STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG HORN REHABILITATION AND CARE CENTER	**1851 BIG HORN AVE SHERIDAN, WY 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
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 5/10/23 to 5/12/23. The survey was prompted by complaint intakes WY00003586 and WY00003581. In addition, a COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted by Healthcare Licensing and surveys from 5/10/23 to 5/12/23. Based on the findings of the survey team, it was determined that no deficiencies were identified pertaining to the infection control survey. The following common abbreviations are used throughout this document: DON- Director of Nursing Services MDS- Minimum Data Set SDC- Staff Development Coordinator LPN- Licensed Practical Nurse CNA- Certified Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		5/13/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/05/2023

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 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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F 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, facility incident investigation review, and policy and procedure review, the facility failed to protect the resident's right to be free from physical abuse by another resident for 1 of 8 sample residents (#6) reviewed with resident-to-resident altercations. This failure resulted in harm to resident #6 who was struck in the face with a belt, resulting in injury to the face. The findings were: 1. Review of the 4/10/23 quarterly MDS assessment showed resident #6 had a brief interview for mental status (BIMS) score of 0 out 15, which indicated severe cognitive impairment, and diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, and anxiety disorder. Further review showed the resident required extensive physical assistance of 1 person for locomotion on the unit, and wandering behavior was not exhibited. Review of the "Trauma" care plan last revised on 5/4/23 showed the resident had potential for trauma related behaviors related to altercation with another resident. Interventions included "... [resident name] will be encouraged to keep [his/her] distance from resident [other resident's facility number]. [Resident #6] has a BIMS of 0 resulting in difficulty for [him/her] to retain education provided. Staff will monitor situation and remove [resident #6] from area if resident [other resident's	F 600	F600 FREE FROM ABUSE AND NEGLECT PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THEFACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Care plans of both residents have been	

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F 600	Continued From page 2 facility number] is present..." Review of the "Secure Care Unit" care plan last revised on 4/10/23 showed the resident was at risk for wandering and being unable to find his/her way back. Interventions included "...Reorient/validate and redirect as needed..." Review of the "Behavior" care plan last revised on 4/10/23 showed the resident had behavior problems and could become physically aggressive. Interventions included "...Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed..." The following concerns were identified: a. Review of a facility incident investigation report showed on 5/4/23 resident #6 and resident #1 were involved in an incident where resident #1 was identified as the alleged perpetrator. The incident report indicated the facility investigated physical abuse. The incident report showed "One of the staff reported that she heard a scream from [resident #6] and seen the [resident #6] wheeling [him/herself] out of [resident #1's] room, then [resident #1] slammed [his/her] door shut. When went [sic] in to interview [him/her] about it [s/he] states [s/he] hit the [resident #6] with [his/her] belt because [s/he] wasn't supposed to be in [his/her] room..." b. Review of a "Skin-Weekly Head to Toe Skin Checks" assessment dated 5/4/23 and timed 8:31 PM showed resident #6 had an altercation with another resident which resulted in a "skin tear" to his/her lower lip. c. Observation on 5/11/23 at 9:46 AM showed resident #6 was in his/her wheelchair and independently moved throughout the unit. At that time, the resident interacted with resident #1 in the common area. No negative interaction	F 600	reviewed with individualized updates made as needed. Staff have been educated to review care plans for interventions when potential behaviors are suspected or when trying to learn about the resident and ways to prevent potential abusive behaviors. Staff were further educated in the abuse and neglect policy. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents with moderate to severe cognitive impairment and or demonstrating wandering behaviors are at risk by this alleged deficient practice. An audit was done of all care plans on the secured unit to measure individualized preventative measures are in place for potential abusive behavior. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: On 5/12/2023 Education was begun to all staff on the secured unit on where to find individualized preventative measures for each resident on the hall. On 5/13/2023 Behavior monitoring sheets were implemented on the secure unit (Courtyard) to determine residents' behaviors at various times of the day. Those forms are being reviewed by the clinical IDT team with updates made to care plans when needed.	

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F 600	Continued From page 3 between the residents was observed. d. Interview with LPN #1 on 5/11/23 at 3:18 PM revealed she was the nurse in the unit at the time of the altercation between resident #6 and resident #1 on 5/4/23. The LPN revealed she did not observe the altercation as she was down the hall in the "living room" and the CNA reported the incident to her. The LPN revealed the CNA reported she heard resident #6 scream and that the resident was bleeding from his/her mouth. The LPN revealed following the incident, resident #6 had a "small skin tear" to the left lower lip which she cleaned and treated. The LPN revealed she had the resident stay near her until s/he was assisted to bed. Further interview revealed resident #6 "wanders a lot" and often goes into other resident rooms. The LPN said the secure unit staff normally make sure a staff member is in the common areas, and to prevent additional incidents, staff would need to keep a better watch on resident #6. The LPN revealed she attempts to keep resident #6 where she can see him/her; however, those types of incidents happen really quickly. e. Interview with CNA #1 on 5/11/23 at 4:10 PM revealed on 5/4/23 she was in the shower room preparing to give someone a shower when she heard someone yell. When she left the shower room, she observed resident #6 being pushed out of resident #1's room. At that time, resident #6 had blood in his/her mouth. The CNA revealed she entered resident #1's room and asked if s/he hit resident #6. The CNA revealed resident #1 said yes, s/he hit resident #6 with his/her belt because s/he didn't want resident #6 in his/her room. The CNA revealed resident #1 confirmed resident #6 had not done anything to resident #1. Further interview revealed resident #6 often goes into other residents' rooms and	F 600	IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The SSD or designee and the DON or designee will monitor the secured unit twice weekly for four weeks and once weekly for two months and report those findings 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. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. Date of Compliance 5/13/2023	

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F 600	Continued From page 4	F 600		

staff try to keep him/her in sight. The CNA confirmed she assisted resident #6 to the nurse where the nurse performed an assessment and cleaned the resident's mouth.

f. Interview with the administrator, DON, and SDC on 5/12/23 at 9:35 AM confirmed the altercation between resident #6 and resident #1 resulted in resident #6 being hit in the face with a belt which resulted in a "split" in the resident's lip. The administrator, DON, and SDC confirmed the resident was mobile in the wheelchair and liked to wander around the unit. The administrator, DON, and SDC revealed interventions which included a stop sign outside resident #1's room, notification of local police, moving a table frequently used by resident #6 when wandering, removal of the belt, and increased supervision were implemented following the altercation.

2. Review of the facility policy titled "Abuse, Neglect, Exploitation and Misappropriation Prevention Program" last revised April 2021, showed "...The resident abuse, neglect, exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including but not necessarily limited to:... b. other residents;..."