

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 05/07/2026	
NAME OF PROVIDER OR SUPPLIER Big Horn Rehabilitation and Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1851 Big Horn Ave , Sheridan, Wyoming, 82801			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 05/07/2026. Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in this section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single story building of Type V(111), with a basement, built in 1962 and 1988. The building was equipped with a supervised automatic dry sprinkler system and an addressable fire alarm system. The facility had a capacity of 128 certified Medicare and Medicaid beds with a census of 72 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.			K0000			06/03/2026
K0291 SS = F Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to test and maintain battery-operated emergency lighting in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly test and maintain battery-operated emergency lighting could result in insufficient lighting in the event of a power outage, resulting in injury or death. The deficiency affected all battery-operated emergency lighting in the facility, and could affect all residents, staff, and visitors. The findings were: Document review on 05/07/26 starting at 1:15 PM revealed that the facility failed to perform all required			K0291	CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Facility Performed 1 ½ hour battery testing on battery backup emergency lighting and exit signs on (June 1st 2026) II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk of being affected by this alleged deficiency. All areas were audited for battery backup emergency lighting and exit signs and any deficiencies found were corrected and documented on (5/29/2026) III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:		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.

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K0291 SS = F Bldg. 01	Continued from page 1 testing of battery-operated emergency lighting. No documentation was available at the time of the survey to demonstrate that the facility had conducted the annual ninety (90) minute test of all battery-operated emergency lighting in the last twelve (12) months. Interview with maintenance staff at the time of the observation acknowledge the deficiency, but indicated that they were aware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2012 NFPA 101 18.2.9.1, 7.9.3.1			K0291	Continued from page 1 The Maintenance Director and Maintenance assistant were educated on 5/29/2026 that all battery backup emergency lighting must be inspected and battery testing must be performed . The Maintenance Director/designee will audit all battery backup emergency month. The audits will be documented. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director/designee performs weekly 30 second testing inspections for 4 weeks, then twice monthly for 2 months, and will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. Hazardous area inspections are now part of the facility CMMS (Tels) monthly physical structures inspections.		06/03/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA			K0918	CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: There is now a maintenance plan for the testing of main and feeder circuit breakers by the maintenance director on (5/29/2026). HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk of being affected by this alleged deficiency. EES system were inspected and any deficiencies found were corrected and documented on (5/29/2026) MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:		06/03/2026

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K0918 SS = F Bldg. 01	Continued from page 2 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to test and maintain main and feeder circuit breakers in accordance with the 2012 NFPA 101, Life Safety Code, and 2012 NFPA 99 Health Care Facilities Code. Failure to properly test and maintain main and feeder circuit breakers could result in a malfunction of the essential electrical system, resulting in injury or death in the event of a power outage. The deficiency affected the essential electrical system (ESS), and could affect all residents, staff, and visitors. Document review on 05/07/26 starting at 1:15 PM revealed that the facility failed to perform the inspection and testing of main and feeder circuit breakers. No documentation was available at the time of the survey to demonstrate that the facility had conducted the annual inspection of the main and feeder circuit breakers associated with the EES in the last twelve (12) months. No maintenance program was available for periodically exercising the components in accordance with manufacturer's recommendation. Interview with maintenance staff at the time of the observation acknowledge the deficiency, but indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2010 NFPA 99 6.4.4.1.2.1	K0918	Continued from page 2 Maintenance plan was developed by the maintenance director (5/29/2026) and reviewed by NHA for compliance on (5/29/2026). Education provided to Maintenance Director and Maintenance crew by the NHA on (5/29/2026) the expectations to the importance of a maintenance plan and its usage as well as the 2012 NFPA 99 Health care facilities code. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: Audit of process will be done once every 6 months using maintenance audit form Results of these audits will be brought to QAPI meetings to determine patterns, trends of concern, and/or if further education is needed. Frequency and continuation of audits will be determined/adjusted at that time. This inspection is now part of the CMMS (Tels) Annual testing of Essential Electrical Systems (EES) inspections.	06/03/2026
K0321 SS = E Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier	K0321	CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident Room 316 was converted to a hazardous area with self-closer, inspected for latch and	06/03/2026

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K0321 SS = E Bldg. 01	Continued from page 3 having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed protect hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly protect hazardous areas could result in the spread of fire and smoke, resulting in injury or death in the event of a fire. The deficiency affected one (1) storage room, and could affect all residents, staff, and visitors in the secure wing. Observation on 05/07/26 at 11:46 AM revealed that the facility failed to protect all storage areas as required. Observation of room 316 in the facility's secure wing revealed the room was being utilized as a storage room. Observation revealed that the room	K0321	Continued from page 3 gap (5/10/2026). All items will be safely secured within a storage room rated as hazardous room, eliminating the spread of fire. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk of being affected by this alleged deficiency. All areas were audited for hazardous area precautions and any deficiencies found were corrected and documented on (5/10/2026) III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The Maintenance Director and Maintenance Assistant were educated on (5/9/2026) that all storage room doors require a self-closing device that allows the door to self-close completely and latch. The Maintenance Director/designee will audit all storage rooms on the location every month. The audits will be recorded on TELS. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director/designee perform weekly inspections 4 weeks, then twice monthly for 2 months, and will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. Hazardous area inspections are now part of the facility CMMS (Tels) monthly physical structures inspections.	06/03/2026

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K0321 SS = E Bldg. 01	Continued from page 4 was greater than 100 s.f. and the door to the room was not equipped with an automatic door closer. Interview with maintenance staff at the time of the observation acknowledge the deficiency, but indicated that they were aware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 20121 NFPA 101 19.3.2.1	K0321				06/03/2026	
K0324 SS = E Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the kitchen hood extinguishing system in accordance with the 2012 NFPA 101, Life Safety Code, and 2011 NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Failure to properly test and maintain the kitchen hood extinguishing system could resulting in injury or death in the event of a fire. The deficiency affected the one (1) kitchen hood extinguishing system, and	K0324	CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Maintenance Director was educated on (5/29/2026) that the kitchen hood extinguishing system must be inspected monthly and the results of the inspection must be documented.. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk of being affected by this alleged deficiency. Kitchen Hood and extinguishing system were inspected and any deficiencies found were corrected and documented on (5/29/2026) III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education provided to Dietary Manager/designee and Maintenance Director and Maintenance crew by NHA on (5/29/2026) to expectations and mandated code requirements in affiliation with Life safety code, 2011 NFPA 96 standard for ventilation control and fire. Limiting device installed on range and floor marked for placement to keep the range in the correct position under the hood on (5/29/2026). IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance			06/03/2026	

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K0324 SS = E Bldg. 01	Continued from page 5 has the potential to affect all staff and visitors in the kitchen. 1) Document review on 05/07/2026 starting at 1:15 PM revealed that the facility failed to conduct the monthly owner's inspection of the kitchen hood extinguishing system as required. No documentation was available at the time of the survey to confirm the kitchen hood extinguishing system had been inspected as required. Kitchen hood extinguishing systems shall be inspected monthly to verify the extinguishing system is in its proper location, the manual actuators are unobstructed, the tamper indicators and seals are intact, the maintenance tag is in place, no obvious damage, the pressure gauges are in the operable range, the nozzle blowoff caps, are intact and undamaged, the equipment has not been replaced, modified, or relocated. Interview with the maintenance staff at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2012 NFPA 101 19.3.2.5.1, 9.2.3; 2011 NFPA 96 10.2.6; 2009 NFPA 17A 7.2 2) Observation on 05/07/2026 at 12:37 PM revealed that the facility failed to provide an approved method of returning the cooking appliance to the approved design location. Observation of the kitchen cook top revealed that there was no means of returning it to the approved design location after being moved for the purpose of maintenance and cleaning. Cooking appliances shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system unless an approved method of returning it to the proper location is provided. Interview with the maintenance staff at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2012 NFPA 101 19.3.2.5.1, 9.2.3; 2011 NFPA 96 12.1.2.2, 12.1.2.3			K0324	Continued from page 5 Director/designee performs 2x weekly inspections for 4 weeks, then 1x monthly for 2 months, and will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. Kitchen hood extinguishing system inspections are now part of the facility CMMS (Tels) monthly physical structures inspections.		06/03/2026

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K0511 SS = E Bldg. 01	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to protect gas-fired appliances in accordance with the 2012 NFPA 101, Life Safety Code, and the 2012 NFPA 54, National Fuel Gas Code. Failure to protect gas-fired appliances could result in damage to the gas lines or appliances resulting in injury or death in the event of a gas leak. The deficiency affected the facility's kitchen, and could affect all staff and visitors in the space. Observation on 05/07/2026 at 12:37 PM revealed that the facility failed to provide a means of restraining the gas cook-top to protect the flexible gas line. Observation of the kitchen cook-top revealed that there was a restraining cable connected to the wall adjacent the cook-top but the cable was not connected to the cook-top. Appliances with casters shall be limited by a restraining device in order to protect the flexible gas line from damage. Interview with the maintenance staff at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2012 NFPA 101 19.5.1.1, 9.1.1; 2012 NFPA 54 9.6.1.2	K0511	CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Testing of the kitchen hood extinguishing system and range placement under the exhaust hood were conducted on (5/8/2026). HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Audit done on (5/9/2029) by Maintenance Director on all paperwork and documentation in required inspection binder to ensure inspections and testing of systems are tested every 6 months Everything is current at time of audit on (5/29/2026). No other issues identified MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education provided to Dietary Manager/designee and Maintenance Director and Maintenance crew by NHA on (5/29/2026) to expectations and mandated code requirements in affiliation with Life safety code, 2011 NFPA 96 standard for ventilation control and fire. Limiting device installed on range and floor marked for placement to keep the range in the correct position under the hood on (5/29/2026). HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director/designee perform weekly inspections 4 weeks, then twice monthly for 2 months, and will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. Kitchen hood extinguishing system inspections are now part of the facility CMMS (Tels) monthly physical structures inspections.	06/03/2026

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E0000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 05/07/2026. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E0000		06/03/2026
E0037 SS = F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:	E0037	CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: All new employees will be educated on Emergency Preparedness and Emergency Operations plan, and all employees will receive documented training annually. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Training will include discussion of the emergency procedures specific to the facilities HVA top 5 vulnerabilities. Education will include Facility Incident Command Structure (ICS), Hierarchy of command, staff roles in an emergency such as evacuation, Facility Fire, Flooding, etc. Staff will be tested during annual training of EOP. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Facility reviewed the entire Emergency	06/03/2026

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(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
E0037 SS = F	Continued from page 1 (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff,			E0037	Continued from page 1 Operations Policy and Procedure manual, is updating for role changes and new ownership. This new policy and Procedure plan will be trained and implemented on (5/29/2026). New hire training will be collected monthly for compliance with all of new hires receiving orientation EOP training. The results will be tracked by QAPI for 2 Months and then quarterly until the committee deems compliance has been met.		06/03/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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E0037 SS = F	Continued from page 2 individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):(1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first	E0037				06/03/2026	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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E0037 SS = F	Continued from page 3 workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to conduct all required training of staff on the emergency preparedness plan (EPP) in accordance with 483.73(d)(1). Failure to conduct all required training of staff on the EPP could result in an incorrect or incomplete understanding by the		E0037			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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E0037 SS = F	Continued from page 4 staff of the EPP, resulting in injury or death in the event of an emergency. The deficiency has the potential to affect all residents, staff, and visitors. Document review on 05/07/26 starting at 2:15PM revealed the facility failed to conduct all required training of the EPP. No documentation was available at the time of the survey to confirm that initial and annual training was being provided to employees on the emergency preparedness policies and procedures. Initial training shall be provided on the emergency preparedness policies and procedures to new and existing staff that is consistent with their expected role. Emergency preparedness training shall be provided annually including a means of demonstrating staff knowledge. Interview with the maintenance staff at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency.			E0037			06/03/2026
E0039 SS = F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from			E0039	CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Emergency Preparedness and Emergency Operations plan, and all employees will perform a documented community exercise and a facility drill or tabletop exercise annually. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The Maintenance director was educated by the NHA on the regulatory requirement of performing annual exercises and the scope that these exercises are documented.		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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E0039 SS = F	Continued from page 5 engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:			E0039	Continued from page 5 HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Facility reviewed the entire Emergency Operations Policy and Procedure manual, is updating for role changes and new ownership. This new policy and Procedure plan will be trained and implemented on (5/29/2026). A documented Tabletop exercise will be performed on (6/9/2026).		06/03/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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E0039 SS = F	Continued from page 6 (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.	E0039				06/03/2026	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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E0039 SS = F	Continued from page 7 *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,			E0039			06/03/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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E0039 SS = F	Continued from page 8 facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.			E0039			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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E0039 SS = F	Continued from page 9 (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and		E0039			06/03/2026	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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E0039 SS = F	Continued from page 10 a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.	E0039				06/03/2026	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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E0039 SS = F	Continued from page 11 *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to conduct all required testing of the emergency preparedness plan (EPP) in accordance with 483.73(d)(2). Failure to conduct all required testing of the EPP could result in an inadequate plan and underprepared staff for an emergency, resulting in injury or death in the event of an emergency. The deficiency has the potential to affect all residents, staff, and visitors. Document review on 05/07/26 starting at 2:15 PM		E0039			06/03/2026	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 Big Horn Rehabilitation and Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1851 Big Horn Ave , Sheridan, Wyoming, 82801			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E0039 SS = F	Continued from page 12 revealed the facility failed to conduct all required testing of the EPP. Document review revealed that the facility had activated their EPP as a result of a power outage that lasted several hours. No additional documentation was available to demonstrate the facility conducted a community based full-scale or tabletop exercise in the last twelve (12) months. Facilities shall participate in at least one (1) full-scale community based exercise a year unless the facility experiences an actual emergency that requires activation of the emergency plan. The facility must still conduct an additional full-scale exercise or tabletop exercise that year. Interview with the maintenance staff at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency.			E0039			06/03/2026