STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535048	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worland Health and Rehabilitation	**1901 Howell Ave , Worland, Wyoming, 82401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint investigation was conducted on 4/1/26 through 4/2/26. The survey was prompted by complaint intakes 2790284, 2799497, 2804833, 2963713, 2967636, and 2970761. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set NHA: Nursing Home Administrator NP: Nurse Practitioner POA: Power of Attorney RN: Registered Nurse SNF: Skilled Nursing Facility SSD: Social Services Director Less commonly used abbreviations will be annotated in each deficiency.	F0000		04/24/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are	F0609	POC Abuse Reporting Preparation and execution of the response and Plan of Correction or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and /or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and Plan of Correction constitute the facility's allegation of compliance in accordance with the State Operations Manual.	04/18/2026

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 reverse for further 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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F0609 SS = D	Continued from page 1 reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on staff and resident representative interview, medical record review, facility investigation review, Office of Healthcare Licensing and Surveys (OHLS) 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 OHLS 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	F0609	Continued from page 1 Resident is no longer a resident at the facility Administrator or Designee will Audit the past 30 days to validate injuries of unknown source are reported within 2 hours to the State Agency. Regional Nurse educated the Administrator and Social Services on reporting injuries of unknown source are reported within 2 hours to the State Agency. Administrator or Designee will audit abuse reporting weekly for 3 weeks, then monthly for 2 months to validate injuries of unknown source are reported within 2 hours to the State Agency. Administrator or Designee will report the tracking and trending of the audits to the facility monthly Quality Assurance Meeting for 90 days or until compliance has been achieved or sustained as directed by the committee. Date of Compliance 4/18/26	04/18/2026

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F0609 SS = D	Continued from page 2 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 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."	F0609		04/18/2026

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F0609 SS = D	Continued from page 3 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	F0609		04/18/2026

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F0609 SS = D	Continued from page 4 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…"	F0609		04/18/2026
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit	F0627	Resident is no longer in the facility DNS or Designee will audit the past 30 days of discharged residents to validate discharge orders are in place. DNS or Designee will educate nurses and social services on transfer/ discharge from the facility to validate discharge orders for residents are in place prior to discharge. DNS or Designee will audit resident discharges 5x per week for 3 weeks, then monthly for 2 months to validate discharge orders for residents are in place prior to discharge. Administrator or Designee will report the tracking and trending of the audits to the facility monthly Quality Assurance Meeting for 90 days or until compliance has been achieved or sustained as directed by the committee.	04/18/2026

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F0627 SS = D	Continued from page 5 the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.	F0627		04/18/2026

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F0627 SS = D	Continued from page 6 §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable	F0627		04/18/2026

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F0627 SS = D	Continued from page 7 readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the	F0627		04/18/2026

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F0627 SS = D	Continued from page 8 extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: 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 3/19/26. 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	F0627		04/18/2026

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F0627 SS = D	Continued from page 9 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.	F0627		04/18/2026

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Worland Health and Rehabilitation	**1901 Howell Ave , Worland, Wyoming, 82401**

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F0627 SS = D	Continued from page 10 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.	F0627		04/18/2026