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	03/06/2025

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 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** 35081 Based on medical record review, resident and staff interview, facility incident investigation review, state survey agency incident database review, and policy review, the facility failed to report allegations of misappropriation of resident property for 1 of 3 sample residents (#59) reviewed for abuse, neglect, and misappropriation. The findings were: 1. Review of the annual MDS assessment dated [DATE] showed resident #59 had a brief interview for mental status score of 14 out of 15 which indicated the resident was cognitively intact. The following concerns were identified: a. Interview with the resident on 3/4/25 at 11:23 AM revealed s/he had $200 which was missing and had told a housekeeper about it. The resident revealed the money went missing about 3 weeks ago and the money had not been found, returned, or replaced. b. Review of the state survey agency incident database review showed no evidence the allegation of missing money was reported. c. Review of an Investigator Interview Form dated 2/10/25 showed the resident told the social services director s/he was missing $200 from a bank envelope that was on his/her bedside table. The resident was unable to say what happened to the money or when it went missing. d. Interview with the social services director on 3/5/25 at 3:29 PM revealed she was aware the resident was missing money and an investigation was completed. Interview with the social services director on 3/5/25 at 4:52 PM confirmed the allegation of missing money and investigation were not reported to the state survey agency. 2. Review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating last revised September 2024 showed .1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility .3. Immediately is defined as: a. within two hours of an allegation involving abuse or result [sic] in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury .

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51658 Based on observation, medical record review, staff interview, facility activities calendar review and policy and procedure review, the facility failed to provide an activities program designed to support residents in their choice of activities for 1 of 2 sample residents (#48) with activity concerns. The findings were: 1. Review of the admission MDS assessment dated [DATE] showed resident #48 had a diagnosis of dementia with behavioral symptoms such as hitting, kicking and wandering. Further review showed it was very important to the resident to do things with groups of people, very important to go outside when the weather was good, and somewhat important to do his/her favorite activities. The resident had a brief interview for mental status score of 5 out of 15, which indicated severe cognitive impairment. Review of the care plan last revised on 2/26/25 showed [the resident is] dependent on staff for meeting emotional, intellectual, physical, spiritual and social needs interventions which included Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility. Please invite me to scheduled activities . Engage in simple, structured activities such as small cognitive games. I like to go for walks to get a snack and soda. I like to be helpful and clean around the building when I am able to. I was a janitor for several years, and I enjoy being helpful. In addition, the resident's plan showed I like to be kept busy with activities and exercise. I like to be busy, and I do not like to be cooped up. I will bang on the SCU [secure care unit] doors and try to exit .Resident is an elopement risk [due to history] of exit seeking and wandering. Interventions included Ask resident if [s/he] would help clean up after meals .Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, play games, games that challenge [his/her] memory and cognition. Exercise, resident likes to walk. Resident has a history of being a school janitor, [s/he] likes to clean. Allow [him/her] to assist with clearing tables, wiping hand rails. The following concerns were identified: a. Review of the activities calendar for the SCU showed the activities for 3/4/25 were 10 AM puzzles, 11 AM music, 2 PM matching game, and 4 PM Storytime with [staff name]. Further review showed activities planned for 3/5/25 were 10 AM chair exercise, 11 AM funny videos, and 4:30 PM wet Wednesday. b. Observation on 3/4/25 from 9:49 AM to 10:20 AM showed the resident was pacing with his/her walker up and down the hallway and around the dining room. At 10:11 AM, the social services director entered the secure unit and told resident #48 they would be going to play balloon tennis soon. The staff member left the secure unit, and the resident remained in the unit. Further observation showed the resident was not assisted to the activity, and the s/he continued to pace. c. Observation on 3/5/25 from 8:55 AM to 11:20 AM showed the resident was pacing around the dining room. A CNA encouraged him/her to sit down and watch TV, which s/he did. At 8:59 AM, the resident got up and began pacing up and down the hallway. S/he continued pacing up and down the hallway until 9:54 AM when s/he sat down to have a snack. At 10:37 AM, the resident left the unit with an aide for a shower. At 11:20 AM, the resident was again walking up and down the hallway and followed a staff member into another resident's room. S/he remained there while the staff member gave medication to the other resident. The resident was not invited to or engaged in activities during the observation. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Observation on 3/5/25 from 1:43 PM to 2:55 PM showed the resident was pacing around the dining room and making statements which included I don't trust that one. She's got a lot of people; she has a network of people. Just between me and you. The resident continued to pace until 1:58 PM when s/he sat and made statements which included Somebody's watching though. But I didn't do it, so I don't care. I didn't do it, so I don't have nothing to hide. I get upset when somebody blames me for something. and There's something wrong somewhere. The resident then asked if s/he could use the broom to sweep up. A CNA told him/her that it was already cleaned up. The resident attempted to empty the trash bin in the dining room. The CNA told him/her they would get it later. The resident pulled the trash bin off the medication cart and began to carry it while staff was engaged with other residents. S/he then began using the broom to mop the floor, dipping it into the trash can and scrubbing the floor with circular motions. d. Review of resident's Life Enrichment Quarterly Review dated 12/29/24 showed Resident loves social activities and Resident continues to be actively engaged in the SNF [skilled nursing facility] community. [S/he] is one of our more outgoing residents in spite of being in the SCU. 2. Interview with the social services director on 3/5/25 at 4:50 PM revealed the facility had one activities staff member on medical leave and one on vacation during the week of the survey. She stated, This is a bad week for us with activities. The social services director revealed they had a planned activities calendar for the SCU, but it was flexible based on what was going on with the residents. She revealed some residents, like [resident #48], like to do activities with the rest of the residents [outside of the SCU]. She revealed the expectation was for the CNAs in the unit to perform structured activities. 3. Review of facility policy titled Activity Programs showed .Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident .Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 Based on observation, medical record review, and staff and resident interview, the facility failed to ensure resident diet orders were followed for 1 of 3 sample residents (#50) reviewed for food and nutrition. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #50 had a brief interview for mental status score of 15 out of 15, which indicated the resident was cognitively intact, and diagnoses which included diabetes mellitus. Further review showed the resident was coded for a therapeutic diet. Review of the resident's physician orders showed the resident was to receive a controlled carbohydrate diet, had fingerstick blood sugar checks before meals and as needed, and received insulin per a sliding scale based on fingerstick blood sugar levels. The following concerns were identified: a. Observation on 3/4/25 at 8:36 AM showed the resident received a full cinnamon roll with glaze that was visible on top of the roll and on the plate. Review of the diet card provided with the meal showed the resident should have received a half portion of cinnamon roll with no glaze. Interview with the resident at that time revealed the facility did not follow his/her diabetic diet plan. b. Interview with the dietitian on 3/5/25 at 3:48 PM revealed the facility's diabetic diet included smaller portions of carbohydrates and sugar. Further interview revealed diet cards should be followed during meal service, unless a resident requests something different than the diet card. c. Interview with the dietary manager on 3/5/25 at 9:36 AM revealed the diabetic diet portion is a half portion served without a topping. Further interview revealed an aide would usually catch it if a resident was given a regular portion, and they would get approval from the nurse if the resident requested a full portion. d. Interview with the dietary manager on 3/5/25 at 4 PM confirmed the resident's diet card should have been followed and any requests for items different from the diet should be indicated on the card provided with the meal. Further interview confirmed the resident did not request a full cinnamon roll or glaze for the meal. 50485

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 Based on observation, medical record review, staff interview, professional standard review, and policy review, the facility failed to ensure infection prevention practices were implemented for 1 of 2 sample residents (#2) observed during personal care. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #2 had a brief interview for mental status score of 5 out of 15, which indicated severe cognitive impairment, and diagnoses which included cerebrovascular accident and hemiplegia or hemiparesis. Further review showed the resident was frequently incontinent of bowel and bladder and was dependent on staff for toileting hygiene and personal hygiene. The following concerns were identified: a. Observation on 3/5/25 at 2:22 PM showed CNA #1 and OT #1 assisted the resident into bed. The staff members removed the resident's soiled pants and CNA #1 placed the pants on the floor by the bed. The CNA performed incontinence care and, without removing the soiled gloves, the CNA touched the resident's clean brief, clean pants, shirt, left shoe, blanket, television remote, bed remote, call light, and the outside of the wipe container. Prior to leaving the room, the CNA removed the gloves and used hand sanitizing gel. At that time, the CNA obtained the resident's soiled pants from the floor and carried them to the soiled linen room down the hallway, without placing them in a bag. b. Interview with CNA #1 on 3/5/25 at 2:40 PM revealed she knew she was expected to remove her gloves after contamination and prior to touching anything else in the room; however, she was nervous. In addition, she revealed she should have placed dirty linen items in a bag before exiting the resident's room. c. Interview with the infection preventionist on 3/5/25 at 2:46 PM confirmed contaminated gloves should be removed before touching clean items and staff should were expected to bag soiled items prior to removing them from a resident room. 2. Review of the website www.cdc.gov/infection-control/hcp/isolation-precautions/appendix-a-table dated 11/27/23 showed Remove gloves after contact with a patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination (see Figure). Do not wear the same pair of gloves for the care of more than one patient. Do not wash gloves for the purpose of reuse since this practice has been associated with transmission of pathogens .Change gloves during patient care if the hands will move from a contaminated body-site (e.g., perineal area) to a clean body-site (e.g., face) . 3. Review of the policy titled Briefs/Underpads dated 2001 showed .12. Perform perineal care [sic] the resident's back side. 13. Remove the underpad from resident by rolling the underpad toward the inside soiled area. Place the underpad in the nearby receptacle/container. 14. Remove gloves, sanitize hands and replace with clean gloves. 15. Place a clean underpad and brief under the resident. 16. Roll the resident on their back. 17. Fasten the brief. 18. Reposition the bed covers. 19. Discard disposable equipment and supplies in designated containers. 20. Remove gloves and perform hand hygiene. 21. Clean the overbed table and return it to its [sic] proper location . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of the policy titled Laundry and Bedding, Soiled dated 2001 showed .2. Contaminated Laundry is bagged or contained at the point of collection (i.e., location where it was used) .