requirements: a. There were no temperature logs available for the Ecolab XL dishwashing machine. 4. Interview with the assistant dietary manager on 2/4/26 at 10:15 AM confirmed there were no logs for dish machine temperatures. Further interview revealed the ice scoop was washed after each use and placed on top of the dish machine. He confirmed the ham was undated, and should have been labeled with the name of the food and date it was opened. He did not know what the spot on the soap dispenser was. He reported the temperature on the walk-in refrigerator should have been at 20 to 30 degrees, and he thought the dietary manager kept logs on the walk-in refrigerator and freezer.	F0812	Continued from page 8 Daily temperature logs for refrigerators, freezers, and dish machine implemented Daily sanitation checklist implemented. Dietary Manager to educate dietary staff on labeling, dating, sanitation, and manufacturer temperature requirements, ice scoop storage on or by 3/10/2026 4. Monitoring: Dietary Manager or designee to audit kitchen sanitation, food appropriately labeled and temperatures of refrigerators, freezers, and dishwasher within range weekly x 4 weeks, then monthly x 3 months. Results of audit will be reviewed at QAPI until substantial compliance is achieved.	

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 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Horn Rehabilitation and Care Center	**1851 Big Horn Ave , Sheridan, 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
F0812 SS = F	Continued from page 9 5. Interview with the director of maintenance on 2/4/26 at 12:11 PM confirmed there were no temperature logs for the walk-in refrigerator or freezer, and the outside temperature of the refrigerator was incorrect. He reported he placed a thermometer in the walk-in and ordered a new thermostat. 6. Review of the Hobart dish machine manufacturer's instructions provided by the NHA on 2/5/25 showed the minimum operating temperatures should be 150 degrees for wash and 180 degrees for sanitizing rinse. 7. Review of the facility policy titled "Monitoring of Cooler/Freezer Temperature," undated, and provided by the NHA on 2/5/26 showed "…1. Logs for recording temperatures for each refrigerator or freezer will be posted in a visible location outside the freezer or refrigerator unit. A. Temperatures will be checked and logged daily by designated personnel. B. Logs will be changed out and filed each month. 2. All refrigerated storage must be maintained at or below 41 degrees F [Fahrenheit], unless otherwise specified by law. 3. All frozen storage must be maintained at or -4 degrees F, unless specified by law…9 Refrigerated food shall be labeled, dated, and monitored so that it is used by the use by date, frozen, or discarded, whichever is applicable…" 8. Review of the facility policy titled "Sanitation Inspection," undated, and provided by the NHA on 2/5/26 showed "…1. All food areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies and other insects. 2. The department shall establish a sanitation program for food services based on applicable state and federal requirements…4. Sanitation inspections will be conducted in the following manner: a. Daily: Food service staff shall inspect refrigerators/coolers, freezers, storage area temperatures, and dishwasher temperatures daily…"	F0812		
F0850 SS = D	Qualifications of Social Worker >120 Beds CFR(s): 483.70(o)(1)(2) §483.70(o) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is: §483.70(o)(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree	F0850	F0850 – Qualifications of Social Worker Corrective Action: The facility secured consultation services with a qualified social worker meeting regulatory requirements. All social service assistants completed training on 2/26/2026 to include job duties and scope of practice including when to escalate concerns to Director/Consultant and chain of command.	03/10/2026

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 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Horn Rehabilitation and Care Center	**1851 Big Horn Ave , Sheridan, 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
F0850 SS = D	Continued from page 10 in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and §483.70(o)(2) One year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, the facility failed to ensure social services were provided to residents by a qualified social worker. The findings were: 1.Interview with the SSD on 2/4/26 at 4:40 PM revealed she started the job in October 2025. Further interview confirmed her bachelor's degree was in criminal justice. She reported she reached out to the social worker in another facility if she had any questions, but did not have any regular scheduled meetings with her. 2.Interview with the NHA on 2/5/26 at 1:55 PM revealed he assumed the SSD had someone she consulted with between her date of hire and now. Further interview revealed he did not have a facility policy on the required qualifications.	F0850	Continued from page 10 2. Identification of Other Residents Potentially Affected: All residents have the potential to be affected by alleged deficient practice. 3. Systemic Changes: Consultant will continue with routine visits and oversight of social service assistants. RDCS educated social service assistants on consultant contract. Ensured social service assistants had correct contact information for consultant on or before 3/10/2026 4. Monitoring: Administrator or designee will verify social services compliance monthly and report to QAPI. 5. Completion Date: 3/10/2026	