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	04/02/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident representative interview, medical record review, facility investigation review, Office of Healthcare Licensing and Surveys ([NAME]) incident report log review, and policy and procedure review, the facility failed to report an injury of unknown source within 2 hours to the State Agency for 1 of 3 sample residents (#1) reviewed for allegations of abuse. The census was 64. The findings were:1. Review of the 11/30/25 quarterly MDS assessment showed the resident had diagnoses which included non-Alzheimer's dementia, anxiety, and depression. The resident had a BIMS assessment of 0 which indicated severe cognitive impairment. The resident was coded as having no falls since admission/entry or the prior assessment. The following concerns were identified:a. Review of a facility reported incident (FRI) dated 3/4/26 showed an allegation of an injury of unknown source occurred on 3/3/26 at 9:40 PM. The staff was made aware on 3/3/26 at 9:43 PM, and the administrator was made aware on 3/3/26 at 9:43 PM. The initial incident report was sent to [NAME] on 3/4/26 at 9:05 PM. b. Review of a progress note dated 3/3/2026 and timed 9:38 PM showed LPN #1 reported new or worsening edema and a change in skin color or conditions. Further review showed the primary care provider (PCP) responded with the recommendation to send the resident to the emergency room (ER) for an x-ray to rule out fractures. c. Review of a progress note dated 3/3/26 and timed 10 PM showed LPN #1 .spoke with [POA] in regards to patient's right knee. Nurse aide had notified this nurse that patient knee looked different than [his/her] baseline. This nurse evaluated patient right knee. There is mild bruising noted to the knee and it is visibly swollen. The knee appears deformed inward slightly. DON as well as MD immediately upon findings. This nurse explained after speaking with MD and MD requested the patient to be sent to ER to evaluate for fractures. When this was all explained to daughter [name], she stated Well, you guys are just going to have to keep her comfortable until tomorrow or something. Who did I call? No one ever answers the phone anyway. This nurse explained again to patient daughter that [his/her] knee is visibly deformed and patient has some mild pain. POA stated she was come to facility or call to try to figure out what to do.d. Review of a progress note by the DON dated 3/04/2026 and timed 12:06 PM showed Resident noted with increased swelling and pain upon touch. Decreased ROM [range of motion] noted to right lower extremity. Resident is non weight bearing. No obvious open areas noted. V/S are WNL [within normal limits], pulse noted to RLE [right lower extremity]. Provider notified of findings. Order received to send resident to ER for evaluation to rule out fracture or dislocation of right knee. Daughter/POA [name] made aware of findings and gave permission to send to ER accompanied by trusted staff member. EMS [emergency medical services] transported resident to ER. Medication list, Facesheet, SBAR [situation, background, assessment, recommendation], transfer packet, and POLST [portable medical order for life-sustaining treatment] given to EMT [emergency medical technician].e. Interview with the SSD on 4/1/26 at 10:45 AM revealed the DON notified the administrative staff of resident #1's right knee injury at the morning staff meeting on 3/4/26. The SSD reported she accompanied resident #1 and his/her POA to the ER, and informed the facility administration the resident had a right femur fracture. Further interview revealed the Adult (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protective Services (APS) caseworker arrived at the facility around 4 PM because she had received a report and told the SSD she had not received a report from the facility. The SSD was instructed to open the report.f. Interview with the resident's representative on 4/1/26 at 12:15 PM revealed the resident received surgery to the fractured femur, entered hospice, and passed away.g. Interview with CNA #1 on 4/1/26 at 12:49 PM revealed the resident had complained of pain for approximately 2 weeks prior to being sent to the ER and she had reported it to the nurses every single day.h. Interview with CNA #2 on 4/1/26 at 1:29 PM revealed for the last 3 weeks the resident was in the facility, his/her right knee had been swollen, had greenish purplish bruising and wasn't normal. She reported she let the nurses know and was told they would give the resident pain medication.i. Interview with CNA #3 on 4/1/26 at 1:50 PM revealed she had worked with the resident in mid-February, and the resident had moaned and groaned and said his/her leg was broken. She reported the resident's pain to the nurse and the resident had been provided with pain medication.j. Interview with CNA #4 on 4/1/26 at 3:07 PM revealed the resident sat at the nurses' station and cried ow, ow on the night of 3/3/26. She transferred the resident with the hoyer lift into bed, and noticed the resident's right leg was larger and almost bent and discolored. She stated she reported it to the nurse .k. Interview with LPN #1 revealed the resident had been yelling out in pain after dinner, which was not unusual, however it had been more than usual that night. She stated the resident reported his/her back was hurting, and she rubbed Biofreeze on the resident's back and gave him/her pain medication. She stated the after the CNA transferred the resident into bed, she asked the nurse what had happened that s/he needed the hoyer lift, and told the nurse how the resident's knee looked. She stated the CNA told her she thought it had been reported, and when she went into the resident's room to look at his/her knee, she knew it was broken because of how it looked. She stated she told the CNA not to do anything else with the resident, she had to report it because it was clearly broken. She stated she called the DON, the resident's representative, and the doctor. She stated the doctor wanted the resident sent to the ER for an x-ray, and when she called the resident's representative, they did not want the resident sent to the ER that late at night, and wanted to wait until the morning. She reported the resident was resting at that time and was not in pain.l. Interview with the NHA on 4/2/26 at 11:45 AM confirmed the SSD had notified the former NHA about resident #1's femur fracture on 3/4/26 at 12:55 PM.2. Review of facility policy titled Abuse Reporting and Response provided by the Regional Director of Clinical Operations on 4/2/26 at 11:50 AM showed .2. Staff reports occurrences of injuries of unknown source immediately to the supervisor and Executive Director.4. The Executive Director or designee reports alleged violations to the state survey agency and other officials in accordance with state law (such as Adult Protective Services and local law enforcement) as follows: a. Immediately but not later than 2 hours - All allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, if the events that cause the allegation involve abuse or result in serious bodily injury.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and provider interview, the facility failed to ensure a safe and orderly discharge from the facility for 1 of 3 sample residents (#2) reviewed for discharge. The findings were:1. Review of the 3/19/26 admission MDS assessment showed resident #2 was admitted to the facility on [DATE]. Review of the initial care plan showed the resident had diagnoses which included nontraumatic hematoma of soft tissue, congestive heart failure (CHF), urinary tract infection (UTI), and mild cognitive impairment. Review of the medical record showed the resident was discharged from the facility on 3/30/26 at 1:30 PM. The following concerns were identified:a. Review of the Physician Medicare Certification dated 3/19/26 and signed by the physician on 3/24/26 showed the resident required daily care for skilled rehab and skilled nursing, and the physician recommended post-SNF care at an assisted living facility (ALF).b. Review of the care conference minutes dated 3/20/26 showed the resident's proposed/approximate discharge date was in 10 days.c. Review of a progress note by LPN #2 dated 3/30/28 and timed 4:18 PM showed Resident discharge from facility @ 1415. Discharge order received and carried out as directed. Vital signs stable at time if discharge. Resident alert and oriented at baseline. No acute distress observed. Discharge instructions, medications and reviewed with resident and responsible party. Education provided regarding medications, treatment plan. Understanding verbalized. All personal belongings sent with resident. Resident left facility via personal transport in stable condition. Appropriate notification completed and documented in medical records.d. Review of a progress note by the SSD dated 3/30/26 and timed 4:38 PM showed This writer spoke to residents [sic] daughter and son regarding residents discharge. The NP was not comfortable signing [his/her] discharge orders d/t [due to] not being able to evaluate resident prior to discharge. e. Interview with the NP on 4/1/26 at 1:05 PM revealed the resident had been admitted to the facility for rehabilitation due to acute CHF. She stated she had been familiar with the resident, who had a history of severe self-care deficits, and a history of skin breakdown. She reported the physician had just signed the resident's certification the week prior for a 30 day stay, and the resident had been discharged from the facility after only 11 days. She stated there were no discharge orders received from the facility at the physician's office, and the physician had been out of town at the time of the discharge. She reported the physician's office received a phone call on 3/30/26 at 2:30 PM from the facility and the caller requested orders to be sent to the pharmacy, and she refused to sign those orders. She reported discharge orders had been requested on 3/30/26 at 4:15 PM for discharge to the resident's apartment, and for physical therapy (PT) and occupational therapy (OT). Further interview revealed there had been no discharge visit, no follow-up physician visit scheduled, no written order for PT and OT, and the discharge was not considered an against medical advice (AMA) discharge.f. Interview with the SSD on 4/2/26 at 10:15 AM revealed the staff thought they had doctor's orders for the discharge because they had lined everything up and sent it off. Staff did not know the doctor had not been contacted until after the resident left. She reported a nurse called the physician's office after they realized the resident needed a narcotic prescription, and the NP would not sign the order because she did not order the discharge.g. Interview with the NHA on 4/2/26 at 10:45 AM revealed the expectation for the discharge process was to have a discharge order from the provider before discharge.h. Interview with LPN #2 on 4/2/26 at 11:18 AM revealed there had been a discharge meeting on 3/37/26, and she had provided the resident with his/her medications with the exception of the narcotics prior to discharge from the facility on 3/30/26.i. Interview with the regional director of clinical operations on 4/2/26 at 11:48 AM confirmed the resident was discharged without signed discharge orders.