STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worland Healthcare and Rehabilitation Center	1901 Howell Avenue Worland, WY 82401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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. 50485 Based on medical record review, staff interview, review of incident and facility documentation, and policy and procedure review, the facility failed to ensure residents were free from physical abuse by other residents for 1 of 9 sample residents reviewed. This failure resulted in actual harm to resident #1. The findings were: The facility had implemented corrective action prior to the survey and was determined to be in substantial compliance as of 9/27/24. 1. Review of the 10/6/24 admission MDS assessment showed resident #1 (victim) had a BIMS of 3, which indicated severely impaired cognitive skills, and had diagnoses of non-Alzheimer's dementia and pelvic fractures. Further review showed the resident had limited ability to make concrete requests and exhibited verbal behavioral symptoms toward others. 2. Review of the 7/22/24 admission MDS assessment showed resident #2 (perpetrator) had a BIMS score of 4, which indicated severely impaired cognitive skills. Further review of the resident's medical record revealed a diagnosis of unspecified dementia, severe, with other behavioral disturbance. Further review showed the resident exhibited physical behavioral symptoms directed toward others, and rejection of care had occurred 1 to 3 days of the 7-day look-back period. The following concerns were identified related to a resident-to-resident interaction between resident #1 and resident #2: a. Review of an incident report showed on 9/24/24 at 8:35 PM resident #1 and resident #2 had been visiting in the dining room of the memory care unit after dinner with another resident. They were assisted to their rooms by the CNA #2. For an unknown reason, resident #2 later entered resident #1's room and left the room telling staff that s/he had pushed resident #1 down. CNA #1 entered the room and found resident #1 on the floor of his/her room with a laceration to the scalp. Resident #1 was provided first aid by the Nurse #2 and was sent to the emergency room for evaluation. Resident #1 was diagnosed with a probable pelvic fracture. b. Review of the history and physical from the hospital dated 9/25/24 showed resident #1 was admitted to the hospital with a severe pelvic fracture and exacerbation of his/her severe bone on bone degenerative joint disease of the right hip. (continued on next page)

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.

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. Interview with the DON on 10/24/24 at 11 AM revealed resident #2 had a gradual dose reduction of his/her antipsychotic medication prior to the incident on 9/24/24, and following the incident the resident's medication was increased back to prior dosage. Further, the resident was moved out of the memory care unit, and had 1-to-1 supervision for 3 weeks before placement in a new facility closer to family. d. Interview with CNA #1 on 10/24/24 at 1:21 PM revealed the incident happened out of nowhere. The CNA reported three residents were sitting at a table and talking to each other when she went to assist another resident to get ready for bed. The CNA then heard a door slam and after she walked into the hall she saw resident #2 had walked out of resident #1's room. The CNA went to resident #1's room and found resident #1 on the floor. The CNA revealed resident #1 was shocked and adamant s/he needed to get off the floor. The CNA placed a pillow under the resident's head and saw the blood from resident #1's head hitting the floor. e. Interview with CNA #3 on 10/24/24 at 2:23 PM revealed there were 3 residents sitting at a table in the dining room and they were getting along great. The CNA guided residents #1 and #2 to their rooms to get ready for bed. While he assisted another resident, the CNA heard a high pitched scream, and after going to the hall to see where the scream came from, the CNA saw resident #2 standing outside resident #1's room, and resident #2 stated s/he won't be doing that again. The CNA redirected resident #2 back to his/her room and got Nurse #2 to assess resident #1. 3. The facility implemented the following corrective action by 9/27/24: a. Resident #1 was provided immediate first aid in-house to the laceration on his/her head and was sent to the emergency room for further evaluation and treatment. b. Resident #2 received 1-to-1 monitoring by staff and labs were ordered to rule out any acute issues. c. The facility reported the incident to the State Survey Agency and the Police Department on 9/24/24. d. Care plans were updated for both residents. e. The DON/Designee reviewed the last 30 days of incidents/accidents to determine any pattern or trends. f. The DON/Designee reeducated all staff who work with residents on abuse and behavior management to decrease the risk of aggression towards other residents. g. Weekly audits were started to review incident/accident documentation and ensure re-education with staff members present during incidents was performed. Audits to be done weekly then monthly and discussed in the QAPI meetings. 4. Review of the facility's policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, showed .Residents have the right to be free from abuse .1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including but not necessarily limited to: . b. other residents .