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 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Horn Rehabilitation and Care Center	**1851 Big Horn Ave , Sheridan, 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 recertification survey was conducted by Healthcare Licensing and Surveys from 5/4/26 through 5/7/26. Also reviewed in the course of the survey were complaint intakes 2747873, 27900307, 2795622, 2798383, 2807616, 2967869, 2982725, 2995085, 3001173, and 3001446. The following common abbreviations are used throughout this document: ADON: Assistant Director of Nursing ADLs: Activities of Daily Living AMA: Against Medical Advice BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing ED: Emergency Department IP: Infection Preventionist LPN: Licensed Practical Nurse MDS: Minimum Data Set NHA: Nursing Home Administrator POA: Power of Attorney Less commonly used abbreviations will be annotated in each deficiency.	F0000		06/03/2026
F0583 SS = F	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F0583	F583 (Privacy & Confidentiality) Corrective Action Resident #83 and Resident #84 no longer reside in the facility.	06/03/2026

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

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F0583 SS = F	Continued from page 1 §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and policy review, the facility failed to ensure residents' right to secure and confidential personal and medical records. The census was 73. The findings were: 1. Review of the medical record for resident #26 showed the resident received hospice facility's beginning on 1/2/26. Further review showed the hospice provided documented notes directly into the electronic medical record system. 2. Review of the medical record for resident #83 showed the resident received hospice facility's beginning on 1/21/26. Further review showed the hospice provided documented notes directly into the electronic medical record system. 3. Review of the medical record for resident #84	F0583	Continued from page 1 The Director of Nursing verified that the hospice company involved no longer has access to login to any portion of the residents' medical records or electronic health information. Identification of Other The Director of Nursing reviewed all Point Click Care user accounts to ensure that no hospice personnel had access to any resident electronic health records. No additional concerns were identified. Systemic Changes The Regional Director of Clinical Services provided education to all staff regarding residents' rights to privacy and confidentiality of their medical records. The training emphasized that hospice personnel are not permitted to access the facility's EHR system. An Ad Hoc QAPI was held with IDT and medical director to review the deficiency, identify root cause analysis, and accept the plan of correction. Monitoring The Director of Nursing or Designee will audit Point Click Care user access monthly for three months to ensure no unauthorized hospice users are present in the system. Any discrepancies will be addressed immediately. Audit results will be reviewed during the monthly QAPI meeting until the committee determines substantial compliance has been maintained. Date of Compliance: June 3, 2026	06/03/2026

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F0583 SS = F	Continued from page 2 showed the resident received hospice facility's beginning on 2/5/26. Further review showed the hospice provided documented notes directly into the electronic medical record system. 4. Interview with the regional clinical director on 5/6/26 at 12:44 PM revealed the only hospice used prior to a change in operator, was given full access to the electronic medical record for all residents. 5. Review of the policy titled "Resident Rights" last revised on 6/10/25 showed "...7. Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records...b. The resident has a right to secure and confidential personal and medical records. i. The resident has the right to refuse the release of personal and medical records except as provided at §483.70 (i) (2) or other applicable federal or state laws..."	F0583		06/03/2026
F0561 SS = E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in	F0561	F561 (Self Determination) Corrective Action Resident #83 and Resident #84 no longer reside in the facility. The POA for Resident #26 was contacted by Social Services to review satisfaction with the current hospice provider and to inform responsible party that an additional hospice agency will be contracted with the facility should she wish to change providers at that time. The POA expressed satisfaction with the current hospice provider and declined any change. Identification of Others The Social Services Director contacted the responsible parties for all residents currently receiving hospice services to inform them of the facility being in the process of contracting with a second hospice provider and to offer choice. Any responsible party expressing dissatisfaction would have been provided with information regarding Sheridan Hospice. No residents or responsible parties reported dissatisfaction with their current hospice provider.	06/03/2026

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F0561 SS = E	Continued from page 3 other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and policy review, the facility failed to ensure residents' right to choose health care and providers of healthcare for 3 of 12 sample residents (#26, #83, #84) reviewed for hospice services. The findings were: 1. Review of the medical record for resident #26 showed the resident received hospice services beginning on 1/2/26. Further review showed no evidence the resident was offered a choice in hospice provider. 2. Review of the medical record for resident #83 showed the resident received hospice services beginning on 1/21/26. Further review showed no evidence the resident was offered a choice in hospice provider. 3. Review of the medical record for resident #84 showed the resident received hospice services beginning on 2/5/26. Further review showed no evidence the resident was offered a choice in hospice provider. 4. Interview with the regional clinical director on 5/6/26 at 12:44 PM confirmed prior to the operator transition, residents on hospice were not given a choice for hospice provider. 5. Review of the policy titled "Resident Rights" last revised on 6/10/25 showed "...5. Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: a. The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part..."	F0561	Continued from page 3 Systemic Changes The Regional Director of Clinical Services provided education to all staff regarding residents' rights to hospice choices, specifically the requirement that residents receiving or needing hospice services must be offered a choice of hospice providers. The facility's admission and hospice referral processes were reviewed and updated to ensure hospice choice is consistently offered and documented. An Ad Hoc QAPI was held with IDT and medical director to review the deficiency, identify root cause analysis, and accept the plan of correction. Monitoring The Director of Nursing or designee will audit all new hospice referrals weekly for four weeks, then monthly for 2 months or until QAPI determines substantial compliance has been achieved to verify that hospice choice was offered, documented, and communicated to the resident or responsible party. Any concerns will be addressed immediately. Audit findings will be reviewed during monthly QAPI meetings until the committee determines substantial compliance has been achieved. Date of Compliance: June 3, 2026	06/03/2026
F0684 SS = E	Quality of Care CFR(s): 483.25	F0684	Corrective Action Residents #69 & #81 have discharged from the	06/10/2026

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F0684 SS = E	Continued from page 4 § 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 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 observation, medical record review, staff and family interview, and policy review, the facility failed to implement interventions and treatment for 4 of 4 sample residents (#1, #6, #69, #81) reviewed for a change in condition. The findings were: 1. Review of the quarterly MDS assessment dated 3/18/26 showed resident #1 had a BIMS score of 15 out of 15, which indicated intact cognition, and diagnoses which included metabolic encephalopathy, coronary artery disease, pulmonary hypertension, peripheral vascular disease, pneumonia, hyponatremia, and chronic respiratory failure. Review of the care plan last revised 4/30/26 showed a focus on safety with tobacco use, ADLs, nutrition related to esophageal obstruction and antidepressant medications. The following concerns were identified: a. Review of a progress note dated 2/1/26 and timed 6:45 AM showed the resident had an unwitnessed fall in his/her bathroom. Vital signs included with the note dated 2/1/26 and timed 6:35 AM were blood pressure (BP) of 150/90, heart rate (HR) of 81, respiratory rate (RR) of 22, temperature of 98.4 degrees Fahrenheit (F) and an oxygen saturation of 88% on 3 lpm via nasal cannula (NC). There was no evidence of a follow up assessment. b. Review of a progress note dated 2/1/26 and timed 7:09 PM showed the resident reported s/he had a fall but was in bed at the time the call light had been answered. The vital signs included with the note were a BP of 126/88, HR of 78, RR of 22, temperature of 98.4 degrees F and an oxygen saturation of 90% on 2 LPM via nasal cannula. Review of the vital signs record showed the recorded vital signs were dated 2/1/26 and timed 2:44 PM, and did not reflect the resident's status at time of the fall. There was no evidence the resident had been assessed following the fall. c. Review of a progress note dated 2/3/26 and timed 2:33 PM showed "3X [3 times] res to request staff to	F0684	Continued from page 4 facility; On 5/24/26, Resident #1 received a assessment and vital signs from the Director of Nursing or designee to ensure the resident was at baseline. Any abnormal findings were reported to the provider. On 5/26/26 Resident #6 received a full assessment and vital signs from the Director of Nursing or designee to ensure the resident was at baseline. Any abnormal findings were reported to the provider. Identification of Others The Director of Nursing reviewed resident progress notes from the past 7 days to identify any residents with a potential change in condition. For any resident identified as having a change in condition without a documented full assessment or vital signs, a assessment and vital signs were immediately completed. The provider was notified of any abnormal findings. Systemic Changes The Director of Nursing provided education to licensed nursing staff regarding the requirement that any resident with a change of condition must receive a assessment and vital signs. The expectation that providers must be notified promptly of abnormal findings. Documentation must clearly reflect the assessment, vital signs, provider notification, and follow-up actions. Monitoring: The Director of Nursing or Designee reviews the 24-hour report from the previous day, reviews the residents medical record specifically the progress notes, clinical assessment and provider notification. If the nurse did not accurately document or report to the provider, the provider will be notified of the change of condition, assessment completed, and an education will be completed with the nurse. The DON or designee will conduct audits	06/10/2026

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F0684 SS = E	Continued from page 5 check [his/her] O2. 3 times [his/her] cannula was in [his/her] nares upside down or completely off. Nurse to place cannula in the correct position and requested res to breath deep with [his/her] nose, and out mouth. O2 was back to baseline in less than 10min. Res without respiratory distress. No cough. Res educated on position of cannula in nares." There was no evidence the resident's vital signs were taken or lungs were assessed. d. Review of a progress note dated 2/4/26 and timed 10:59 AM showed the resident refused his/her shower due to not feeling well. There was no evidence the resident had been assessed. e. Review of a progress note dated 2/4/26 and timed 12:48 showed "floor nurse alerted this nurse resident not looking well," the resident could not respond verbally and had been on 3 lpm oxygen via NC. The resident's oxygen had been turned up to 5 lpm and was recorded at 88%. The resident had used accessory muscles with dyspnea, and lungs were auscultated as clear but diminished in bases bilaterally. Further review showed the resident was sent by ambulance for assessment and treatment following the assessment. f. Review of the discharge summary dated 2/11/26 showed a transfer on 2/4/26 where the resident had been taken to the emergency department due to respiratory failure with oxygen saturations in the 50 % range, requiring oxygen at 10 liters per minute (lpm). Further review showed the additional oxygenation needs escalated to BiPAP assistance for respiratory failure, left lower lobe pneumonia, acute heart failure, and dry gangrene. The resident was treated with antibiotics, thoracentesis for a pleural effusion and diuretics. g. Review of a progress note dated 3/5/26 and timed 11:10 AM showed the resident was "lethargic" during medication pass. There was no evidence of vital signs or assessment. h. Review of a progress note dated 3/5/26 and timed 12:06 PM showed the resident was sent to the emergency room for lethargy, confusion and abnormal sodium level. There was no evidence of assessment or vital signs. i. Review of a late entry progress note titled "progress note*NEW*" dated 3/5/26 at 9 AM contained resident assessment and vital signs. Review of the progress notes showed a "Late entry" note for the incident dated 3/5/26 and timed 9 AM was added on 5/6/26, 62 days after the incident.	F0684	Continued from page 5 as follows: Review residents with documented changes of condition, (1) times per week for eight (8) weeks; Each audit will verify: A assessment was completed. Vital signs were obtained. Provider notification occurred when indicated. Documentation is complete and timely. Audits will continue until QAPI determines substantial compliance has been achieved. Any discrepancies will be corrected immediately. Audit results will be reviewed during monthly QAPI meetings.	06/10/2026

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F0684 SS = E	Continued from page 6 j. Review of the hospital admission progress note dated 3/10/26 showed the resident had been admitted on 3/5/26 for hyponatremia with decreased serum osmolality, metabolic encephalopathy, and pulmonary edema. The resident required fluid restriction, diuresis, and a PICC line placement. k. Review of the late entry progress note titled “progress note*NEW*” dated 4/27/26 at 5:40 PM showed the resident had been found by a dietary aid unresponsive and an ambulance had been called. There was no evidence of an assessment or vital signs. l. Review of the hospital admission note dated 4/30/26 showed resident was admitted on 4/27/26 after s/he had an episode of unresponsiveness for 20 minutes with hypoxia. The admission diagnoses were encephalopathy, critical hypokalemia, hypomagnesemia, hyponatremia, new onset atrial fibrillation with RVR, and acute kidney injury. 2. Review of the quarterly MDS assessment dated 4/18/26 showed resident #69 had a BIMS score of 14 out of 15, which indicated minimal to no cognitive dysfunction with diagnoses of chronic myeloid leukemia, coronary artery disease, seizure disorder, traumatic brain injury, and chronic obstructive pulmonary disease. Review of the care plan dated 2/3/26 indicated staff would evaluate his/her respiratory rate and effort, skin color, temperature and characteristics related to risk of impaired gas exchange. The following concerns were identified: a. Observation on 5/4/26 at 4:10 PM showed the resident was on the edge of his/her bed and had his/her hands on his/her knees leaned forward. The resident’s respiratory rate was 30-40 times a minute and s/he had a grey pallor. Further observation showed the resident did not have oxygen on. b. Interview with medication assistant-certified (MA-C) #1 on 5/5/26 at 8:26 AM revealed the resident had been sent to the hospital due to respiratory failure. c. Review of the progress notes on 5/5/26 showed no evidence of documentation related to the transfer. d. Review of a progress note provided by the facility dated 5/6/26 and timed 5:14 PM showed LPN #1 documented for 5/4/26 at 11 PM the nurse went to check on the resident to get obtain vital signs and	F0684		06/10/2026

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F0684 SS = E	Continued from page 7 s/he had an oxygenation of 60% on 4 lpm NC with difficulty breathing. The nurse administered a breathing treatment when the resident became lethargic and would not respond to verbal stimuli. The note showed the nurse placed a call to “on call” and gathered transfer paperwork. Further review showed the nurse attempted to call his/her guardian but it was after hours. e. Interview with LPN #1 on 5/7/26 at 12 PM revealed on the afternoon of 5/4/26 the resident had been reported as unsteady on his/her feet which prompted her to assess the resident. She had him/her sit down and checked his/her oxygen and it was a little low. She checked on the resident “a little later” and she found him/her on the floor with an elevated temperature and an oxygen saturation in the 50-60’s. The LPN revealed she provided the resident with a nebulizer treatment, and tried to contact the administrator, but was unsuccessfully. The LPN revealed she rechecked the resident’s oxygen, which was 70%, and she then made the decision to send him/her to the emergency department. The LPN revealed she was the only one working on the unit at the time and was unable to notify the guardian and reported that at shift change to the next nurse. Further interview revealed she was asked by administration to come in on her day off to document the assessment and transfer. 3. Review of the admission MDS assessment dated 4/26/26 showed resident #81 had a BIMS score of 5 out of 15, which indicated severe cognitive impairment, and had diagnoses which included cervical spondylolysis, atrial fibrillation, coronary artery disease, diabetes, non-Alzheimer’s dementia, and chronic obstructive pulmonary disease. Further review showed the resident was at risk for falls and had two or more falls since admission. The following concerns were identified: a. Review of the fall risk assessment dated 4/20/26 at 2:59PM showed a fall risk score of 12 which indicated the resident was at medium risk for falls. b. Review of a progress note dated 4/20/26 and timed 11:45 PM showed the resident had fallen and vital signs had been obtained. Further review showed the area of the template for resident assessment had been left blank. c. Review of the document titled “N-Adv skilled evaluation” created on 5/5/26 at 3:54 PM and dated for 4/23/26 at 3:35 PM showed an assessment that identified the resident had pain, confusion and unsteadiness on standing and no risks for safety	F0684		06/10/2026

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F0684 SS = E	Continued from page 8 concerns. d. Review of a progress note dated 4/25/26 and timed 1:24 PM showed housekeeping reported the resident was on the floor in the reception area. The resident's vital signs were taken, the resident assessment was within normal limits, and staff did not know if the resident hit his/her head. Further review showed no evidence follow up assessments were performed. e. Review of a progress note dated 4/30/26 and timed 5:16 AM showed the resident had been found on the floor outside his/her door with his/her back against the wall after staff had heard a loud crash. The resident had been found with hands on his/her head and complained of pain. f. Review of the interdisciplinary team event review meeting on 4/30/26 at 10:07 AM showed a review of the fall. The root cause had been identified as impaired cognition, weakness and self-transfers. The immediate intervention had been to perform a head-to-toe assessment where a new skin tear had been identified. g. Interview with the resident's representative #2 5/7/26 at 12:58 PM revealed for the 10 days the resident at the facility, she had checked on him/her daily and watched him/her decline. She revealed when she arrived on 4/30/26 the resident appeared to be in a high level of pain, which appeared to affect his/her cognition, and the resident was not acting at his/her baseline. The representative revealed the resident had been visibly disheveled, his/her brief was saturated, and the room smelled of urine. She revealed she observed swelling in his/her neck and the resident did not have his/her pain patch on. The representative revealed the facility stated they were going to run tests for him/her and nothing happened. The representative revealed she decided to call the ambulance for the safety of the resident and to get his/her pain addressed, however; the facility staff said they would call for her. She revealed she followed the resident to the hospital and reported s/he returned to his/her baseline after the pain was under control and the swelling in his/her neck went down. Further interview revealed she reported no vital signs had been taken or an assessment performed from the time she arrived at the facility until the time the resident was sent to the hospital. 4. Review of the quarterly MDS assessment dated 4/5/26 showed resident #6 had a BIMS assessment of 12/15 which indicated moderate cognitive	F0684		06/10/2026

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F0684 SS = E	Continued from page 9 impairment, and diagnoses which included cancer, coronary artery disease, heart failure, renal insufficiency, renal failure, or end-stage renal disease, obstructive uropathy, Alzheimer's disease, and non-Alzheimer's dementia. Review of the medical record showed the resident received a diagnosis of severe sepsis with septic shock on 12/1/25. The resident had an indwelling catheter. Review of the care plan last revised on 12/8/25 showed the resident had a risk of UTIs related to the foley catheter, urinary retention, and prostate cancer. Interventions in place were to monitor and record output, changes in amount, color, or odor of urine. The following concerns were identified: a. Review of a practitioner note dated 12/22/25 and timed 10:57 PM showed "...This is a 81 y/o [identifier] being seen [sic] follow-up visit at Big Horn rehab. [S/he] returned to the facility yesterday after a hospitalization over the weekend for acute sepsis related to [his/her] UTI/prostate cancer. [S/he] has completed [his/her] vancomycin treatment at this time[sic] [Name] is pleasant siting up in [his/her] recliner and denies needs. [S/he} denies pain. Nursing denies acute mentation change. Trending vital signs stable. No fever night sweats or chills. Unfortunately, labs were not obtained...Urinary tract infection, site not specified, Sepsis, unspecified organism. ..No acute concern for systemic infection, cardiac or respiratorydistress[sic]." b. Review of a progress note dated 12/26/25 and timed 5:46 AM showed "thick cloudy output in Cath drainage bag." c. Review of a progress note dated 12/27/25 and timed 4:51 AM showed "...This resident was complaining of pain and has had no output from [his/her] catheter since the previous shift had changed the urine bag [sic] The family had called several times to tell us we need to send [him/her] to the ER. I spoke with the ER nurse who stated she had spoken with the same family member and the ER nurse told the family we are capable of changing the catheter without a trip to the ER. I changed the foley catheter using sterol technic [sic]. The foley was draining well but had some bloody urine output. The resident complained of pain but the source of the pain appeared to be in his stomach area not [his/her] bladder." d. Review of the treatment administration record (TAR) for December 2025 showed on 12/24/25 the resident's output was 300 milliliters (mL) between 6 AM to 6 PM and 250 mL between 6 PM and 6 AM.	F0684		06/10/2026

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F0684 SS = E	Continued from page 10 On 12/25/25 the resident's output was 600 mL between 6 AM and 6 PM, 50 mL between 6 PM and 6 AM and 250 mL between 6 PM and 6 AM. On 12/26/25 the resident's output was 50 mL between 6 AM and 6 PM, and 120 mL between 6 PM and 6 AM. On 12/27/25 the resident's output was 550 mL between 6 AM and 6 PM, and 550 mL between 6 PM and 6 AM. e. Review of a progress note dated 12/28/25 and timed 9:58 AM showed "...Resident did not get up for breakfast., Nurse did get [him/her] to take [his/her] meds. Received phone call from [name] who wanted us to send [him/her] to the hospital. Resident said [s/he] didn't want to go to hospital. Nurse called [name] and reported [his/her] response. V/s [vital signs] 98.2 = t [temperature] rsp [respirations].. 24 bpm [beats per minute] pulse 82 ; 140/85; 02 [oxygen] 92% Nurse has called NOC [nurse on call] and reported Action." f. Review of a progress note dated 12/28/25 and timed 10:46 AM showed "...Resident able to sit up 2 assist. washed face, changed shirt, drank 120 cc [cubic centimeters] fluid. with cuing. Nurse held glass, Assist of two to transfer to wheelchair, and then to recliner. Urine in cath bag cloudy grayish yellow, Noc [nurse on call] notified that resident will go to the hospital, Said [s/he] be right in. [name] notified of action..." g. Review of a progress note dated 12/28/25 and timed 11:43 showed the resident was transferred to the ED at 12:45 PM. Further review showed no evidence of the resident's catheter output. h. Review of the emergency room (ER) final report dated 12/28/26 and timed 1:09 PM showed "...Reportedly care team at BHR changed his/her foley yesterday but unfortunately caused traumatic injury and hematuria d/t inflating the balloon in the prostatic urethra. It has since been repositioned and is draining purulent urine...recently admitted 11/26/25 to 12/1/25 for sepsis d/t UTI...[S/he] is also found to have AKI [Acute Kidney Injury] with creatinine of 2.55 with baseline approximately 1.25..." h. Interview with the DON on 5/7/26 at 12:50 PM revealed the staff watched the resident's output for 1 shift, changed the resident's catheter, and initiated vitals. She confirmed the nurses did not always follow through with her expectations for assessments. Further interview confirmed only vitals were completed, and from 12/26/25 until the resident was sent to the hospital on 12/28/25, the ongoing assessment was not completed as	F0684		06/10/2026

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F0684 SS = E	Continued from page 11 expected. 5. Interview with the DON on 5/7/26 at 9:40 AM revealed she expected documentation for resident transfers to include a discharge note with the resident condition, vital signs, family notification, physician notification, nurse management notification, and a report to the facility and ambulance services. She revealed the documentation should be done immediately or within 24 hours. She revealed she expected vital signs to be performed when concerns for change of condition had occurred and the nurses had discretion on the appropriate clinical response after they assessed residents.	F0684		06/10/2026
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, review of manufacturer's instructions, and policy and procedure review, the facility failed to label medications with the date medications were opened and/or expired in 2 of 2 medication fridges. The findings were:	F0761	F761 (Medication Storage, Labeling, and Discarding) Corrective Action The Director of Nursing audited the Rock Creek medication room to ensure all Ozempic pens were labeled with the appropriate open date. The Director of Nursing audited the Secure Unit refrigerator to ensure Tubersol and Ativan multi-dose vials were labeled with both open and discard dates. Any pens or vials found without proper labeling were discarded immediately and replaced. Identification of Others The Director of Nursing completed an audit on all medication carts and medication refrigerators throughout the facility to ensure all insulin pens and multi-dose vials were labeled with required open and discard dates. Any items found without proper labeling were discarded and replaced. Systemic Changes The Director of Nursing provided education to all nurses and medication aides regarding the facility's policy and regulatory requirements for labeling insulin pens and multi-dose vials with both open and discard dates. Staff were instructed on proper labeling procedures and the importance of compliance to ensure medication safety.	06/03/2026

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F0761 SS = E	Continued from page 12 1. Observation on 5/6/26 at 10:48 AM in the Rock Creek medication fridge showed an Ozempic 8mg/3ml pen with no “opened on” or “discard on” date. 2. Interview with medication assistant-certified (MA-C) #1 on 5/6/26 at 10:49 AM confirmed the Ozempic pen was opened and used the day before and there was no “opened on” or “discard on” date written on it. 3. Observation on 5/6/26 at 12:12 PM in the secure unit fridge, showed an opened Tubersol with no “opened on” or “discard on” date. Further observation showed an opened Ativan oral solution 2mg/ml with no “opened on” or “discard on” date. 4. Interview with LPN #2 on 5/6/26 at 12:13 PM confirmed the Tubersol and Ativan were in use and there was no “opened on” or “discard on” dates on either. 5. Interview with the DON on 5/7/26 at 12:34 PM confirmed she expected an “opened on” or “discard by” date written on in-use multi dose vials. 6. Review of the manufacturer’s medication guide, page 29, for Ozempic date last revised 1/2025 showed “After first use of the OZEMPIC pen, the pen can be stored for 56 days at controlled room temperature 59°F to 86°F (15°C to 30°C) or in a refrigerator 36°F to 46°F (2°C to 8°C).” 7. Review of manufacturer’s medication guide, page 2, for oral liquid Lorazepam showed “Discard opened bottle after 90 days.” 8. Review of manufacturer’s package insert, page 10, for Tubersol date last revised 03/18/22 showed “A vial of TUBERSOL which has been entered and in use for 30 days should be discarded.” 9. Review of the facility policy titled “Labeling of Medications and Biologicals” dated 5/16/25 showed “…8. Labels for multi-use vials must include: a. The date the vial was initially opened or accessed (needle-punctured); b. All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial…”	F0761	Continued from page 12 An Ad Hoc QAPI was held with IDT and medical director to review the deficiency, identify root cause analysis, and accept the plan of correction. Monitoring The Director of Nursing or designee will conduct audits of medication rooms, medication carts, and medication refrigerators ensuring all locations are audited each week for four weeks, then monthly for two months to ensure all insulin pens and multidose vials are properly labeled with open and discard dates. Any issues identified will be corrected immediately. Audit results will be reviewed during monthly QAPI meetings until substantial compliance is achieved and maintained. Date of Compliance: June 3, 2026	06/03/2026
F0849 SS = E	Hospice Services CFR(s): 483.70(n)(1)-(4)	F0849	F849 (Hospice Services Coordination) Corrective Action	06/03/2026

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F0849 SS = E	Continued from page 13 §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to	F0849	Continued from page 13 Resident #83 and Resident #84 no longer reside in the facility. Resident #7 was evaluated by the provider for hospice appropriateness, and an order for hospice services was obtained. Identification of Others The Director of Nursing provided the attending provider with a list of all current hospice residents to ensure each resident was evaluated for hospice appropriateness and that corresponding hospice orders were entered when indicated. No additional concerns were identified. Systemic Changes The Regional Director of Clinical Services educated the IDT team on required process for hospice referrals, specifically that any resident referred for hospice must be evaluated by the provider and have a hospice order entered before transfer to hospice services occurs. The facility's hospice referral workflow was reviewed and updated to ensure compliance. An Ad Hoc QAPI was held with IDT and medical director to review the deficiency, identify root cause analysis, and accept the plan of correction. Monitoring The Director of Nursing or designee will audit all new hospice referrals weekly for four weeks and then monthly for two months or until QAPI determines substantial compliance has been achieved to verify that provider evaluations and hospice orders are completed prior to transfer to hospice services. Any discrepancies will be corrected immediately. Audit results will be reviewed during monthly QAPI meetings until substantial compliance is achieved and maintained. Date of Compliance: June 3, 2026	06/03/2026

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F0849 SS = E	Continued from page 14 alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement	F0849		06/03/2026

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F0849 SS = E	Continued from page 15 must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides	F0849		06/03/2026

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F0849 SS = E	Continued from page 16 orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review and staff interview, the facility failed to ensure hospice services met professional standards for 3 of 12 sample residents (#7, #83, #84) reviewed for hospice services. The findings were: 1. Review of the medical record for resident #7 showed the resident received hospice services beginning on 3/31/26. Further review showed no evidence the resident had a physician order for a hospice referral or evaluation. 2. Review of the medical record for resident #83 showed the resident received hospice services beginning on 1/21/26. Further review showed no evidence the resident had a physician order for a hospice referral or evaluation. 3. Review of the medical record for resident #84 showed the resident received hospice services beginning on 2/5/26. Further review showed no evidence the resident had a physician order for a hospice referral or evaluation. 4. Interview with the regional clinical director on 5/6/26 at 12:44 PM confirmed residents who were placed on hospice did not receive a physician order for eval and the hospice used at that time was given access to the medical record for all residents.	F0849		06/03/2026
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F0880	Corrective Action: On 5/4/26, Resident #69 had clean linens changed and on 5/25/26, discharged from the facility.	06/11/2026

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F0880 SS = E	Continued from page 17 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F0880	Continued from page 17 As of May 7, 2026, Residents #55 and #67 were assessed for adverse outcomes related to cross contamination of food and beverage. Both showed no signs of adverse effects. On May 7, 2026, Oxygen tubing for resident #66 and #71 was replaced and dated. Identification of Other The DON or designee rounded on residents to ensure there were no residents with soiled linens. If there were soiled linens on a bed, the linens were changed. Dining area rounds by the DON or designee will show residents were assessed for adverse outcomes related to cross contamination of food and beverage. No adverse effects were identified. Resident nasal cannulas were clean and off the floor dated with the most recent Sunday's date. Systemic Changes DON or designee educated staff on the following infection control expectations: When staff identify soiled linens on a bed, the staff are to change the linens. Oxygen tubing to be changed every Sunday and if staff notice oxygen tubing on the floor, tubing must be replaced and dated. Hand Hygiene, food handling practices and cross contamination were presented to prevent resident adverse outcomes and contamination. Monitoring The DON or designee will conduct audits on:	06/11/2026

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F0880 SS = E	Continued from page 18 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and policy review, the facility failed to ensure infection prevention and control standards were implemented for 3 of 8 sample residents (#66, #69, #71) reviewed for resident care. In addition, the facility failed to implement infection prevention and control in 1 of 3 dining areas (main dining room) reviewed for meal service. The census was 73. The findings were: Related to Dining: 1. Observation on 5/4/26 beginning at 5:02 PM showed CNA #3 touched his hair then began handling the resident meal tickets. The CNA grabbed a bag of chips from a box on the tray cart and placed the bag of chips on top of a residents hamburger patty and top half of the hamburger bun. The CNA covered the plate with a cover an took it to resident #67 who was seated at a dining table. The CNA removed the cover and the resident removed the bag of chips from on top of his/her hamburger. Then with his exposed hand, the CNA grabbed the top of the resident's hamburger bun and applied jelly to the bun. The CNA placed the top of the bun on the burger and the resident ate the burger. No hand hygiene was performed until after the meal tray was delivered. After performing hand hygiene, the CNA pulled up his pants by touching the outside fabric and then began passing additional meal trays. At 5:11 PM the CNA touched his hair while applying a hairnet, then obtained a drink cup, holding it by the rim, and delivered the drink to a resident at a table. Without performing hand hygiene, the CNA returned to the steam table and continued passing	F0880	Continued from page 18 Random resident beds twice weekly to identify if there are soiled linens on beds. Random residents for oxygen tubing twice weekly for four weeks, then monthly for two months. Random dining room observation for Hand Hygiene, food handling practices and cross contamination twice weekly for four weeks, then monthly for two months Audit results will be reviewed during monthly QAPI meetings by the Medical Director until substantial compliance is achieved and maintained.	06/11/2026

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 05/07/2026

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

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F0880 SS = E	Continued from page 19 meal trays. The CNA was observed adjusting his pants 3 times while passing 2 meal trays in which he touched the eating surface of each plate, before performing hand hygiene. At 5:15 PM, the CNA was observed placing another bag of chips on top of a burger patty and top bun, prior to delivering it to a resident. At 5:18 PM the CNA was observed touching his hair, and without performing hand hygiene, he obtained a coffee cup by grabbing the rim of the cup. The CNA filled the cup with coffee and delivered it to resident #55. At 5:23 PM the CNA was observed readjusting his pants and at 5:27 PM he was observed touching the back of his hair, and without per then obtained 3 drinking cups by touching the rims of each glass, filled the cups from a carafe near the coffee, and took them to the meal cart. The CNA obtained 3 plastic lids, touching each side of the lid, and placed the lids on the glasses. 2. Interview with the infection preventionist and DON on 5/7/26 at 9:27 AM revealed they would expect staff to perform hand hygiene after touching anything that would cause contamination, such as hair, skin, or clothing. Further they confirmed the CNA should not have touched resident meal items without performing hand hygiene. Related to soiled linens: 1. Observation on 5/4/26 at 2:49 PM showed resident #69 had linen with visible bowel movement incontinence. Continued observation showed: a. At 2:56 PM the resident's top blanket was pulled up over sheets by staff. b. At 3:10 PM the resident was on the bed resting which had pulled down the top blanket and soiled linen was visible. c. At 3:39 PM the resident laid on top of his/her oxygen cannula that was on top of his/her soiled sheets. d. At 4:17 PM the resident was sat on the edge of his/her bed, the nasal cannula had fallen on floor and housekeeping had picked it up off the floor and placed it on the resident. Related to oxygen cannulas 1. Observation on 5/5/26 starting at 8:25 AM showed resident #71's nasal cannula had fallen on the floor and was dated 4/19/26. The medication assistant-certified (MA-C) #1 entered the resident's room and did not pick up the cannula. CNA #4	F0880		06/11/2026

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F0880 SS = E	Continued from page 20 entered the resident's room, removed the meal tray, and did not pick up the cannula. MA-C #1 entered the resident's room and administered the resident his/her inhaler, and tried to put the oxygen back on the resident after she picked it up off the floor and the resident declined. Continued observation showed: a. Observation on 5/6/26 at 9:11 AM showed the resident wore the oxygen tubing dated 4/19/26. b. Observation on 5/7/26 at 10:42 AM showed the oxygen tubing was dated 4/19/26 and the tubing was on the ground. 2. Observation on 5/5/26 at 2:52 PM showed resident #66's nasal cannula connected to oxygen concentrator was on the floor and was not dated. Continued observation showed: a. On 5/6/26 at 9:22 AM the resident's tubing to the concentrator was labeled 5/3/26 and was on the floor. b. Observation on 5/6/26 at 9:22 AM the resident's portable oxygen tubing was unlabeled. c. Observation on 5/7/26 at 10:50 AM the resident was wearing the oxygen tubing on the concentrator labeled 5/3/26. 3. Interview with the IP on 5/7/26 at 9:27 AM confirmed oxygen tubing should be changed and labeled weekly and as needed, or when visibly soiled. He stated staff who observed oxygen cannulas on the floor should not use them on residents, and were expected to replace the cannulas. Further interview confirmed soiled linens should be changed immediately. 4. Review of facility policy titled "Oxygen Concentrator", last revised on 5/1/25 showed "…5.c. Nurse responsibilities: i. change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated…"	F0880		06/11/2026
F0883 SS = E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-	F0883	Corrective Action Resident #4 was offered the pneumococcal vaccine. Consent was declined per resident's preference, and appropriate documentation was completed. Resident #33 was offered the pneumococcal vaccine and declined per resident's preference,	06/06/2026

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F0883 SS = E	Continued from page 21 (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the	F0883	Continued from page 21 and appropriate documentation was completed. Resident #66 was offered the pneumococcal vaccine. Consent was declined per resident's preference, and appropriate documentation was completed. Resident #1 was offered the pneumococcal vaccine. Consent was declined per resident's preference, and appropriate documentation was completed. E. Resident #69 has been discharged from facility. Identification of Others Director of Nursing reviewed all resident charts. to identify any individuals who were not up to date with pneumococcal vaccination. Any resident identified as not current was offered the vaccine. For those who accepted, the vaccine was ordered through the pharmacy and administered per protocol. Consent and declines were documented under the immunization tab. Systemic Changes The Director of Nursing provided education to all staff on the requirement to offer pneumococcal vaccines to all new residents at the time of admission. Education also included the expectation that pneumococcal vaccination status is reviewed annually and vaccines are offered accordingly. An Ad Hoc QAPI was held with IDT and medical director to review the deficiency, identify root cause analysis, and accept the plan of correction. Monitoring Director of Nursing will audit new admissions will Monday through Friday for four week and then weekly for two months during the morning clinical meeting to verify that pneumococcal vaccine consent has been obtained or declined. For residents who consent, the audit will confirm that the vaccine order has been entered and the vaccine	06/06/2026

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F0883 SS = E	Continued from page 22 pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and review of CDC recommendations, the facility failed to ensure the residents were immunized for pneumococcal disease in 5 of 5 sample residents (#66, #69, #1, #33, #4) reviewed for current vaccination status. The findings were: 1. Review of medical records for residents' #66, #69, #1, #33 and #4 showed no pneumococcal conjugate vaccine had been assessed or offered. 2. Interview with the IP on 5/7/26 at 12:32 PM confirmed there was no evidence of pneumococcal vaccination status. 3. Interview with the IP on 5/7/26 at 9:27 AM revealed the facility process for immunizations immunizations were assessed and tracked on admission. The facility offered annual covid and influenza vaccines and documented results. He reported the facility had been delayed in an audit of pneumococcal vaccines due to the inability to access records. 4. Review of the Center for Disease Control "Recommended Adult Immunization Schedule for ages 19 years or older", last revised 2025 showed for routine adult vaccination "Age 50 years or older who have not previously received a dose of PCV13, PCV15, PCV20, or PCV21 or whose previous vaccination history is unknown should receive 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21."	F0883	Continued from page 22 administered. Auditing will continue until the QAPI committee determines substantial complianc e has been achieved. Monitoring will continue until substantial compliance is achieved and sustained, with results reviewed during monthly QAPI meetings.	06/06/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do	F0609	F609 – Reporting of Alleged Violations Corrective Action: The cited incident was reported to the State Portal. No further action was required for the resident involved, as the staff member in question no longer works at the facility. Identification of Other: The Administrator reviewed the last 30 days of grievances and concerns submitted by residents, families, and staff. Any grievance containing an	06/03/2026

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F0609 SS = D	Continued from page 23 not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on grievance review, resident, volunteer, and staff interview, state survey agency incident database review, and policy and procedure review, the facility failed to ensure allegations of abuse were reported timely for 1 of 3 sample residents (#55) reviewed for abuse allegations. The findings were: 1. Review of a "Complaint/Grievance Report Form" dated 2/26/26 showed the volunteer reported "Verbal Abuse to residents during activity by activities employee [activities staff member #1]" on 2/14/26. The grievance showed resident #55 "called out bingo at which point [activity staff member #1] proceeded to yell at [him/her] and told [him/her] to stop interrupting her while she was talking. It continued for a couple of minutes at which time I stepped over and told [activities staff member #1] to stop yelling at [resident #55] as [s/he] was playing the game and telling her [s/he] has a bingo. She then started yelling at me telling me I was talking over her. I told her I was in fact talking over her to prevent her from yelling at residents." Further review showed the volunteer said 2 residents, resident #55 and resident #66, reported the activities staff member "yells at them all the time" and "speaks to them the same way every time they play bingo." The following concerns were identified: a. Interview with resident #55 on 5/5/26 at 2:17 PM revealed s/he had an issue with activities staff member #1 in BINGO when she was rude to resident #55. The resident revealed s/he had complained about something in BINGO and the activities staff member was upset, then stormed out. The resident revealed activities staff member #1 "in a smart-ass way" said "weren't you paying attention?" The resident revealed the statement made him/her angry	F0609	Continued from page 23 allegation of abuse, neglect, or mistreatment was reviewed and reported. Systemic Changes: The VP of Operations provided education to the Administrator regarding federal and state expectations for reporting all allegations of abuse, neglect, and misappropriation. Education included timeframes for reporting to the State Portal, requirements for immediate investigation, Documentation standards expectations for identifying and escalating any allegation that may constitute abuse or neglect The administrator provided education to all staff regarding the requirements of reporting abuse and neglect allegations to the abuse coordinator. The Administrator and Designee will ensure that all grievances and concerns are reviewed daily for potential reportable allegations. An Ad Hoc QAPI was held with IDT and medical director to review the deficiency, identify root cause analysis, and accept the plan of correction. Monitoring: The Administrator or designee will audit all grievances, incident reports, and 24-hour reports daily for 4 weeks, then weekly for 8 weeks, to ensure any allegation of abuse or neglect is reported within required timeframes, or until QAPI determines substantial compliance has been achieved. Any discrepancies will be corrected immediately. Audit results will be reviewed during monthly QAPI meetings until substantial compliance is achieved and maintained. Date of Compliance: June 3, 2026	06/03/2026

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F0609 SS = D	Continued from page 24 and s/he called the staff member names. Further interview revealed the staff member was terminated following the incident. b. Interview with facility volunteer #3 on 5/6/26 at 12:15 PM revealed on the day of the incident, she was at the facility with other resident family members, sorting cookies and balloons inside the doorway by the Rock Creek dining room and activities staff member #1 was calling Bingo in the Rock Creek dining room. She revealed she heard resident #55 call out Bingo and heard activities staff member #1 saying the resident was interrupting her. She revealed the activities staff member was speaking to the resident very loudly and rudely, and told the resident to stop interrupting her. She revealed she went around the corner and told the activities staff member to stop talking to the resident in that way and the activities staff member said "[s/he] doesn't have a right to interrupt" and then yelled at the volunteer. She revealed following the interaction, the activities staff member "stormed off." c. Review of the state survey agency incident database showed no evidence the allegation was reported. 2. Interview with the regional clinical director on 5/6/26 at 4:36 PM confirmed the facility did not have evidence the allegation of verbal abuse was reported. She revealed the former employee filed a grievance regarding the incident and while looking into the incident, they learned about the allegation of verbal abuse toward the resident. She confirmed the incident should have been reported and revealed she was unsure why the incident was not reported. 3. Review of the policy titled "Abuse, Neglect and Exploitation" dated 7/25/25 showed "...VII. Reporting/Response A. The facility will have written procedure that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury..."	F0609		06/03/2026
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse,	F0610	F610 - Investigate Alleged Violations Corrective Action:	06/03/2026

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F0610 SS = D	Continued from page 25 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on grievance review, resident, volunteer, and staff interview, and policy and procedure review, the facility failed to ensure allegations of abuse were thoroughly investigated for 1 of 3 sample residents (#55) reviewed for abuse. The findings were: 1. Review of a "Complaint/Grievance Report Form" dated 2/26/26 showed the volunteer reported "Verbal Abuse to residents during activity by activities employee [activities staff member #1]" on 2/14/26. The grievance showed resident #55 "called out bingo at which point [activity staff member #1] proceeded to yell at [him/her] and told [him/her] to stop interrupting her while she was talking. It continued for a couple of minutes at which time I stepped over and told [activities staff member #1] to stop yelling at [resident #55] as [s/he] was playing the game and telling her [s/he] has a bingo. She then started yelling at me telling me I was talking over her. I told her I was in fact talking over her to prevent her from yelling at residents." Further review showed the volunteer said 2 residents, resident #55 and resident #66, reported the activities staff member "yells at them all the time" and "speaks to them the same way every time they play bingo." The following concerns were identified: a. Interview with resident #55 on 5/5/26 at 2:17 PM revealed s/he had an issue with activities staff member #1 in BINGO when she was rude to resident #55. The resident revealed s/he had complained about something in BINGO and the activities staff member was upset, then stormed out. The resident	F0610	Continued from page 25 The cited incident was fully investigated by the Administrator and reported to the State Portal. No further corrective action was required for the resident involved. The staff member involved in the incident is no longer employed by the facility. Identification of Other: The Administrator interviewed residents who still reside in the facility and who were present at the time of the incident to determine whether any additional residents were affected. No additional concerns were identified. Systemic Changes: The Vice President of Operations provided education to the Administrator, regarding expectations for investigating all allegations of abuse, neglect, and mistreatment. Education included: • Requirements for immediate initiation of an investigation • Documentation standards • Interview expectations • Timeframes for reporting and follow-up • Ensuring all allegations are treated as reportable until proven otherwise B. All Staff were educated regarding Adult Abuse, Neglect, and Misappropriation. Monitoring:	06/03/2026

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F0610 SS = D	Continued from page 26 revealed activities staff member #1 "in a smart-ass way" said "weren't you paying attention?" The resident revealed the statement made him/her angry and s/he called the staff member names. Further interview revealed the staff member was terminated following the incident. b. Interview with facility volunteer #3 on 5/6/26 at 12:15 PM revealed on the day of the incident, she was at the facility with other resident family members, sorting cookies and balloons inside the doorway by the Rock Creek dining room and activities staff member #1 was calling Bingo in the Rock Creek dining room. She revealed she heard resident #55 call out Bingo and heard activities staff member #1 saying the resident was interrupting her. She revealed the activities staff member was speaking to the resident very loudly and rudely, and told the resident to stop interrupting her. She revealed she went around the corner and told the activities staff member to stop talking to the resident in that way and the activities staff member said "[s/he] doesn't have a right to interrupt" and then yelled at the volunteer. She revealed following the interaction, the activities staff member "stormed off." c. Review of the state survey agency incident database showed no evidence an investigation of the incident was reported. 2. Interview with the regional clinical director on 5/6/26 at 4:36 PM confirmed the facility did not have evidence the allegation of verbal abuse was investigated. She revealed the former employee filed a grievance regarding the incident and while looking into the incident, they learned about the allegation of verbal abuse toward the resident. She confirmed the incident should have been investigated and revealed she was unsure why the incident was not reported and investigated. 3. Review of the policy titled "Abuse, Neglect and Exploitation" dated 7/25/25 showed "...V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warrented when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect, or exploitation occur..."	F0610	Continued from page 26 The Administrator or designee will review all grievances, incident reports, and 24-hour reports daily for 4 weeks, then weekly for 8 weeks, to ensure all allegations of abuse or neglect are immediately investigated and reported as required or until QAPI determines substantial. Any discrepancies will be corrected immediately. Audit results will be reviewed during monthly QAPI meetings until substantial compliance is achieved and maintained. Date of Compliance: June 3, 2026	06/03/2026
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge-	F0627	Plan of Correction – F627 Corrective Action:	06/03/2026

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F0627 SS = D	Continued from page 27 §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is	F0627	Continued from page 27 Resident #82 has been discharged from the facility. Identification of Others: The Social Services Director reviewed all resident discharges from the past 30 days to determine whether any other residents were discharged without a completed discharge plan and summary. For any resident identified as not having received a copy of their discharge plan and summary, the resident or responsible party was contacted and offered a copy of the documentation. Systemic Changes: The Regional Director of Clinical Services provided education to the Interdisciplinary Team regarding the expectations for all residents being discharged from the facility. Education included: Requirement that a completed discharge plan and discharge summary assessment must be finalized prior to discharge. Requirement that a copy of the discharge plan and summary must be offered to the resident or representative at the time of discharge. Review of appropriate and inappropriate discharge locations and situations to ensure regulatory compliance. B. The Director of Nursing provided education to nursing staff to complete the nursing section of the discharge plan and summary assessment. Reviewing the entire discharge assessment with the resident at the time of discharge. Offering and providing the resident with a copy of the completed discharge documentation. An Ad Hoc QAPI was held with IDT and medical director to review the	06/03/2026

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 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0627 SS = D	Continued from page 28 documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services	F0627	Continued from page 28 deficiency, identify root cause analysis, and accept the plan of correction. Monitoring: The Social Service Director or designee will audit all discharges M-F for four weeks, then weekly for two months to ensure a complete discharge plan and summary assessment is present documentation that resident was offered their copy or until QAPI determines substantial compliance has been achieved. Any discrepancies will be corrected immediately. Audit results will be reviewed during monthly QAPI meetings until substantial compliance is achieved and maintained. Date of Compliance: June 3, 2026	06/03/2026

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F0627 SS = D	Continued from page 29 (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences.	F0627		06/03/2026

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F0627 SS = D	Continued from page 30 (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her	F0627		06/03/2026

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F0627 SS = D	Continued from page 31 new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and policy review, the facility failed to ensure residents were allowed to return following acute hospitalization for 1 of 4 sample residents (#82) reviewed for transfer and discharge. The findings were: 1. Review of a progress note dated 3/11/26 and timed 8:33 PM showed resident #82 was transferred to the hospital emergency room due to "altered mental status/increased confusion." The following concerns were identified: a. Review of the medical record showed no evidence a transfer/discharge notice was provided at the time of transfer. b. Review of a discharge MDS assessment dated 3/11/26 showed the resident's return to the facility was anticipated and the discharge was unplanned. Further review showed the discharge status was "Short-Term General Hospital (acute hospital, IPPS)." c. Interview with the DON on 5/7/26 at 9:45 AM revealed the resident did not return following the hospital transfer and the decision to not allow the return was financial. Further interview confirmed a discharge notice was not provided after transfer and revealed the facility did not assist in finding alternate placement. d. Interview with the business office manager on 5/7/26 at 10:54 AM confirmed the resident was not allowed to return to the facility following the hospital transfer; however, he revealed he thought the reason was due to insufficient staffing. 2. Review of the policy titled "Transfer and Discharge (including AMA)" last revised on 6/10/25 showed "...10. Emergency Transfers to Acute Care ...i. The resident will be permitted to return to the facility upon discharge from the acute care setting. j. Not permitting a resident to return following hospitalization constitutes a discharge. In situations where the facility has decided to discharge the resident while the resident is still hospitalized, the facility will send a notice of discharge to the	F0627		06/03/2026

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F0627 SS = D	Continued from page 32 resident and resident representative before the discharge, and must also send a copy of the discharge notice to the Office of State Long-Term Care Ombudsmen. Notice to the Ombudsman will occur at the same time the notice to discharge is provided to the resident and resident representative, even though, at the time of the initial emergency transfer, only needed to occur as soon as practicable..."	F0627		06/03/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send	F0628	Plan of Correction – F628: Corrective Action: Residents #69 and #77 have been discharged from the facility and since expired. Resident #6 was provided copies of the facility's Bed Hold and Transfer Agreement. Identification of Others: The Director of Nursing completed an audit of all resident transfers to ED from the past 30 days to determine whether any resident was transferred without a completed Bed Hold and Transfer form and validate that a copy of the transfer/discharge notice was sent to the Office of the State Long-term care Ombudsman. Any resident identified as not having received the form was provided with a copy and notifications sent to Ombudsman. Systemic Changes: The Director of Nursing provided education to all nursing staff regarding the facility's expectations for completing the Bed Hold and Transfer Form and Ombudsman notification. Education included: Completing the form prior to any resident transfer, reviewing the information with the resident or representative, providing the resident or representative with a copy of the completed form at the time of transfer, requirement that that a copy of the transfer/discharge notice is sent to the Office of the State Long-term care Ombudsman.	06/03/2026

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F0628 SS = D	Continued from page 33 a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and	F0628	Continued from page 33 An Ad Hoc QAPI was held with IDT and medical director to review the deficiency, identify root cause analysis, and accept the plan of correction. Monitoring: The Director of Nursing or designee will audit all resident transfers weekly for 12 weeks to ensure a Bed Hold and Transfer Form is completed prior to transfer the resident or representative received a copy, documentation is present in the medical record or until QAPI determines substantial compliance has been achieved. Also, that notification to Ombudsman is sent. Any discrepancies will be corrected immediately. Audit results will be reviewed during monthly QAPI meetings until substantial compliance is achieved and maintained. Date of Compliance: June 3, 2026	06/03/2026

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F0628 SS = D	Continued from page 34 telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the	F0628		06/03/2026

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F0628 SS = D	Continued from page 35 resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff and guardian interview, the facility failed to provide a notice of transfer/discharge prior to a facility-initiated hospital transfer for 3 of 6 sample residents (#6, #69, #77) and failed to provide written information on the bed-hold policy to the resident or the resident's representative for 1 of 6 sample residents (#77)	F0628		06/03/2026

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F0628 SS = D	Continued from page 36 reviewed for facility-initiated transfers. In addition, the facility failed to send a copy of the transfer/discharge notice to a representative of the Office of the State Long-Term Care Ombudsman. The findings were: 1. Review of the medical record showed resident #6 was transferred to the hospital on 12/28/25. Further review showed no evidence the facility had issued a written transfer/discharge notice to the resident and/or the resident representative. There was no evidence a representative of the Office of the State Long-Term Care Ombudsman was notified of the transfer. a. Interview with the Regional Clinical Director on 5/7/26 at 11:45 AM confirmed there was no evidence a transfer/discharge notice had been provided to resident #6. 2. Review of the medical record showed resident #69 was transferred to the hospital on 5/4/26. Further review showed no evidence the facility had issued a written transfer/discharge notice to the resident and/or the resident representative. a. Interview with LPN #1 on 5/7/26 at 12 PM revealed she did not notify the resident's guardian because she had been the only nurse on the unit and she did not have time. She stated she had reported to the next shift that the resident's guardian had not been notified. b. Interview with the resident's guardian on 5/7/26 at 3:11PM confirmed she had not been notified the resident was transferred to the hospital. 3. Review of the medical record showed resident #77 was transferred to the hospital on 3/4/26. Further review showed no evidence the facility had issued a written transfer/discharge notice and written information on the bed-hold policy to the resident and/or the resident representative. There was no evidence a representative of the Office of the State Long-Term Care Ombudsman was notified of the transfer. a. Interview with the Regional Clinical Director on 5/7/26 at 11:45 AM confirmed there was no evidence the bed-hold and transfer/discharge notices were provided to resident #77.	F0628		06/03/2026
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)	F0679	Corrective Action: On 6/4/26, Resident #80 had an Activities	06/10/2026

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F0679 SS = D	Continued from page 37 §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: Based on observation, medical record review, resident representative and staff interview, and policy review, the facility failed to ensure individual activities of preference were provided to 1 of 3 sample residents (#80) reviewed. The findings were: 1. Review of resident #80's care plan initiated on 4/24/26 showed s/he had a diagnosis of Alzheimer's disease, and was at risk for depression and impaired social interaction. Further review showed the resident "will participate in social situations, activities of choice..." The following concerns were identified: a. Interview with the resident's representative on 5/5/26 at 9:46 AM revealed the resident had not received activities at the facility. She reported the resident needed to stay busy, and s/he was unable to focus due to his/her diagnosis of dementia. She reported when she attempted to talk to activity staff about appropriate activities for the resident, they were "always on their way to somewhere else." b. Observations throughout the survey showed the resident wandered in the halls and sat in the front lobby. The resident was not observed participating in facility activities. c. Interview with the DON on 5/7/26 at 1:12 PM revealed there was no record of activity participation for the resident. d. Interview with activity staff member #2 on 5/7/26 at 1:17 PM revealed she sat and talked to the resident "once in a while," but she was the only person on the activity staff and did not have time. 2. Review of the policy titled "Activities" dated 6/5/25 showed "...9. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs..."	F0679	Continued from page 37 Assessment completed, and cape plan updated to ensure individual activities of preference. Activities Director or designee will document activity attendance Identification of Other A review was completed by the Activities Director or designee for residents to ensure each have a Activities Assessment, ensure individual activities of preference and activity attendance. Systemic Change The Administrator provided education to IDT members and Activities staff to document resident attendance in activities according to plan of care for residents Monitoring The Activities Director or designee will document resident attendance in activities. The Activity Director or designee will conduct resident activity attendance audits weekly for 4 weeks then monthly for 2 months to verify that Activity's attendance. The Medical Director and QAPI committee will review Audit result during monthly QAPI meetings until compliance is achieved and maintained.	06/10/2026

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 05/07/2026

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

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F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on resident interview, staff interview, and medical record review, the facility failed to ensure that residents received care that accounted for resident preferences that mitigated triggers for past trauma for 1 of 8 sample residents (#66) reviewed for trauma informed care. The findings were: 1.Review of the quarterly MDS assessment dated 2/18/26 showed the resident had a BIMS score of 13 out of 15 which indicated little to no cognitive impairment, and had diagnoses which included schizophrenia, anxiety, and post-traumatic stress disorder (PTSD). a. Interview with the resident on 5/4/26 at 3:21 PM revealed the s/he had requested to not have men bathe her/him due to PTSD from sexual assault in the past, and s/he has had to remind staff weekly of his/her preference. b. Review of the care plan dated 1/23/26 showed no identification of the resident's preference for female staff only to assist in the areas of personalized care, ADL's and bathing, and mood and behavior, and no identification of triggers for PTSD or the resident's preference of only having females assist with bathing. c. Interview with CNA #2 on 5/7/26 at 10:37 AM confirmed the resident preferred female staff due to past trauma.	F0699	F699-Trauma Informed Care Corrective Action Resident #66's care plan was updated to reflect her history of PTSD related to past sexual assault Her stated preference not to have male staff perform bathing was added to the care plan and communicated to all care staff. Identification of Others The Director of Nursing completed a review of all current residents to ensure that each had a trauma-informed care assessment. Any identified trauma of history or care preferences were added to the corresponding care plans. Systemic Change The Regional Clinical Director provided education to the Interdisciplinary Team regarding: the process for completing trauma-informed care assessments for all new admissions and quarterly ensuring trauma-related needs and preferences are incorporated into care plans An Ad Hoc QAPI was held with IDT and medical director to review the deficiency, identify root cause analysis, and accept the plan of correction. Monitoring The Director of nursing or designee will audit assessments of new admissions and residents who are due for quarterly MDSs 1 x a week for 12 weeks. Audits will continue until QAPI determines substantial compliance has been achieved. Any discrepancies will be corrected immediately. Audit results will be reviewed during monthly QAPI meetings until substantial compliance is achieved and maintained. Date of Compliance June 3, 2026	06/03/2026

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 05/07/2026

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F0680 SS = C	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interview, the facility failed to ensure the activities program was directed by a qualified professional. The census was 73. The findings were: 1. Interview with resident #55 on 5/5/26 at 2:17 PM revealed the facility did not have an activity director and had been without for "about a month." 2. Interview with the administrator and regional clinical director on 5/6/26 at 11:45 AM confirmed the facility did not have a qualified activity professional at that time; however, they revealed a new activity professional had been hired. They revealed the new director who would be starting was not qualified either and the program would be overseen by occupational therapy until qualification was met. 3. Interview with the regional clinical director on 5/7/26 at 12:32 PM revealed the activity program was not being overseen by a qualified person and the previous activity director left on 3/18/26.	F0680	F680 Qualifications of Activity Professions Corrective Action: Occupational Therapist started oversight of the activity department. Identification of Others: It was identified that all residents could be at risk from the facility not having a certified activities director. Systemic Change: The Regional Clinical Director provided education to the Interdisciplinary Team regarding: the process for Occupational Therapist oversite of the Activity department during the absence of a director. Facility hired an Activity Director. Occupational Therapy will provide oversite for the Activity Department. An Ad Hoc QAPI was held with IDT and medical director to review the deficiency, identify root cause analysis, and accept the plan of correction. Monitoring: The administrator or designee will assess and monitor the activity department to ensure that an Occupational Therapist reviews the resident's monthly calendar for appropriate activities for the residents during the absence of an activity director. The QAPI committee determines substantial compliance is achieved and reviewed during monthly QAPI meetings. Date of Compliance: June 3rd , 2026	06/03/2026