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	09/02/2022

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 Based on observation, medical record review, facility incident review, staff and resident interview, and policy and procedure review, the facility failed to ensure residents were free from abuse for 3 of 6 (#3, #7, #8) sample residents involved in resident to resident altercations. This failure resulted in actual harm to residents #3 and #7, who sustained injuries during resident to resident altercations. The findings were: 1. Review of a facility incident report dated 8/23/22 and timed 1:30 PM showed resident #7 asked resident #8, who was seated in a wheelchair in front of the vending machines, to move. Resident #7 then attempted to move resident #8's wheelchair which resulted in an altercation. Further review showed the administrator found resident #7 with his/her .right arm wrapped around the other resident's [resident #8] throat. The other resident was punching and scratching at [resident #7's] arm .[Resident #7] claims [s/he] went to walk around the other resident and was then attacked. The following concerns were identified: a. Review of a progress note for resident #7 dated 8/23/22 and timed 1:50 PM showed [Resident #7] assessed by DON and ADON after altercation with another resident. [Resident #7] sustained minor injuries. Injuries include: skin tear x 3 to right forearm, scratch to center of chest (appears to be scratch to mole/growth), and abrasion to left knee. Wounds cleansed and dressed. Resident reports pain of 2 out of 10. Resident refused further evaluation at ER or urgent care. Resident states 'my pride hurts more than anything'. Resident instructed to stay away from other resident. Resident verbalized understanding. Resident remained in room watching tv for the afternoon. b. Review of a progress note for resident #7 dated 8/23/22 and timed 4:45 PM showed This nurse and DON assessed resident after [s/he] was involved in an altercation with other resident. [S/He] has multiple new bruises to [his/her] right and left arms. A skin tear to the back of right hand, wrist, upper forearm and under arm close to elbow. Abrasion to the left knee. Mid sternum it appears that [s/he] abraded the top of a growth resulting in some bleeding. All wounds have been cleansed with dressings applied. Skin tears with present flaps were approximated and steri-stipped with dry dressing placed over strips. Orders have been obtained and updated for wound care. Will continue to monitor for any s/s of infection or deterioration. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	c. Review of a progress note for resident #8 dated 8/23/22 at 1:40 PM showed Resident assessed by ADON after altercation with another resident. Resident does not appear to have any injuries. Resident [#8] states that the other resident had a hold of [his/her] right thumb. No bruising noted at this time but will continue to monitor. Resident went to chapel for confessional with NHA [nursing home administrator]. Nursing to ensure both resident remain separated. d. Review of an incident report dated 6/11/22 and timed 2:30 PM showed resident #7 wanted to go the vending machine and resident #8 was blocking the hallway. Resident #7 tried to move the wheelchair of resident #8 by pushing his/her wheelchair, which resulted resident #8 screaming, yelling and hitting at resident #7. Review showed resident #7 received bruising to his/her forearm and knuckles. Resident #7 reported resident #8 grabbed his/her arm which caused bruising. Further review showed Victim has been educated that in future times, to not touch another resident's wheelchair and to ask for assistance when needed to move someone .The perpetrator has been known to yell at staff at times when they feel like they are trying to get [him/her] to move out of the way in the hallway . e. Review of a progress note for resident #8 dated 6/9/22 and timed 5:47 PM showed the resident became upset after another resident bumped his/her wheelchair accidentally. The resident began yelling following the incident. Staff attempted to deescalate the situation and asked the resident to stop yelling. Staff intervention resulted in the resident yelling vulgar statements at the staff member. f. Interview with resident #7 on 8/31/22 at 3:11 PM revealed s/he had been attacked twice in a common area by the same person who blocked the vending machines. Observation at that time showed the resident's bilateral arms were discolored and skin tears were present on both arms. g. Interview with the administrator, DON, ADON, and SDC on 9/2/22 at 9:23 AM revealed on 8/23/22 the administrator observed resident #7 on his/her knees with his/her arm around resident #8's neck. Resident #8 was hitting and grabbing resident #7's arm. At that time, resident #8 was positioned in a wheelchair, blocking the vending machines and the walk area. Further interview revealed they were unsure if any interventions were developed following the 6/11/22 altercation which occurred in the same area, however, interventions were implemented following the 8/23/22 altercation which included having resident #7's family bring in snacks to prevent vending machine use, placement of the residents on units on opposite sides of the building, discussions with the family of resident #7 about alternate placement due to psychological needs, a medication review, and a request to vendors to move to the vending machines to an alternate location. 2. Review of the 7/6/22 quarterly MDS assessment for resident #2 was coded as having physical behavioral symptoms directed toward others 4 to 6 days of the 7-day lookback period. Review of the resident's behavior care plan showed interventions, dated 1/3/22, that included Allow [resident] to make decisions about treatment regime, to provide sense of control .Encourage as much participation/interaction by [resident] as possible during care activities .Give clear explanation of all care activities prior to and as they occur during each contact .If [resident] becomes agitated take [him/her] away from the situation. Allow [resident] to express [his/her] emotions and be a listening ear to [his/her] frustrations .Praise [resident] when behavior is appropriate. Review of the 7/26/22 quarterly MDS assessment for resident #3 showed the resident was coded as wandering 1 to 3 days during the lookback period. The following concerns were identified: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	a. Review of a facility incident report dated 8/12/22 and timed 10:50 PM showed resident #2 hit resident #3 over the head with a foot pedal from a wheelchair. Resident #3 was self-propelling around the hallway while the nurse and CNA assisted another resident in their room. When the CNA and Nurse returned to the nurse's station, they heard a loud noise followed by resident #3 crying out in pain. The staff members exited the nurse's station and observed resident #2 holding a wheelchair foot pedal over his/her head and resident #3 was holding his/her head and was bleeding. Resident #3 sustained a small laceration to his/her head. b. Review of a progress note for resident #2 dated 8/12/22 and timed 11:30 PM showed Heard a yell from out in the hallway just after hearing a sound like something mechanical being hit. Ran to the hall an [sic] saw [identifier] res sitting in the hall in front of room [ROOM NUMBER] holding [his/her] head and cussing. Blood was dripping from between [his/her] fingers. [Resident #2] was in [his/her] w/c [wheelchair] in the doorway of [his/her] room with the foot pedal from a w/c raised over [his/her] head as though to strike the other res again. Removed res from harm's way, taking [him/her] into the office to perform first aide. After first aide complete, attempted to have [resident #2] surrender the foot pedal s/he was still holding. [S/He] refused to give it to this RN or the CNA and waved it in a threatening manner when we approached [him/her]. [S/He] was adamant we would not take the pedal from [him/her] and verbally threatened harm if staff attempted to take the pedal. After a several minute stand-off, this RN was able to retrieve the foot pedal from [resident #2]. Asked [resident #2] to please return to [his/her] room and CNA staff sat in with [him/her] x 30 minutes to help him calm [him/herself]. This RN attempted to ascertain what had occurred. [Resident #2] readily admitted [s/he] struck the other resident with the foot pedal. During conversation [resident #2] indicated the other resident was, coming at me, and indicated that [his/her] hands were up in front of [him/her]. Unable to determine if the other resident was trying to get into [resident #2]'s room or was simply passing by. Prior to the actual strike, there was no verbal interaction heard between the 2 residents. Encouraged [resident #2] to remain in [his/her] room until the other resident was assisted to bed. Snack was offered and [resident #2] remained calmly in [his/her] room. c. Review of a progress note for resident #3 dated 8/12/22 and timed 11:45 PM showed the resident sustained injuries described as .a laceration 1.5 X [by] 0.2 cm, with a bruised area around laceration approx [approximately] 5 cm across. Able to slow/stop the bleeding with several minutes of direct pressure . d. Review of the Behavior care plan for resident #2 last revised on 8/15/22 showed new interventions implemented were Resident to be monitored for escalation in behaviors to other residents that [s/he] knowingly does not like as resident had recent altercation with another resident. When both residents in the same common area, residents to be monitored and redirected from each other. e. Review of the Behavior care plan for resident #3 last revised on 8/15/22 showed new interventions implemented were Resident to be monitored recent altercation with another resident. When both residents in the same common area, residents to be monitored and redirected from each other. f. Interview with the administrator, DON, ADON, and SDC on 9/2/22 at 9:23 AM revealed the facility implemented 1-to-1 monitoring of resident #2 during the remainder of the shift following the altercation and the discussed the altercation with staff. Due to the residents' dementia, no additional interventions were implemented for either resident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	3. Review of the policy titled Abuse Prevention Program last revised 12/2016 showed .As part of the resident abuse prevention, the administration will: 1. protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents .6. Identify and assess all possible incidents of abuse .

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F 0678 Level of Harm - Actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 Based on medical record review, staff interview, review of the facility policy and procedure, review of a facility performance improvement plan, and review of professional standards, the facility failed to ensure basic life support was administered to 1 of 1 sample resident (#10) who required and elected cardio-pulmonary resuscitation. This failure resulted in actual harm to resident #10, who went into cardiac arrest and did not receive CPR. The findings were: 1. Review of undated WyoPOLST which was signed by resident #10 and located in the resident's medical record on [DATE] showed the resident elected to have CPR/attempt resuscitation if s/he was found to have no pulse and was not breathing. 2. Review of the resident's electronic medical record face sheet on [DATE] showed the resident's code status was listed as Full Code. 3. Review of a progress note for resident #10 dated [DATE] and timed 2:45 PM showed CNA's called to have nurse check on resident. Resident was lethargic, and was not verbalizing at anything at this time. Told other CNA/Med aide to go get other nurse [name] from Courtyard to come and check on resident. Please see her note on resident. 4. Review of a progress note dated [DATE] and timed 3:10 PM showed On-call nurse was called @ [at] 1510. [Name], RN called back and was told resident had passed. Was told to call family and on-call dr. On-call dr. called at 1522. Dr. [name] called @ 1526 and was told that resident had passed Family was called and talked to [name] @ 1530. Family called back @ 1533 and did not want to spend anytime with resident. Family said they will come in later to pickup residents clothes and other items. Family said they would call [name] funeral home to come and pickup resident. Coroner was called @ 1535. Coroner told this nurse that this was an unattended death. 5. Review of a progress note dated [DATE] and timed 3:24 PM showed Assessment of resident at 3:04, [resident name] absent of all vital signs, Skin warm and dry. Eyes fixed and dilated. No respirations, No responsive to verbal or tactile stimuli. 6. Review of a progress note dated [DATE] at 5:50 PM showed Notified that resident passed. The resident was full code, code was not called. AIT [name] called POA and explained the situation. POA verbalized they wanted the resident to pass peacefully but didn't have a chance to update POLST to DNR. POA understanding of resident's recent decline. POA provided information on the funeral home for the resident to be sent to. 7. Interview with MA-C #1 on [DATE] at 9:41 AM revealed on [DATE] she heard CNAs yell for the nurse. At that time, LPN #1 asked her to get RN #1 from another unit. MA-C #1 went and got the other nurse, returned to the unit to finish medication pass, then sat down to chart. The MA-C revealed approximately 5 minutes after the resident was found without a pulse she identified the resident had a full code status and notified the LPN and RN. The MA-C revealed neither nurse initiated CPR after learning the resident's code status. (continued on next page)

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F 0678 Level of Harm - Actual harm Residents Affected - Few	8. Interview with RN #1 on [DATE] at 9:51 AM revealed the MA-C came to her unit and said the resident was short on breath. The RN finished the task she was performing and went to the resident's room approximately 3 minutes later. The RN revealed the resident was absent of vital signs at that time so she assessed the resident and pronounced his/her death. The RN began telling LPN #1 where to locate the procedure book and was told the resident was a full code. The RN said the code was identified approximately 5 minutes after she pronounced the resident's death. Further interview confirmed CPR was not initiated after the RN learned the resident's code status. 9. Interview with CNA #1 on [DATE] at 19:06 AM revealed the nurse asked her to obtain a weight on resident #10. When the CNA attempted to get the resident up, the resident went unresponsive. Further interview revealed the CNA was not on the unit when the resident's code status was identified. 10. Interview with LPN #1 on [DATE] at 10:57 AM revealed she had visited with the resident at approximately 2 PM in [DATE]. Following the interaction, the LPN asked the CNAs to obtain a weight on the resident. When the CNAs attempted to obtain the resident's weight, they reported the resident was weak. The LPN revealed when she went to the room the resident was gasping for air and she asked the MA-C to get RN #1. The LPN revealed the RN arrived to assess the resident between 5 and 10 minutes later, at which time, the resident was deceased . LPN #1 revealed the she was not told of the resident's code status until 20 minutes or half an hour after the resident was pronounced deceased . The LPN stated she learned of the code status when the on-call nurse asked why she did not initiate CPR. The LPN confirmed CPR was not performed when the resident was pronounced deceased or when the full code status was identified. Further interview with the LPN revealed she was suspended following the incident and she felt she did not receive adequate training prior to working independently at the facility. 11. Review of a Performance Improvement plan dated [DATE] showed on [DATE] a Resident with full code status reportedly had abnormal breathing and when checked on next was found without pulse. After approx. [approximately] 10 minutes was discovered to be Full Code. Staff did not respond accordingly, CPR was not initiated. Further review showed the plan of correction included interdisciplinary team will verify and update POLST of all resident, staff will be knowledgeable of Full Code precautions, staff will be proficient in performing life saving measure, and the facility will examine and improve ways to determine code status for clinical staff. 12. Interview with the administrator, DON, ADON, and SDC on [DATE] at 9:23 AM confirmed the performance improvement plan was not fully implemented and the facility planned to have it completed by the end of the month. 13. Review of the policy titled Emergency Procedure-Cardiopulmonary Resuscitation last revised ,d+[DATE] showed .3. Victims of cardiac arrest may initially have gasping respirations or may appear to be having a seizure. Training in BLS [basic life support] includes recognizing presentations of SCA [sudden cardiac arrest] .6. If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless: a. It is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual; or b. there are obvious signs of irreversible death (e.g. rigor mortis) . (continued on next page)

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F 0678 Level of Harm - Actual harm Residents Affected - Few	14. According to [NAME], [NAME], and [NAME] in Nursing Interventions and Clinical Skills, 7th edition, 2020, page 812 .Immediate recognition of cardiac arrest and activation of emergency medical response are critical. Early CPR and recommended health care team-level coordination that switches the provider who performs chest compressions every 2 minutes improves the performance of high-quality CPR (AHA, 2017).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 Based on medical record review, staff interview, review of a facility performance improvement plan, and policy and procedure review, the facility failed to ensure residents received necessary wound treatment and services to promote healing for 1 of 3 sample resident (#1) with a pressure injury. This failure resulted in harm to resident #1, whose pressure injury went unassessed over a period of weeks, and deteriorated to a stage III pressure injury. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #1 had diagnoses which included cancer, Alzheimer's disease, non-Alzheimer's dementia, seizure disorder or epilepsy, metabolic encephalopathy, and muscle wasting and atrophy. The resident required total physical assistance of 2 people for bed mobility, transfers, dressing, toilet use, and personal hygiene. Further review showed the resident was at risk for development of pressure injuries, and had 1 unstageable pressure injury that was not present at the time of admission. Review of the Integumentary care plan last revised 5/17/22 showed resident #1 had a pressure ulcer to the coccyx and interventions included provide wound care/preventative skin care per order, every 2 hour position changes to ensure resident was not lying in one position for too long, every 2 hour check and change to ensure the resident was dry, skin checks weekly per facility protocol, document findings, and turn and reposition frequently to decrease pressure. The following concerns were identified: a. Review of a Head to Toe Skin Check dated 2/9/22 and timed 5 PM showed the resident had no new or existing pressure ulcers. Review of a Head to Toe Skin Check dated 2/16/22 and timed 6 AM showed the resident had an existing pressure ulcer; however, no location or description was provided. Review of the Head to Toe Skin Check documents from 2/23/22 through 8/31/22 showed the resident was listed as having a pressure ulcer on 24 out 25 assessments; however, wound measurements were documented only 4 times, a wound description was documented only 8 times, and wound stage was documented only 2 times. Further review showed there was no Head to Toe Skin Check performed on 4/6/22, 4/20/22, or 8/10/22. b. Review of the Weekly Pressure Ulcer Record from February 2022 to August 2022 showed the date of onset for a pressure injury to the coccyx was 2/24/22; however, there was no evidence of a weekly pressure ulcer monitoring from 2/24/22 until 3/18/22. At that time the pressure injury measured 1.2 centimeters (cm) by 1 cm by 0.1 cm and was listed as a stage II. Further review showed there were no documented assessments for 7 weeks between 3/24/22 and 5/13/22, 19 days between 5/20/22 and 6/1/22, and 11 weeks between 6/3/22 and 8/19/22. Review of the Weekly Pressure Ulcer Record dated 8/26/22 at 10:15 PM showed the coccyx wound measured 0.75 cm by 0.75 cm by 0.2 cm and was indicated to be a stage III pressure injury. c. Review of a progress note dated 8/19/22 and timed 2:41 PM showed Assessment of pressure ulcer to coccyx completed this afternoon. Wound continues to show positive progress with decrease in depth. Wound has approximately 2% epithelium, 50% yellow slough, 25% red granular tissue to wound bed with no maceration undermining or tunneling at this time . d. Observation of the wound with the ADON on 9/2/22 at 9:18 AM showed a small wound to the coccyx area of the resident. At that time the ADON described the wound as having scant slough. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2. Interview with the administrator, DON, ADON, and SDC on 9/2/22 at 9:23 AM revealed the facility discussed wounds daily, nurses were expected to perform weekly assessments, and nurses were expected to communicate deterioration or healing of wounds. Further interview revealed the team identified the lack of documentation during the survey and wrote a performance improvement plan to correct the identified issues; however, the plan not been implemented at that time. The ADON was going to take over weekly assessments to ensure consistent evaluation of wound progress, wound measurement, and treatment monitoring was performed. 3. Review of the performance improvement plan dated 9/1/22 showed the review of 3 resident charts with pressure injuries demonstrated 2 out of 3 charts were not compliant with weekly pressure assessments. Goals for correction included the ADON will have oversight for all pressure injuries and assessments, the ADON will create an audit tool to ensure weekly documentation, the ADON will complete weekly progress notes on pressure injuries, and the ADON will complete one on one education with nursing staff on wound care specific to each resident. 4. Review of the policy titled Big Horn Rehabilitation Wound Care Policy provided by the facility on 9/9/22 showed .8. Nurse will provide wound care per physician orders and continue to implement and evaluate the plan of care based on the effectiveness of treatment regimen, response to treatment, effectiveness of interdisciplinary services, need for assessment by Wound Care Specialist, residents' participation and identification of obstacles/risk factors interfering with wound healing. The nurse will notify the physician for any change in the patient condition or lack of progress. 9. Head to Toe Skin assessments will be completed weekly. 10. At least once every week, the wound assessment and documentation will include measurement of length, width, depth, and undermining and tunneling if present .