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 _____	04/04/2024

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 recertification survey was conducted by Healthcare Licensing and Surveys from 4/1/24 through 4/4/24. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status DON: Director of Nursing MDS: Minimum Data Set mg: milligrams Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and MDS 3.0 Resident Assessment Instrument (RAI) manual review, the facility failed to ensure MDS assessments were accurate for 2 of 4 sample residents (#37, #41) reviewed for MDS discrepancies. The findings were: 1. Review of the significant change MDS assessment dated 2/7/24 showed resident #37 was coded as taking anticoagulant and antiplatelet medications. Review of the physician orders showed the resident received Plavix (antiplatelet medication) 25 mg (milligrams) by mouth, one time daily for unspecified sequelae of unspecified cerevrovascular disease; however,	F 641	F641 Corrective Action: 1. Resident #37 admission MDS assessment corrected/ modified and accepted on 4/8/24 to only reflect anti-platelet medication. 2. Resident #41admission MDS assessment corrected/ modified and accepted on 4/4/24 to reflect anti-coagulant medication. Identification of others: All residents receiving anti-coagulants and/ or anti-platelets at Big Horn Rehabilitation and Care Center are at risk. A facility wide audit was performed on	4/10/24

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

Electronically Signed | 04/19/2024

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 _____	04/04/2024

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 641	Continued From page 1 there was no indication the resident received an anticoagulant medication. 2. Review of the admission MDS assessment dated 1/30/24 showed resident #41 was coded as not taking an anticoagulant; however, review of physician orders showed the resident received Rivaroxaban [anticoagulant] 20 mg once per day for a diagnosis of atherosclerotic heart disease of native coronary artery. 3. Interview with the MDS coordinator on 4/4/24 at 11:18 AM confirmed the assessments for both residents were not coded correctly. 4. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User Manual version 1.18.11 last revised October 2023 showed "...code all high-risk drug class medications according to their pharmacological classification, not how they are being used. Column 1: Check if the resident is taking any medication by pharmacological classification during the 7-day observation period (or since admission/entry or reentry if less than 7 days). Column 2: If Column 1 is checked, check if there is an indication noted for all medications in the drug class...N0415E1. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). N0415E2. Anticoagulant: Check if there is an indication noted for all anticoagulant medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days)...N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g., aspirin/extended	F 641	4/5/2024 regarding anti-coagulants and anti-platelets and no further concerns were found. Systemic Changes: DON/ designee will educate MDS coordinator prior to the date of compliance regarding accuracy of MDS coding related to anti-coagulants and anti-platelets that meets this regulation. DON/ designee will audit four times a week for one month, then weekly for one month, then monthly for one month and as needed. Any concerns will be addressed. Monitoring: Any issues will be tracked and trended. DON/designee will report the results to QAPI monthly as needed to assure the plan is implemented, sustained, and evaluated for its effectiveness until substantial compliance is met. Date of compliance: April 10, 2024.	

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 _____	04/04/2024

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 641	Continued From page 2 release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). N0415I2. Antiplatelet: Check if there is an indication noted for all antiplatelet medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days)..."	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		4/10/24

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 _____	04/04/2024

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 657	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff, resident and family interviews, and review of facility policies, the facility failed to ensure residents and their representative(s) participated in the development of the care plan for 2 of 2 sample residents (#8, #41) reviewed for care planning. The findings were: 1. Review of the 2/14/24 initial MDS assessment showed resident #8 was admitted on 2/7/24 and had a BIMS score of 15 out of 15, indicating intact cognition. Review of a progress noted dated 2/12/24 showed "Resident recently discharged return not anticipated and it was a failed discharge. Resident readmitted within 72 hours of discharge. Care plan reviewed from previous stay prior to discharge and updated to reflect any changes to resident's care plan." The following concerns were identified: a. During an interview on 4/2/24 at 10:47 AM the resident stated s/he had not been invited to a care conference to participate in the development of a care plan. b. Review of the medical record showed a care conference note from 12/18/23, but no care conference note since the resident's re-admission to the facility on 2/7/24. c. During an interview on 4/4/24 at 10:33 AM the social services designee stated he was unable to find evidence a care conference was completed for the resident after re-admission. 2. Review of the 1/30/24 initial MDS assessment showed resident #41 was admitted on 1/24/24, had a diagnosis of dementia, and had a BIMS score of 7 out of 15, indicating severe cognitive impairment. Review of guardianship papers dated	F 657	F657 Corrective Action: 1. The guardian of resident #41 was offered a care conference/care plan review meeting and was completed 4/9/2024. The guardian attended via a conference call and the resident was physically present with the IDT. The facility confirmed on 4/3/2024, via the phone, is the best way for the guardian to communicate and attend resident care conferences. 2. Resident #8 had a care conference/care plan review meeting on 4/05/2024. Identification of others: All residents that reside at Big Horn Health and Rehabilitation Center are at risk. A facility-wide audit was conducted on or before 4/10/2024 for the last 90 days and found no other concerns. Systemic Changes: The NHA/ designee will educate the social service director and IDT team on or prior to the date of compliance, regarding when care plan meetings are scheduled to accommodate residents and/or their representative and documented; and determine if the resident and representative were unable to participate, did facility staff consult them in advance about care and treatment changes and document the consult in the resident chart, that meets this regulation. The NHA/ designee will audit the care plan meeting schedule two times a week for one month, then weekly for one month,	

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 _____	04/04/2024

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 657	Continued From page 4 4/21/23 showed the resident met the definition of an incompetent person and the resident's daughter was appointed as guardian and conservator. The following concerns were identified: a. During an interview on 4/2/24 at 4:07 PM the daughter stated there had not been a care conference yet. She stated she had left messages with the case manager, but had not received a call back. b. Review of a progress note dated 1/26/24 showed a care conference was held with staff and the resident. The note did not indicate if the daughter, who was the legal guardian, was invited. c. Review of a nursing note dated 4/3/24 showed the daughter was called to provide an update on the resident. The note read "... [daughter] stated she has requested a care plan but has not received a call. Care plan scheduled for Tuesday at 1 PM." d. During an interview on 4/4/24 at 10:33 AM the social services designee and the social services assistant stated family members were usually invited for care conferences. They stated they would leave a note if the family was invited but did not participate. 3. Review of the facility's policy "Care planning-Resident Participation," revised 1/1/24, showed "...The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes...If the participation of the resident and/or resident representative is determined not practicable for the development of the resident's care plan, an explanation will be documented in the resident's	F 657	then monthly for one month and as needed. Any concerns will be addressed immediately. Monitoring: Any issues will be tracked and trended. NHA/designee will report the results to QAPI monthly as needed to assure the plan is implemented, sustained, and evaluated for its effectiveness until substantial compliance is met. Date of compliance: April 10, 2024.	

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 _____	04/04/2024

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 657	Continued From page 5 medical record."	F 657		
F 761 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, and review of the facility policy, the facility failed to ensure medications available for resident use were not expired in 1 of 3 medication storage areas (medication storage room). The findings were: 1. Observation of the medication storage room on	F 761	F761 Corrective Action: Expired medications found during survey were immediately removed from medication room and discarded. All house stock medications in the medication room were examined and no further issues	4/10/24

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 _____	04/04/2024

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 761	Continued From page 6 4/3/24 at 5:12 PM showed 2 bottles of Geri-mox (liquid antacid) on the shelf with an expiration date of 3/2024. 2. Interview with the DON on 4/3/24 at 5:19 PM confirmed the medications were available for resident consumption and had expired. They were immediately removed by the DON at that time. 3. Review of the facility policy "Medication Storage" revised 1/1/24 showed "It is the policy of this facility to ensure all medications housed on the premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations...8. Unused medications: The pharmacy and all medication rooms are routinely inspected by the consult pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy."	F 761	found. Identification of others: All residents that reside at Big Horn Rehabilitation Care are at risk. A facility-wide audit for expired medications was conducted on 4/5/2024 and no other concerns were identified. Systemic Changes: The DON/ designee will educate all nurses and medication aides on or prior to the date of compliance regarding removal and discarding expired medications from storage and medications carts upon hire, annually, return to work from leave and as needed that meets this regulation. DON/ designee will audit the medication room and all medication carts two times a week for one month, then weekly for one month, then monthly for one month and as needed. Any concerns will be addressed immediately. Monitoring: Any issues will be tracked and trended. DON/designee will report the results to QAPI monthly as needed to assure the plan is implemented, sustained, and evaluated for its effectiveness until substantial compliance is met. Date of compliance: April 10, 2024.	