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 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG HORN REHABILITATION AND CARE CENTER	**1851 BIG HORN AVE SHERIDAN, WY 82801**

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 1/14/25 through 1/15/25 which was prompted by complaint intakes WY00004040, WY00004094, WY00004099, WY00004105, WY00004120, WY00004125, WY00004128, WY00004149, and WY00004179.	F 000		
F 609 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 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.	F 609		2/24/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/08/2025

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 609	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on the facility's abuse investigation forms, State Survey Agency incident database review, policy and procedure review, and staff interview, the facility failed to implement policies and procedures for ensuring the reporting of 3 of 3 resident-to-resident altercations reviewed for allegations of abuse which involved resident #2, #3, #4, and #5. The findings were: 1. Review of the facility's policy "Abuse, Neglect, and Exploitation, implemented on 4/1/24, showed "...Reporting/Response...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..." The following concerns were identified: a. Review of a nurse progress note, dated 12/21/24 and timed 5:18 PM, showed resident #4 and #5 were involved in an altercation which resulted in a minor injury to resident #4. Review of the state survey agency incident database showed the allegation occurred on 12/21/24 at 4:30 PM and was reported to facility administration at 5 PM; however, the allegation was not reported to the agency until 12/23/24 at 4:59 PM. b. Review of the state agency incident report form showed a resident-to-resident altercation occurred on 11/26/24 at 6 PM between resident #2 and #3 and was reported to the facility administration on 11/27/24 at 10 PM. The allegation of abuse was not reported to the agency until 11/30/24 at 9:42 PM.	F 609	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules o civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community, or any employee, agent, officer, director, attorney, or shareholder of the Community of affiliated companies. 1. CORRECTIVE ACTION Allegations were reported to DOH and the Nursing Home Administrator was re-educated on 2 hour time frame of reporting the day of the survey The Nursing Home Administrator at that time is no longer with the community 2. Residents # 2, 4 and 5 had head-toe assessments completed at the time of the	

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F 609	Continued From page 2 c. Review of a nurse progress note, dated 11/28/24 and timed 6:20 PM, showed resident #2 and #3 were involved in a resident-to-resident altercation which resulted in minor injury to resident #3. Review of the state survey agency incident database showed the allegation occurred on 11/28/24 at 6 PM and was reported to the facility administration on 11/28/24 at 7 PM; however, the allegation was not reported to the agency until 11/30/24 at 9:42 PM. 2. Interview with the administrator on 1/15/25 at 10:13 AM confirmed the allegations of abuse were not reported within the required timeframe. .	F 609	incident, they sustained no injuries, because of the incidents. An investigation was conducted immediately by the Director of Nurses and the Administrator 3. Residents #2, 4 and 5 families and physicians were all notified Resident # 3 was reassessed by Nursing on 11-28-24 to verify the location and extent of any injury. The physician and the resident□s family were notified promptly. A thorough investigation was initiated by the Director of Nursing Services and the facility Administrator. Resident #3 was noted to have a red mark which was completely gone upon assessment on 11-29-24 and she sustained no adverse effects. Safety Interventions were immediately put into place at the time of these incidents to determine the degree of severity, distress and potential safety risk to the self or others and develop a plan of care accordingly. Safety interventions were implemented immediately if indicated to protect the residents and others from harm. II. How to identify other residents 100% audit will be conducted for like residents to ensure that 2 hour time frame for reporting allegations of abuse to DOH is in compliance by 2-13-2025 by Director of Nurses/Designee An AD Hoc meeting was held on 2-13-25 with the Interdisciplinary Team and Psychiatric Nurse Practitioner to ensure evaluation was done for any abuse allegations and to evaluate residents with combative behaviors, or changes in	

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F 609	Continued From page 3	F 609	condition related to a medication change to determine the degree of severity, distress and potential safety risk to their self or others and develop a plan of care accordingly, and ensure safety interventions were implemented immediately if indicated to protect the residents and others from harm or abuse. It was determined that there were no incidents or abuse allegations at that time that warranted DPH notification at that time. in addition, other like residents had appropriate interventions and care plans III. Systemic changes . Staff were educated by the Director of Nurses/Designee on 2-14-2025 to the Facility□s Abuse Policy and Procedure which includes abuse prevention strategies, abuse reporting and requirements including timely notification to Administrator/DNS. As well as 2-hour time frame for reporting to DOH. Staff will also be educated by the DON/Designee by 2-14-25 on the facility's Protocol for Incident and Accidents reporting including timely reporting to the Administrator/DNS. Newly hired staff will be educated during orientation. Staff that are on vacation or leave will remain off schedule until they are educated in all areas required . The 24- hour facility report will be reviewed daily by the DNS/Designee to ensure there were no abuse allegations and that behaviors are addressed and the plan of care revised if indicated to ensure safety of residents. If after the training any	

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F 609	Continued From page 4	F 609	allegations not reported to the Administrator within the 2 hour reporting time frame, the employee will be suspended up to and including termination of employment. Newly hired staff will be educated during orientation. IV, Monitoring Process The Director of Nursing Services, or designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and interviewed to ensure that any injuries are identified, safety measures were put into place if needed and properly investigated and was reported to the appropriate people in house as well as the 2 hour time frame adhered to for reporting to DOH. Findings of this audit. will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. .	