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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worland Health and Rehabilitation	1901 Howell Ave 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of incident and facility documentation, and policy and procedure review, the facility failed to protect the resident's right to be free from physical abuse by another resident for 1 of 7 sample residents (#2) reviewed for abuse. This failure resulted in actual harm to resident #2. The facility had implemented corrective action prior to the survey and was found to be in substantial compliance as of 9/11/25. The findings were:1. Review of the 11/14/25 quarterly MDS assessment showed resident #2 had severely impaired memory, and had verbal behavioral symptoms directed toward others. Further review showed the resident had a diagnosis of non-Alzheimer's dementia. Review of the 8/8/25 admission MDS assessment showed resident #3 had a BIMS score of 10 out of 15, which indicated moderate cognitive impairment. Further review of the resident's medical record showed diagnoses which included dementia and anxiety. The following concerns were identified: a. Review of the facility incident report dated 9/10/25 showed a CNA heard yelling from the room where resident #2 and resident #3 were roommates. The CNA witnessed resident #3 with a Bible in his/her hand raised toward resident #2. The CNA questioned what was going on, and resident #3 responded well [s/he] was in the way. Both residents stated they were fighting. The CNA separated the residents and witnessed blood and scratches on resident #2's face. The nurse assessed both residents for injuries. Resident #3 did not have any injuries. Resident #2 sustained 2 small abrasions to the left cheek. Resident #3 was assigned a 1:1 staff member. A urinalysis (UA) and an order for Seroquel were ordered for resident #3, and his/her family member decided to take the resident home due to the aggression toward his/her roommate. b. Interview with RN #1 on 2/24/26 at 5:55 PM revealed resident #2 and resident #3 had been roommates, and one of them thought the other one was in his/her way. She reported resident #2 had a red spot on his/her check and she cleaned it and left it open to air.c. Interview with CNA #4 on 2/25/26 at 10:59 AM revealed she had taken resident #2 into his/her room to watch television, and resident #3 was on his/her side of the room looking through his/her personal belongings. She went to the nurses' station, and then heard loud noises coming from the room. When she went to check on the residents, they were next to each other, and resident #2 was holding his/her fist up, and resident #3 was holding up a Bible. She stopped them and noticed resident #2 was bleeding from his/her face. She reported resident #3 had tried to leave the room and resident #2 had been in the way. She separated the residents and took resident #2 to the nurse. d. Interview with the SSD on 2/25/26 at 12:20 PM revealed she got resident #2 a beverage and took him/her to an activity and resident #3 was assigned a 1-to-1 staff for supervision. She discussed the 1-to-1 supervision with resident #3's daughter, who opted to take him/her home that day. Further interview revealed all staff received education and a POC (plan of correction) was initiated that day.2. The facility implemented the following corrective action by 9/11/25: a. Resident #2 was provided immediate assessment by the RN for the abrasion on his/her left cheek, the physician was notified for further (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	assessment, and the SSD provided emotional support. b. The families of both residents were immediately notified by the SSD. c. Resident #3 received 1-to-1 supervision by activities staff and the SSD, and a UA was ordered. d. The SSD and resident #3's daughter discussed an action plan to ensure the safety of all residents going forward. The SSD sent referral paperwork to another facility, and the resident's daughter initiated discharge for the resident on 9/10/25. The resident's UA was positive, and the SSD forwarded the results to the resident's family as the resident had already been discharged . e. The facility reported the incident to the [NAME] and the Ombudsman on 9/10/25. f. The facility initiated the abuse investigation which included resident interviews on 9/10/25. g. The facility determined that residents resided in the community were potentially at risk. The DON, SSD, NHA or designee conducted random resident interviews to identify if other residents had experienced mistreatment of any kind. No other issues or concerns were identified. h. The DON and SSD re-educated all staff on de-escalating residents with dementia. All current staff completed the training. New hires completed training upon orientation. i. Weekly audits were started to review the incident reporting database, the grievance management system, resident and family interviews, and Ombudsman feedback. Audits to be done monthly and then as needed for 3 months, and then as needed. On the spot re-education would occur at the time a staff member was president for an incident. Counseling would be provided as indicated. Any issues identified would be trended and reviewed in the facility QAPI meeting to ensure the plan was implemented, sustained, and evaluated for its effectiveness.3. Review of the facility policy, Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation updated March 2025 showed .Each resident has the right to be free from abuse, including verbal, mental, sexual or physical abuse .The Center implements policies and processes so that residents are not subjected to abuse by staff, other residents .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure residents received adequate supervision and devices to prevent accidents for 5 of 5 sample residents (#1, #9, #10, #11, #15) reviewed for accident hazards. This failure resulted in actual harm to resident #1 who received burns from hot liquid. The failure resulted in a determination of immediate jeopardy due to a lack of implementation of interventions, including adequate supervision and use of safety equipment. The census was 67. The findings were:1. Review of the quarterly MDS assessment dated [DATE] showed resident #1 had a BIMS score of 9, which indicated moderate cognitive impairment, and had diagnoses which included stroke, hemiplegia, and dysphagia. Further review showed the resident required setup or cleanup help with eating. Review of the care plan last revised on 2/22/26 showed interventions which included use of a Kennedy cup (spill-proof cup with a lid) for all hot beverages, which was initiated on 01/19/26, and food and fluid should be served at a temperature that was not scalding, which was initiated on 12/11/24. The following concerns were identified:a. Review of an Event Investigation Final Summary dated 1/19/26 showed resident #1 spilled coffee on him/herself on 1/19/26 at 6:30 AM which caused a burn on right leg and a raised reddened area on him/her left thigh. The resident was identified as being at risk for hot liquid injury related to hemiplegia and hemiparesis which had caused hand contractures on one side. The resident used hard cups with a handle that provided him/her with a better grip. The resident was given a Styrofoam cup with no handles at the time of incident. The facility referred the resident to speech therapy for evaluation to see if s/he required special cups or utensils for drinking.b. Review of the emergency department record dated 1/19/26 and timed 12:30 PM showed . burns to the upper inner thighs. These appear to be second-degree burns and do not involve the genitalia and are not circumferential.c. Observation in the dining room on 2/25/26 at 6:50 AM showed an unidentified visitor gave resident #1 a cup of coffee, in a regular cup with no lid. Continued observation showed CNA #2 refilled resident #1's cup at 7:32 AM. The CNA did not provide a lid for the cup or obtain a new cup with a lid.d. Interview with CNA #1 on 2/25/26 at 10:18 AM revealed on 1/19/26 she had given resident #1 a cup of coffee in a Styrofoam cup with no lid due to the facility using disposable dinnerware because of an influenza outbreak. She revealed she left the room to care for another resident, heard screaming, and immediately returned to resident #1's room where she found the resident with coffee spilled into his/her lap. The CNA placed a towel in the resident's lap and tried to dry up what she could; however, she was unable to assist the resident into bed independently, went to get the RN for assistance, and to assess the resident.e. Interview with RN #1 on 2/24/25 at 5:55 PM revealed on the day of the incident, she responded to CNA #1 reporting resident #1 had spilled their coffee in their lap and the CNA needed assistance with the resident. The RN revealed upon entering the room, she observed the resident had wet pants. The RN revealed after staff removed the resident's pants, s/he had what appeared to be burns to the right thigh and a raised, reddened area on his/her left thigh. RN #1 revealed she cleaned the wounds and applied silver wound gel then notified the DON and administrator of situation, and it was determined the resident should be sent to the emergency department for evaluation and treatment.2. Observation in the dining room on 2/24/26 at 2:10 PM showed resident #11 independently obtained coffee from the coffee carafe, into a cup with no lid. Further observation showed the resident placed the coffee cup on his/her walker seat and ambulated by pushing the walker, which caused the coffee to spill.3. Observation in the dining room on 2/25/26 at 7:30 AM showed resident #9 independently obtained hot water from the coffee machine water spout into an open cup with no lid. Further (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	observation showed the resident walked back to his/her table with the cup in one hand, while pushing his/her walker with the other hand.4. Observation in the dining room on 2/25/26 at 7:31 AM showed CNA #2 obtained a cup of water from the coffee machine water spout and checked the temperature, which was 176.7 degrees Fahrenheit.5. Observation in the dining room on 2/25/26 at 7:40 AM showed resident #10 independently obtained coffee, from the coffee machine, in a cup with no lid. The resident then walked back to a table with the cup in one hand while pushing his/her walker with the other. Further observation showed the resident spilled coffee on him/her and the table when trying to set it down. There was no evidence of injury from spilling on him/herself.6. Observation in the dining room on 2/25/26 at 11:30 AM showed resident #15 independently obtained hot water from the coffee machine water spout into a cup without a lid, and mixed it with a packet of cocoa. The resident ambulated back to his/her seat holding the cocoa in his/her right hand, pushing his/her walker with his/her left hand.7. Observation in the dining room on 2/25/26 at 11:32 AM showed resident #9 independently obtained hot water from the coffee machine water spout and walked back to his/her table. 8. Observation in the dining room on 2/25/26 at 11:40 AM showed CNA #2 obtained a cup of water from the coffee machine water spout and checked the temperature, which was 168.7 degrees Fahrenheit.9. Interview with cook #1 on 2/24/26 at 3:25 PM revealed water from the coffee machine was never to be given to residents.10. Interview with dietary aid #1 on 2/24/26 at 5:05 PM revealed coffee and water temperatures were checked in the kitchen and were never to be served directly from the coffee machine.11. Interview with CNA #2 on 2/25/26 at 10:27 AM revealed residents were allowed to independently obtain beverages but they try to help everyone they can. She revealed there was supposed to be two aides in the dining room for meals a half hour prior to meal times for resident assistance; however, there was usually only one. She revealed she was unaware of any interventions in place to keep residents from filling cups with water from coffee machine and residents did not like waiting for an extended time which resulted in them obtaining items independently. Further interview revealed specialty items, such as cups, plates, and utensils were identified on meal trays; however, beverages were usually provided to residents prior to those coming out.12. On 2/25/26 at 2:59 PM the regional clinical director, interim administrator, and administrator were informed of an immediate jeopardy related to a failure to identify and remove accident/hazard risks to residents.13. The facility submitted a removal plan on 2/25/26 at 4:41PM which included:a. The hot beverage machine being taken out of service on 2/25/26 at 3:30 PM.b. Adaptive equipment audits on all residents on 2/25/26 by 7:00 PM. c. Implementation of access to the hot beverage machine only by dietary staff on 2/25/26 by 3:30 PM.d. Signage posted to ask for assistance with beverages 2/25/26 by 3:50 PMe. Education provided for all staff on hot beverages and all the above interventions 2/25/26 by 7:00 PM.14. The removal plan was accepted on 2/25/26 at 5:13 PM.15. The implementation of the removal plan was verified and immediacy was removed on 2/26/26 at 9:05 AM; however, deficient practice remained at a scope and severity of G.