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 04/30/2026

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 4/29/26 through 4/30/26. The survey was prompted by complaint intakes 2977100, 2977169, 2981120, 2993346, and 2996783. The following abbreviations are used throughout this document: CNA: Certified Nursing Assistant DON: Director of Nursing Less commonly used abbreviations will be annotated in each deficiency.	F0000		05/02/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F0761	F 0761 Label/Store Drugs and Biologicals Preparation and execution of this 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 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. Medication was removed from residents' room immediately. DNS completed the initial audit in other residents' room to validate no medication at bedside and medication is stored properly. No other resident is affected by this deficiency. DNS/designee will educate nursing staff on proper medication administration and proper medication storage.	05/02/2026

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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F0761 SS = D	Continued from page 1 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, medical record, and staff and resident interview, the facility failed to ensure medications were safely stored for 1 of 3 residents (#1) reviewed for medication administration. The census was 64. The findings were: Based on observation, medical record, and staff and resident interview, the facility failed to ensure medications were safely stored for 1 of 3 residents (#1) reviewed for medication administration. The census was 64. The findings were: 1. Review of the medical record showed resident #1 had diagnoses that included chronic kidney disease, hypertension, and atherosclerotic heart disease. The following concerns were identified: a. Observation on 4/30/26 at 12:14 PM showed resident #1 had an unlabeled medication cup that contained 1 unmarked white pill. b. Interview with resident #1 on 4/30/26 at 12:14 PM revealed a traveling nurse gave him/her "a sodium chloride salt pill" a "few months ago." The resident reported s/he had high blood pressure (BP) and noticed the pill was not the sodium bicarbonate that s/he had been prescribed, and stated s/he refused to take the medication. S/he reported the nurse had told him/her it did not make a difference and it "did the same thing." Further interview revealed the nurse left the medication after the resident refused to take it. c. Review of the physician orders showed the resident had an order for sodium bicarbonate oral tablet 325 milligram (mg) 2 tablets by mouth twice daily for acute kidney failure. Further review showed the resident did not have an order for sodium chloride. d. Review of the medical record showed no evidence of a self-administration of medication assessment. e. Interview with the DON at 12:35 PM revealed the medication in the resident's possession was an over-the-counter (OTC) medication, and she was unable to verify what the medication was. She stated she did not know when the medication was provided to the resident, and could not verify if the medication had been signed off on the medication administration record (MAR). Further interview	F0761	Continued from page 1 DNS/designee will conduct an audit for proper medication administered of 5 residents per week for 90 days to validate medication is administered correctly and to validate that medication is stored properly DNS/designee will track, trend data, and report findings at the monthly QAPI committee meeting for 90 days to demonstrate continued compliance. Date of Compliance 5/2/2026	05/02/2026

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F0761 SS = D	Continued from page 2 confirmed she expected the nurses to watch residents take their medication. d. Interview with the regional clinical nursing director on 4/30/26 at 1:05 PM revealed the facility did not have a policy on medication administration.	F0761		05/02/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F0880	Preparation and execution of this 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 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. F880 Infection Prevention and Control CNA was educated regarding proper soiled linen handling policy DNS/designee completed the initial audit on other unit(s) to validate staff member handle soiled linen prop erly. No other deficiency is noted. DNS/Designee will provide education to staff me mbers on the proper procedure for handling soiled linen. DNS/designee will monitor 5 staff per week for 90 days to validate proper handling of soiled linen. DNS/designee will report tracking and trending of the audits to the facility monthly Quality Assurance Meeting for 90 days until compliance has been achieved or sustained as directed by facility. Date of compliance: 05/02/2026	05/02/2026

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F0880 SS = D	Continued from page 3 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure infection control techniques were utilized in 1 of 4 units. The findings were: 1. Observation on 4/30/26 at 6:01 AM showed CNA #1 exited room 105 with unbagged, soiled bed linens in her hands. She walked down the hall with the soiled linens and put them in the dirty linen bin. 2. Interview with the DON on 4/30/26 at 10:40 AM confirmed soiled linens should be put in a bag before leaving the room. 3. Review of the facility policy titled "Soiled Laundry and Bedding" last revised February 2026 showed "...3. Place and transport contaminated laundry in bags or containers in accordance with established policies governing the handling and disposal of contaminated items..."	F0880		05/02/2026