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 _____	R 11/07/2024

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

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{F 000}	INITIAL COMMENTS A revisit survey was conducted on 11/6/24 through 10/7/24 for all previous deficiencies cited on 9/13/24. The following common abbreviations are used throughout this document: DON: Director of Nursing CNA: Certified Nursing Assistant MA-C: Certified Medication Aide Less commonly used abbreviations will be annotated in each deficiency.	{F 000}		
{F 725} SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not	{F 725}		12/2/24

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

Electronically Signed | 12/02/2024

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{F 725}	Continued From page 1 limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews, and review of the staff schedule, the facility failed to ensure sufficient nursing staff was provided on 1 of 4 units (Courtyard) reviewed for medication administration. The findings were: 1. Review of resident #7's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of finasteride 5 milligrams (mg) related to benign prostatic hyperplasia with lower urinary tract symptoms, fluoxetine 10 mg related to depression, tamsulosin 0.4 mg related to benign prostatic hyperplasia with lower urinary tract symptoms, and protonix 40 mg related to gastrointestinal hemorrhage, at 6 AM. Further review showed the resident had a hold order on 10/10/24, which was signed off by the administrator, for losartan 100 mg, apply moisturizing lotion, and triamcinolone acetonide external cream 0.1% at 6 AM. 2. Review of resident #8's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of cyanocobalamin 1000 micrograms (mcg) related to supplementation, metformin 1000 mg related to type II diabetes mellitus, multiple vitamins tablet related to supplementation, vitamin D3 capsule 25 mcg related to supplementation, acetaminophen 650	{F 725}	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 the provisions of federal and state law require it. 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 the facility's allegation of compliance in accordance with section 7305 of the state operations manual. I. Corrective Action Residents #7, #8, #9, #10, #11, #12, #13 and #14 suffered no ill effects due to staffing. This is evidenced by chart review completed on 11/30/24 by the DON/designee and provider documentation. II. How to Identify Other Residents The administrator and DON reviewed the	

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{F 725}	Continued From page 2 mg related to pain and pacing, losartan 50 mg related to hypertension (hold for blood pressure less than 100/60), and Risperdal 1 mg related to dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance at 6 am. 3. Review of resident #9's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of dexlansoprazole 60 mg related to gastro-esophageal reflux disease, Zoloft 50 mg related to major depression, divalproex sodium 250 mg related to unspecified dementia, unspecified severity, with other behavioral disturbance, midodrine 5 mg related to orthostatic hypotension, and Seroquel 100 mg related to degeneration of the brain, at 6 AM. Further review showed the resident had a hold order on 10/10/24, which was signed off by the administrator, for acidophilus probiotic related to cellulitis of the left lower limb, aloe vera capsule related to urinary health, aspirin 81 mg related to prophylaxis, d-mannose 500 mg related to urinary health, MiraLAX 17 grams (gm) related to fecal impaction/constipation at 6 AM, nutritional snacks at 10 AM and 3 PM, Seroquel 100 mg at 11 AM, and midodrine 5 mg at 12 PM. 4. Review of resident #10's medication administration record for October 2024 showed the resident had a hold order on 10/10/24, which was signed off by the administrator, for glycolax powder 17 gm related to constipation, meloxicam 15 mg related to bilateral primary osteoarthritis of the knee, multivitamin-minerals related to supplementation, levetiracetam 500 mg related to seizures, sennosides 8.6 mg related to constipation, Tylenol 650 mg related to pain, at 6	{F 725}	acuity 12/2/2024. These daily acuity reviews will occur in each hall daily with the clinical schedular to ensure that the units have sufficient and appropriate staffing. Resident acuity is reviewed daily by DON or designee as well to ensure sufficient nursing staff; This information will be stored in excel data sheet after review. Resident and staff interviews were completed by administrative staff 12/2/24 to audit staffing efficiency. III. Systemic Changes Staff were educated ON 12/2/24 by the administrator on appropriate staffing for the facility. Administrative staff will complete audits daily to ensure staffing remains sufficient to provide adequate care for the residents. The facility has initiated multiple incentives for hiring such as increased pay, sign-on bonuses and offers to assist with housing/travel costs, and Human Resources has contacted a Certified nursing Instructor to begin classes offsite as written in the approved waiver granted by the State of Wyoming. IV. Monitoring Process Administrative staff will conduct audits daily for 6 weeks on (ALL) hallways to monitor staffing and resident care to ensure that the facility has the appropriate staffing to provide adequate care for residents. Administrative staff will also be conducting satisfaction surveys daily for 6 weeks with these audits. The findings of these audits and the surveys will be reviewed daily in the stand-up meeting.	

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{F 725}	Continued From page 3 AM, Tylenol 650 mg at 11 AM, haloperidol 2 mg related to schizophrenia at 6 AM and 11 AM, and nutritional supplements at 9 AM and 2 PM. 5. Review of resident #11's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of amlodipine 10 mg related to hypertension, donepezil 5 mg related to unspecified dementia without behavioral disturbance, lisinopril 5 mg related to hypertension (hold if blood pressure less than 100/60), meloxicam 7.5 mg related to low back pain, MiraLAX powder 17 gm related to constipation management, and Tylenol 1000 mg related to low back pain, at 6 AM. 6. Review of resident #12's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of calcium-vitamin d 600 mg-220 mg related to vitamin D deficiency and docusate sodium 100 mg related to constipation, at 6 AM. Further review showed the resident had a hold order on 10/10/24, which was signed off by the administrator, for urea external cream 40% related to keratosis at 6 AM and oral nutritional supplement at 2 PM. 7. Review of resident #13's medication administration record for October 2024 showed the resident had a hold order on 10/10/24, which was signed off by the administrator, metoprolol 25 mg related to chronic diastolic heart failure (hold if blood pressure is less than 100/60), polyethylene glycol 17 gm related to bowel health, quetiapine 50 mg related to vascular dementia with behavioral disturbance, sertraline 100 mg related to anxiety disorder, and acetaminophen 1000 mg	{F 725}	DON/designee and the BOM/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for 3 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 Business office manager/designee will be responsible for following up on any recommendations made by the QAPI Committee.	

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{F 725}	Continued From page 4	{F 725}		

related to pain, at 6 AM, sennoside-docusate 8.8 mg-50 mg related to bowel management and spironolactone 25 mg related to edema at 8 AM, acetaminophen 1000 mg at 11 AM, and trazadone 50 mg related to unspecified vascular dementia, unspecified severity, with other behavioral disturbance, at 12 PM.

8. Review resident #14's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of folic acid 1 mg related to supplementation, levothyroxine 75 mcg related to drug-induced thyroiditis, potassium chloride 20 milliequivalent (mEq) related to hypokalemia, tamsulosin 0.4 mg related to benign prostatic hyperplasia, thiamine 100 mg related to supplementation, and pantoprazole 40 mg related to gastro-esophageal reflux disease, at 6 AM. Further review showed the resident had a hold order on 10/10/24, which was signed off by the administrator, for Tums 500 mg related to heartburn, probiotic, at 6 AM, and the 9 AM and 11 AM snacks.

9. Review of the staff schedule dated 10/10/24 showed no nurse or MA-C was scheduled for the 6 AM to 6:30 PM shift in the courtyard unit.

10. Interview with CNA #1 on 11/6/24 at 2 PM revealed the staff member was moved to the courtyard unit on 10/10/24 due to someone being ill and not being available to work. The CNA revealed there was not a staff member passing medications to residents that day and another CNA came to the unit at 8 AM.

11. Interview with CNA #2 on 11/6/24 at 2:16 PM revealed she replaced CNA #1 on 10/10/24

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{F 725}	Continued From page 5 because they did not have anyone to work Courtyard. 12. Interview with MA-C #1 on 11/6/24 at 2:23 PM revealed when she left on 10/10/24 she was told to give the keys to the Courtyard medication cart to MA-C #1 until the former DON came in. MA-C #2 was assigned to the Rock Creek unit and the only staff member on the Courtyard unit was a CNA. When MA-C #1 returned later that day for her next shift, there continued to be only a CNA on the Courtyard unit. The MA-C revealed the CNA told her no medications had been administered to the residents on the unit and MA-C #1 would need to administer the missed medications. At that time, MA-C #1 notified the administrator and regional operations director, the medications had not been administered. The MA-C revealed she was told it was a serious medication error and they would need to notify the regional clinical director. The MA-C revealed the residents in the Courtyard unit were pacing and some had elevated blood pressures and she attempted to keep them calm. Further interview revealed that when she reviewed the residents' notes they indicated medications had been held due to provider orders. 13. Interview with the former DON on 11/6/24 at 2:35 PM revealed on 10/10/24 he was the only nurse in the building. He stated if he remembered right, he did the morning medications. He revealed he tried to help out but was probably caught up somewhere else or probably kept getting pulled away. 14. Interview with MA-C #2 on 11/7/24 at 12:10 PM revealed she was asked to work on the Rock Creek unit on 10/10/24 and when she learned	{F 725}		

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{F 725}	Continued From page 6 there was nobody scheduled for the Courtyard unit, she said she could not do both units. The MA-C revealed she gave the Courtyard unit medication cart keys to the former DON at 8 AM. She revealed she told the former DON she had not administered any medications to residents on the unit. At 11 AM, she was notified by the CNA on the Courtyard unit, of resident behaviors and the CNA needed help. The MA-C went to the unit to try and calm residents. The MA-C revealed the residents were yelling and screaming, threatening others, seemed unsettled, and were getting worked up. The MA-C revealed the behaviors seemed normal for the residents when they had not received their medications. At that time, the CNA reported the residents had not received any medications that day and the former DON had not been on the unit. 15. Interview with the administrator on 11/6/24 at 2:43 PM revealed on 10/10/24, MA-C #1 reported none of the medications were administered to residents on the Courtyard unit. The administrator revealed the former DON was assigned to administer the medications and said he forgot. The administrator revealed the former DON said he had not administered any medications to residents on the Courtyard unit that day. She revealed the scheduling that day was supposed to be a CNA in Courtyard and the former DON was to be available. 16. Interview with nurse practitioner #1 and the administrator on 11/7/24 at 8:56 AM confirmed the staff members scheduled on Courtyard between 6 AM and 6:30 PM were not able to administer medications.	{F 725}		