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 07/07/2026

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 by healthcare licensing and surveys on 6/29/26 through 7/7/26. The survey was prompted by complaint intakes 3007114, 3007453, 3008426, 3008965, 3017912, 3017998, 3041116, and 3044333. The following abbreviations are used throughout this document: ADL: Activity of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F0000		07/10/2026
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, medical record review, staff and resident representative interview, the facility failed to ensure an assessment was performed for 7	F0684	F0684 Quality of Care 1. Residents #1, #4, #5, #7 and # 8 are no longer residing at the facility. 2. DNS/designee completed 14 days look back audit of current residents with changes a conditions to validate assessments including vitals sign if indicated, treatment and notifications are in place. No other residents are affected by this deficiency. 3. DNS/designee provided education to nursing staff on changes in condition assessment including vital sign if indicated and reassessment requirements, change in condition recognition, physician, responsible party notification expectation and documentation standards. 4. DNS/designee will conduct the audit during the clinical meeting to validate resident with changes in	07/10/2026

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

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 07/07/2026

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
F0684 SS = G	Continued from page 1 of 9 sample residents (#1,#3, #4, #5, #6, #7, #8) reviewed for change of condition. This failure resulted in actual harm to residents #4 and #8 who experienced a delay in treatment. The findings were: 1. Review of the quarterly MDS assessment dated 2/7/26 showed resident #4 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included stroke, anemia, hypertension, renal disease, hemiplegia, and seizure disorder. The following concerns were identified: a. Review of a nursing progress note dated 4/30/26 and timed 5:22 PM showed “Resident complained of nausea. [S/he] had incontinent dark tarry stool, outside of baseline as [s/he] is usually continent. Neuro exam attempted, very weak grasp in right and left. Resident able to stand and pivot to bed with x1 assist. Resident eyes unable to meet nurses upon command, PERRL intact. VSS around baseline. Resident had breakfast, refused lunch.” Review of a progress note dated 4/30/26 and timed 5:49 PM showed the resident was transferred to the hospital. Further review showed no evidence additional assessments were performed prior to transfer. b. Review of the hospital A emergency department physician note dated 4/30/26 showed s/he arrived from the facility at 5:48 PM due to “decreased responsiveness/altered mental status and abdominal pain.” The physician described the resident as encephalopathic, exhibiting limited participation, "intermittently opening eyes," and wincing. Laboratory results showed a white blood cell count of 0.9 with an absolute neutrophil count (ANC) of 210, a lactic acid level of 2.2, and a procalcitonin of 13.08, “confirming the resident is clearly septic" without a history of chemotherapy or immunosuppressants. A troponin level of 33 which the physician noted was expected due to renal failure. While waiting for further reports, the resident experienced a self-limiting episode of ventricular tachycardia lasting one minute, during which s/he remained alert. The resident also had an episode of "black tarry stool," possibly related to a vasovagal response. Consult with the on-call surgeon revealed the CT scan did not indicate a volvulus; however, the surgeon recommended immediate transfer due to the clinical picture of sepsis, gastrointestinal bleeding, pain, and altered mental status. Further review showed transfer diagnoses of sepsis, altered mental state, abdominal pain, prolonged QT interval, and nonsustained ventricular tachycardia. c. Review of the hospital B discharge summary with	F0684	Continued from page 1 conditions have a complete nursing assessment, proper notification and treatment as indicated by the provider and document appropriately 5 days a week x 90 days. 5. 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: 7/10/2026	07/10/2026

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 07/07/2026

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
F0684 SS = G	Continued from page 2 a discharge date of 5/1/26 showed the resident developed hypotension and tachycardia during transport, although oxygen saturation remained normal on room air. Interventions included Levophed and multiple liters of intravenous fluids. Laboratory results showed a CMP with a creatinine of 2.87, which was near the resident's baseline of 2.8, and normal potassium, liver enzymes, albumin, and total bilirubin. A CBC revealed a hemoglobin of 14, a white blood cell count of 0.7 with an ANC of 70, and an MCV of 102 with normal platelets. There was no evidence of bacteriuria. Further review showed a worsening lactic acid level of 3.7, an increase from the previous 2.2. A CTA of the abdomen and pelvis showed abnormal enhancement of the rectum and sigmoid colon, with possible sigmoid pneumatosis indicative of colonic ischemia. The report specified there were no signs of mesenteric arterial occlusion. Following a discussion between the surgical team and the resident's granddaughter and POA regarding the significant risks and minimal benefits of surgery, the POA declined surgical intervention. Due to the poor prognosis, the granddaughter elected to transition the resident to comfort care. Resident #4 was admitted to the intermediate care unit and began receiving IV opioids for pain management. Efforts were made to stabilize the resident until additional family members could arrive; however, the resident's condition deteriorated rapidly. The resident expired with his/her granddaughter present. The cause of death was listed as cardiac arrest due to severe acidemia due to lactic acidosis due to colonic ischemia (when at least a 75% reduction in intestinal blood flow for more than 12 hours), with contributing factors listed as renal disease, severe neutropenia (defined as an absolute neutrophil count of less than 0.5 × 109/L (<500/µL), is uncommon but can cause morbidity and mortality from infections), and possible drug induced agranulocytosis (a rare, life-threatening blood disorder characterized by a severe lack of neutrophils) from depakote. d. Review of the medical records showed no head-to-toe physical nursing assessments had been completed since 9/25/25 when there had been a prior reported change of condition. Further review showed a full set of vital signs had been completed on 2/21/26 and the next full set of vital signs was at the time of transfer on 4/30/26. e. Interview with CNA #1 on 7/2/26 at 9:23 AM revealed she had worked with the resident the week prior to his/her transfer and on 4/28/26 s/he had complained of a headache, had been "crying," would not eat, slept more, and had episodes of "staring off	F0684		07/10/2026

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 07/07/2026

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
F0684 SS = G	Continued from page 3 in space." She stated she reported it to the nurse but did not document it as she was told she wasn't allowed to anymore by DON #2. There was no evidence of an assessment or vital signs for 4/28/26. f. Interview with resident's representative on 6/30/26 at 10:27 AM revealed the resident had blood in his/her stool for a few months and she did not believe the resident had been assessed and followed for this appropriately. S/he had an episode on 4/30/26 of bloody stool and was sent to the hospital. From there the resident was life-flighted to another hospital. She reported the physician told her "[his/her] death was preventable," and she felt the resident had been ignored. g. Interview with the regional nurse manager and DON #1 on 7/1/26 at 4 PM confirmed there had been a lack of assessment and they would have expected an assessment to be done for change of condition, pain, or decreased food intake. 2. Review of the quarterly MDS assessment dated 4/29/26 showed resident #8 had no BIMS score or staff cognitive assessment, and diagnoses which included severe vascular dementia with agitation, cognitive communication deficit, macular degeneration, peripheral vascular disease, hypertension, and depression. The following concerns were identified: a. Review of a nursing progress note dated 5/11/26 and timed 4:51 AM showed "The resident had one episode of emesis during the shift. The emesis contained undigested food. The writer observed the resident coughing frequently during meals and drinking water. Dr.[name] notified." There was no evidence a physical assessment or vital signs were taken. b. Review of a nursing progress note dated 5/12/256 and timed 10:31AM showed "resident is lethargic. difficult to awaken.lung sounds diminished. unable to safely swallow. Vitals : 97.3 56 16 90/50 spo2 87% on r/a." There was no evidence of intervention or reassessment. c. Review of a nursing progress note dated 5/13/26 and timed 3:34 PM showed "Shallow breathing, nurse alerted & [and] is aware of Change. resident is currently on comfort measure @ [at] this time." d. Review of a nursing progress note dated 5/14/26 and timed 5:29 AM showed "Resident continues shallow breathing during the night. 118/59 14 98.0 60	F0684		07/10/2026

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 07/07/2026

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
F0684 SS = G	Continued from page 4 O2 sat 91% room air. No s/sx of pain or discomfort observed. Comfort measures continued, care ongoing." e. Review of a progress note dated 5/20/2026 and timed 2:47 AM showed the resident expired at 2:15 AM. f. Review of the medical record showed an order dated 5/9/23 which indicated the resident had elected a DNR (do not resuscitate) status, but requested hospitalization. Further review showed no evidence the resident had an order for comfort care. Interview with the DON on 7/7/28 at 11:05 AM confirmed a comfort care order was not obtained until 5/18/26. g. Interview with the regional nurse manager and DON #1 on 7/1/26 at 4 PM confirmed the lack of assessments and there was no alert charting for change of condition. Further interview confirmed the resident was documented as being on comfort care prior to an order being received for comfort care, when the resident's advanced directives indicated the resident wanted hospitalization. 3. Review of the quarterly MDS assessment dated 6/16/26 showed resident #3 had a BIMS score of 13 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included right sided hemiplegia, hypertension, peripheral vascular disease, respiratory failure with hypoxia, dysphagia, and encephalopathy. The following concerns were identified: a. Review of a progress note dated 5/5/26 and timed 5:45PM showed "Resident feeling SOB [shortness of breath]overnight as reported by night team. Vital signs are stable. Resident has cough, general malaise more than baseline, weakness, congestion symptoms. [S/he] requested to go out to hospital. Sent to local hospital. MD, family notified." Further review showed no evidence of an assessment performed by the previous "night team." b. Review of a progress note dated 5/5/26 and timed 6:15 PM showed a blood pressure (BP) of 132/78, heart rate (HR) of 98, and oxygen (O2) of 90% on room air, respiratory rate (RR) of 22, and a temperature of 98 degrees fahrenheit (F). Further review showed no evidence of vital signs from the previous shift with the complaint of shortness of breath. In addition, there lacked evidence of vital signs prior to the vitals that were taken at the time of the transfer with the complaint of shortness of breath.	F0684		07/10/2026

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 07/07/2026

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
F0684 SS = G	Continued from page 5 c. Review of the emergency department (ED) note dated 5/5/26 showed “The patient is an 86-year-old [female/male] presenting to the ED with cough for the past 2-3 days. [S/he] reports expectorating sputum approximately once daily and had nausea this morning. [S/he] denies fever or chills, vomiting, diarrhea, and home oxygen use. [S/he] arrived from a nursing home and reports that many residents there have had similar symptoms. [S/he] has not taken antibiotics or other medications for these symptoms but reports taking "lots of Tylenol." [S/he] denies abdominal pain but reports abdominal soreness after heaving from coughing; [s/he] reports sore throat this morning that has resolved. [S/he] was transported here by EMS from the nursing home. At the nursing home they noted an Spo2 of about 82%. EMS gave a breathing treatment and applied oxygen. On arrival to the ER [s/he] had quite a bit of coughing and apparently cleared some secretions. [S/he] now has an SPo2 of 92% on just 2L by nasal canula [sic].” Further review showed the admission diagnoses of respiratory syncytial virus (RSV) infection, acute hypoxemic respiratory failure and lactic acidosis. d. Interview with the social services director on 6/30/26 at 5:20 PM revealed the resident had felt sick on 5/5/26 and it was reported to her by CNA #1 that the nurses refused to assess him/her and s/he wanted to go to the hospital. She reported that the DON #2 had forced the resident to put on a mask in her/his own room and told her/him s/he had allergies during an RSV breakout at the facility. She reported she heard the resident coughing and s/he appeared short of breath. When she got to the hallway that the resident was in she could hear them coughing and s/he appeared short of breath when she got to her/his room. She asked the primary nurse to call the ambulance for the resident. When EMS arrived they took the resident’s oxygen saturation and they reported it was low. e. Interview with activities staff #1 on 7/2/26 at 8:16 AM revealed she went to the resident’s room to invite him/her to an activity, and the resident had been in bed, which was unusual for that resident. The resident reported s/he had been sick. She asked DON #2 if the resident had been tested for RSV, and had been told s/he had been tested. She reported she checked on the resident later and s/he was feeling worse, so she reported it to DON #2 who said she would assess the resident. She stated DON #2 stopped at the nurses station and asked if any residents in the hallway had been sick, and the CNAs reported resident #3 had been sick. She	F0684		07/10/2026

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 07/07/2026

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
F0684 SS = G	Continued from page 6 reported DON #2 went to the resident's room and she heard her tell the resident they just had allergies. There was no evidence the resident had been tested for RSV and no evidence of assessment. f. Interview with CNA #1 on 7/2/26 at 9:23 AM revealed resident #3 had stated s/he wasn't feeling well, and asked to go to the hospital and DON #2 told him/her "no." She reported DON #2 forced the mask on resident #3, and stated it was "not even on properly and very forcefully." Resident #3 then tried to take off the mask but was physically unable to on his/her own. CNA #1 reported that she had told the primary nurse the the resident wasn't feeling well earlier in the day before the incident with DON #2 but did not chart it as DON #2 told her CNAs were writing too much in the charts. She then went to the social worker and told her about what happened and filled out a grievance for resident #3, and asked if she could help get the resident sent to the hospital or at least assessed. g. Interview with CNA #3 on 7/2/26 at 10:11 AM revealed on 5/13/26 resident #3 was sick with vomiting and diarrhea and DON #2 looked the resident over and told her s/he was fine. She was able to get another nurse to go in and assess her/him who was able to send her/him to the hospital. There was no evidence of vital signs at that time. h. Interview with the regional nurse manager and DON #1 on 7/1/26 at 4 PM confirmed there was a lack of assessment with a change of condition. 4. Review of the quarterly MDS assessment dated 3/6/26 showed resident #5 had a staff cognitive assessment of 3 out of 15, which indicated severe cognitive impairment for daily decision making, and diagnoses which included vascular dementia, hypertension, diabetes, CVA, depression and need for assistance with personal care. The following concerns were identified: a. Review of a nursing progress note dated 4/26/26 and timed 12:33 PM showed "CNA reported resident had 1 episode of vomiting after lunch time. The resident was cleaned. The resident shows no s/s of acute distress.VSS. HOB elevated to 30 degrees. On-call MD was present in the facility and made aware. New order for Ondansetron Give 4 mg by mouth every 6 hours as needed for Nausea and vomiting. PRN medication gives as prescribed and tolerated well." There was no evidence vital signs had been documented and no evidence of physical assessment. Further review showed the last full set	F0684		07/10/2026

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 07/07/2026

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
F0684 SS = G	Continued from page 7 of vital signs had been documented on 2/21/26. b. Review of a nursing progress note dated 4/26/26 and timed 4:55 PM showed “The resident was seen in bed during rounds throughout shift .No s/s of acute distress noted.The resident had diarrhea3x [sic] during shift. The stool was noted to be foul smelling. PRN Imodium given as prescribed and hydration protocols were implemented throughout shift as well as dietary precautions.On call MD made aware.New order received to test resident for c-diff.Safety and comfort measure maintained.Call light and personal items within reach.All cares and routines rendered.Oncoming nurse made aware.” There was no evidence vital signs were obtained or an assessment was performed. c. Review of a nursing progress note dated 4/27/26 and timed 5:42 PM showed “Resident drank fluids with assistance. Unable to collect any stool. No bowel movement today.” There was no evidence vital signs were obtained or an assessment was performed. d. Review of a nursing progress note dated 4/30/26 and timed 12:06 PM showed “Resident refused lunch meal. CNA and nurse both attempted to feed resident. Ensure protein shake was offered and refused by resident. Resident comfortable, no pain noted, VSS. Will try to assist with suppertime meal.” There was no indication what the vital signs were or evidence an assessment was performed. e. Review of the medical record showed no documentation when the resident left the facility, no reason for transfer, and no condition was provided at time of transfer. Further review showed a progress note dated 5/7/26 and timed 10:02 PM showed “SN contacted [facility name] for update in Resident condition. Charge RN reports pt was admitted at this time for hypernatremia and dehydration. Pt receiving IV fluids at this time. SN contacted POA for update.” f. Review of the medical record showed no head-to-toe physical nursing assessments since 2/19/25, when the resident had experienced a previous change of condition. g. Review of the emergency department note dated 5/7/26 and timed 5:30 PM showed “The patient is a 78-year-old [male/female], presenting to the ED with markedly decreased oral intake for 1 week. Per family, the patient's spouse/caregiver (who shared a room with the patient and ensured the patient ate) died unexpectedly last week; since then, the patient	F0684		07/10/2026

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 07/07/2026

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
F0684 SS = G	Continued from page 8 has been eating and drinking very little…Family reports increased sleepiness over the past few days, noted to be more than baseline (previously a frequent napper), with the most sleep reported since Monday…" The resident was admitted for hypernatremia with a critical high sodium of 156 mmol/L and failure to thrive. The hypernatremia was corrected in 72 hours and the resident was transferred to a swing bed for end of life care on 5/11/26. The resident expired on 5/22/26 with cause of death listed as hypernatremia, intravascular volume depletion, decreased oral intake and advanced dementia. h. Interview with the resident's representative on 6/30/26 at 10:27 AM revealed s/he had both grandparents residing at the facility and noted that resident #4 frequently assisted with the care of resident #5. Following the unexpected death of resident #4, the representative felt that the quality of care for resident #5 declined significantly. On 5/7/26, she was notified that the resident had been hospitalized. She reported that upon her arrival at the facility, the resident appeared to be in poor condition and had a strong, foul odor. i. Interview with the regional nurse manager and DON #1 on 7/1/26 at 4 PM confirmed there had been a lack of assessments and appropriate follow up assessments for change of condition. Further interview confirmed there had been no documentation for assessment of the resident, their reason/condition for transfer, or the date the resident had been transferred to the hospital. 5. Review of the quarterly MDS assessment dated 5/30/26 showed resident #6 had a BIMS score of 14 out of 15 which indicated the resident was cognitively intact, and had diagnoses which included chronic obstructive pulmonary disorder, anemia, hypertension, acute on chronic respiratory failure with hypoxia, malnutrition, and pulmonary fibrosis. The following concerns were identified: a. Review of the nursing progress note dated 4/19/26 showed "Pt c/o SOB. no other symptoms. O2sat 85%. Pt on 02@4lpm [oxygen at 4 liters per minute] via nasal cannula, Resp 20 and labored. B/p 120/44, HR 60. Nurse increased O2 to 6lpm elevated HOB and notified MD. NO response. Nurse continued to monitor pt. @1145 Pt states [s/he] breathing feels more stable. 02 remained 90-93%. Nurse was able to decrease 02 to 4lpm. Pt was able to maintain o2 sats 91-93. 1200 Pt sitting up in bed Resp unlabored. He ate lunch. He is stable at this time. Will continue to monitor and report to oncoming nurse." There was	F0684		07/10/2026

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 07/07/2026

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
F0684 SS = G	Continued from page 9 no evidence of repeat vital signs or assessment until 4/30/26. b. Review of a nursing progress note dated 4/30/26 and timed 7:04 AM showed “Summoned to room per med tech. Resident 02 at 68%. Resident assessed by nurse. Call placed to Dr. [name] unable to reach by phone. Text message sent to MD. Resident currently at 4L/NC. Resident 02 increased to 6L/NC per orders. Vitals noted at 160/64, 72, 20, 97.4, 66%. Call place to ambulance. Call placed to [family]. At 6:58a.m. Ambulance here at present. Resident now in route to [facility name]. sent to hospital for hypoxia.” c. Review of the emergency department (ED) note dated 4/30/26 showed the resident was seen in the ED for increased oxygen needs at 6 liters per minute (LPM) up from 3LPM. S/he was admitted to the hospital for acute on chronic respiratory failure and treatment of hypoxia. d. Review of the readmission note to the nursing facility dated 5/2/26 showed an oxygen saturation of 86% and no evidence of interventions provided for abnormal vital signs or a follow up assessment was completed. e. Review of a nursing progress note dated 5/3/26 and timed 2:21 PM showed “Resident readmitted from hosp. yesterday, is on Doxycycline with no adverse reaction noted. T. 98.0, P. 78, R. 18, BP 129/59, 2 sat 78%. 02 is on, nasal can. Sat retaken and remains in upper 70's.” There was no evidence of interventions, a lung assessment, or vital signs being retaken until 5/4/26. f. Review of the nursing progress note dated 6/16/26 and timed 11:29 AM showed “Resident reports not feeling well. VS 134/60, 74, 22, 97.6, 89%.” No evidence of interventions for low oxygen saturation, a physical assessment, or vital signs were obtained. g. Interview with the regional nurse manager and DON #1 on 7/1/26 at 4 PM confirmed there had been a lack of assessment for change of condition and interventions for abnormal vital signs with appropriate follow up. 6. Review of the quarterly MDS assessment dated 4/16/26 showed resident #7 had a BIMS score of 9 out of 15, which indicated moderate cognitive impairment, and diagnoses which included obstructive and reflux uropathy, urine retention, and seizure disorder. The following concerns were	F0684		07/10/2026

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 07/07/2026

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
F0684 SS = G	Continued from page 10 identified: a. Review of a progress note dated 6/25/26 and timed 5:23 AM showed the resident was given tylenol for abdominal pain. There was no evidence vital signs were obtained or an assessment was performed. b. Review of a progress note dated 6/25/26 and timed 11:53 AM showed “resident vomited x1 with no further episodes ,plan of care continues.” There was no evidence vital signs were obtained or an assessment was performed. c. Review of a progress note dated 6/27/26 and timed 8:53 AM showed “resident ambulating in hall way, no c/o pain or distress noted , v/s are wnl , appetite normal , hydration and call light are within reach , plan of care continues”. d. Review of the progress note dated 6/27/26 at 11:04 AM showed “changed residents Foley cath at this time , return urine , and some bleeding noted , will monitor for output and heavy bleeding ,plan of care continues.” There was no evidence vital signs were obtained until 6/28/26 or an assessment was performed. e. Interview with LPN #1 on 7/1/26 at 11:41 AM revealed that regarding the episode of vomiting on 6/25/26 she did not check any vitals but did palpate his/her abdomen and did not chart it. She stated vital signs should be taken daily. Further interview showed on 6/27/26 the resident had walked down the hall and complained of pain. She reported s/he held his/her abdomen and pointed to her/his catheter. She checked on him/her later and s/he continued to complain of pain and she changed the foley catheter. She remembered she removed approximately 100mls return output that had some blood in it and she had planned to reassess the resident later. f. Review of a nursing progress note dated 6/28/26 and timed 7:15 AM showed “The writer was alerted by the aide that the resident was complaining of bladder pain. The writer observed the Foley catheter tubing with no kinks, a small amount of blood, and the catheter bag was empty. The resident's Foley bag was previously emptied with a total of 500cc. The resident's catheter was irrigated with 60 mL of sterile water. There was resistance and the writer allowed the solution to flow out by gravity. Approximately 10 mL of solution flowed out of the catheter. The catheter was removed. The writer inserted a new Foley , no urine observed in tubing.	F0684		07/10/2026

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 07/07/2026

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
F0684 SS = G	Continued from page 11 There was resistance when the writer attempted to inflate the balloon. The residents are as follows: BP 116/68, T 97.2, O2 SAT 93%, RR 18, P 88. 4:00 the writer notified the DON. 4:10 the writer contacted the primary care provider. Awaiting a call back. 4:18 PRN Tylenol given for pain. 4:25 call placed to 911.4:45 the resident left the facility." g. Review of the medical record showed the resident had output as follows: on 6/27/26 at 5:50 AM 400 milliliters (mls), at 11:28 AM 750 mls, at 8:36 PM 15 mls; on 6/28/26 at 4:02 AM no output. There was no evidence the decreased urine output was assessed or interventions were implemented. h. Review of the nursing progress note 6/28/26 at 8:48 AM showed "Writer received a phone call from ER Provider at [name of facility] at 0830 this morning regarding this resident. She stated that they were able to replace [his/her] foley catheter, however, in the process of evaluation, it was also determined he was experiencing the beginnings of sepsis due to cholecystitis…Provider stated that resident's [family] and HCP knows and has spoken with resident regarding [his/her] wishes, and does not want to pursue surgical intervention. The provider states she understands the risks of not treating and has spoken with the resident who, due to some lifelong mental limitations, sometimes has difficulty communicating; however, sister states [s/he] understands the risks of choosing comfort care measures. The ER Provider let writer know they have contacted [name of facility] who will be evaluating resident at our facility tomorrow. [S/he] will be transported back to our facility shortly with orders for pain medication as needed…" i. Interview with the regional nurse manager and DON #1 on 7/1/26 at 4 PM confirmed assessments were not performed as expected for change of condition or decreased urine output. 7. Review of the discharge MDS assessment dated 5/8/26 showed resident #1 had a BIMS assessment score of 13 out of 15, which indicated the resident was cognitively intact, and diagnoses that included acute on chronic respiratory failure with hypercapnia and hypoxia, congestive heart failure, pneumonia, pulmonary hypertension, pleural effusion, obstructive sleep apnea and urine retention. The following concerns were identified: a. Review of the nursing progress note dated 5/5/26 and timed 7:34 PM showed "Resident came to our facility on 5/4/2026 as a new resident. Resident's med orders were put into PCC for pharmacy to	F0684		07/10/2026

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 07/07/2026

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
F0684 SS = G	Continued from page 12 process and meds were stuck in queue. Therefore, meds were not process by pharmacy until today. Meanwhile, resident did not receive [her/his] medication last night or this morning. This writer administered medication according to physician's orders. This writer took Meds out of the pixel and administered the meds to the resident. The resident's v/s were taken before meds were given. (B/P 140/70 HR 119 O2 91% Temp 98.0 R 19) Resident was assessed. Md notified Family [name] notified New Orders implemented V/S were taken." There was no evidence of an assessment since the initial assessment and no evidence of additional vital signs until the resident's discharge on 5/8/26. b. Interview with social services on 6/30/26 at 5:20 PM revealed that she had been contacted by resident #1's family about not getting his/her medications and no vital signs were taken. c. Interview with the resident's representative on 6/30/26 at 10:03 AM revealed s/he was told the resident arrived at the facility on 5/4/26 at 11:30 AM and the resident had not had medications at that time. The representative revealed she asked staff about getting her/his routine medication and a tylenol for a headache; however, the next day she was told the resident had not received any medications until late evening on 5/5/26. d. Interview with the occupational therapist on 7/1/26 at 2:02 PM revealed she had performed an initial evaluation and bed mobility assessment on the resident and remembered him/her having shortness of breath during the exams. e. Interview with the regional nurse manager and DON #1 on 7/1/26 at 4 PM confirmed the resident had not received medications for 5/4/26 and received some medications on 5/5/26. Further interview confirmed there was no assessment for the elevated heart rate documented on 5/5/26 and no appropriate follow up. 8. Interview with the regional nurse manager on 7/2/26 at 11:50 AM revealed the expectation for alert charting was to do an assessment and vital signs if indicated and report to the next nurse, and a resident should be on alert charting for at least 72 hrs. She reported concerns and changes of condition were supposed to be communicated during verbal reports and written in the charting to reflect the same. Further interview revealed there was no set time for baseline assessments and reassessments for nursing staff, and if new staff or contract staff wanted to know the residents'	F0684		07/10/2026

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 07/07/2026

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
F0684 SS = G	Continued from page 13 baseline they could ask other staff or family members. 9. Review of “Open Resources for Nursing (Open RN)”; Ernstmeyer K, Christman E, editors. Nursing Fundamentals [Internet]. Eau Claire (WI): Chippewa Valley Technical College; 2021. Chapter 4 Nursing Process showed that an admission assessment should include “A comprehensive assessment completed when a patient is admitted to a facility that involves assessing a large amount of information using an organized approach.” and an ongoing assessment should include a head-toe assessment is to be completed and any changes in patient condition are reported to the healthcare provider… “4.7 implementation of interventions… After the initial plan of care is developed, continual reassessment of the patient is necessary to detect any changes in the patient’s condition requiring modification of the plan. The need for continual patient reassessment underscores the dynamic nature of the nursing process and is crucial to providing safe care… At times, patients may experience a change in condition that makes a planned nursing intervention or provider prescription no longer safe to implement. This decision and supporting assessment finding should be documented in the patient’s chart and also communicated during the shift handoff report, along with appropriate notification of the provider of the patient’s change in condition.”	F0684		07/10/2026
F0585 SS = E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on	F0585	F085 Grievance Resident #1, #2 are no longer reside in the facility during this deficiency. Resident #3 and #17 grievances were addressed and resolved by the facility administrator. DNS/designee completed an audit on the grievances for the last 30 days to validate that grievances are documented, and investigation completed in a timely manner per facility policy. No other residents were affected by this deficiency. 3. DNS/designee provided staff educate on the facility grievance policy, investigation process and documentation. Grievance look boxes were installed; grievance forms were reprinted on color paper to ensure no lost grievance and easy to identify. Grievance process was discussed	07/10/2026

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 07/07/2026

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
F0585 SS = E	Continued from page 14 how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary	F0585	Continued from page 14 resident council meeting. 4. Administrator/designee will audit grievances received weekly for 4 weeks and audit grievances monthly for an additional 2 months. 5. The administrator/designee will track trend data, and report findings at the monthly QAPI committee meeting for 90 days to demonstrate continued compliance. Date of compliance: 7/10/2026	07/10/2026

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 07/07/2026

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
F0585 SS = E	Continued from page 15 of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on resident interview, resident representative interview, staff interview, record review and policy review, the facility failed to properly obtain grievances and maintain evidence demonstrating the appropriate action and issuance of the grievance decision without repercussions for 4 of 4 residents (#1, #2, #3, #17) reviewed for grievances. The findings were: 1. Interview with resident #2's representative on 7/2/26 at 8:45 AM revealed that on 5/10/26 she turned in a grievance regarding medications and on 5/12/26 she had turned in a grievance regarding staffing and 2nd request for a care meeting for the resident. She reported she had taken a picture of the grievance policy on the wall and should have had a resolution on the grievances within 5 days. She stated she never got the meeting she requested or a resolution on the medications. She had also reported grievances on a policy stating she couldn't stay with her family and the DON #2 kept quoting it and could not produce it. She reported that the DON #2 was rude after filing grievances. a. Review of a progress note by DON #2 dated 5/13/26 at 5:18 PM showed "[resident #2] already knew about the policy from the first day of admission. The Administrator did allow [resident #2's family] to stay over the first two nights to help her with her anxiety of admitting [resident #2] to this facility. This writer and the Administrator both explained to [resident #2's family], we do not get these types of requests. Due to the level of anxiety [resident #2's family] presented @ the time we	F0585		07/10/2026

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 07/07/2026

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
F0585 SS = E	Continued from page 16 allowed her to stay with the complete understanding it would only be for these two days! [resident #2's family] stated, "I understand this is something you don't allow but I appreciate it, and I understand it's only for these two days". As of May 11th, 2026, [resident #2's family] refuses to follow the policy and is requesting a meeting with the Administrator and this writer. This writer explained that the Administrator is not available this week and that the week of May 18th, 2026, we would be setting up a meeting. On May 12th, 2026, [resident #2's family] saw me a few times in the hallways, never once did she approach me to speak to this writer about a meeting or anything else! As soon as this writer left the facility [resident #2's family] approached the charge nurse on hall 1 and gave her a note directed to this writer, and she stated " This is my 2nd request for a mtg w/you & team" Again, [resident #2's family] was informed that we would not be meeting until next week when the Administrator is back in the building!" b. Review of a progress note dated 5/13/26 and timed 5:20 AM showed "[resident #2's family] left a handwritten note with this nurse requesting to see speak with the DON and/or management team. Family member requested this nurse to give the note to the DON, note left under DON's door." c. Interview with the social services director on 6/30/26 at 5:20 PM revealed she had been aware of resident #2's family's request for care plan meetings and had written a grievance for the family at their request. d. Interview with the human resources director on 6/30/26 at 12:12 PM revealed she had conversations with staff over complaints about DON #2 for staff and residents but did not write up any formal complaints. She had been unaware of a protocol for making it an official complaint. She confirmed she witnessed DON #2 speaking harshly to resident #2's family. e. Interview with medication tech #1 on 6/30/26 at 5:45 PM revealed she witnessed DON #2 "yelled at resident #2's family in front of residents and other families and at one point another family tried to step in to help resident #2's family from DON #2's behavior." f. Interview with RN #1 on 7/1/26 at 1419 revealed she had witnessed poor behavior from DON #2 towards resident #2 and his/her family. g. Interview with the administrator on 7/2/26 at	F0585		07/10/2026

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 07/07/2026

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
F0585 SS = E	Continued from page 17 12:30 PM revealed that she did not receive either grievance from the resident's family for 5/10/26 or 5/12/26 or from staff. She reported she never received a request for a meeting with the family. 2. Review of a grievance form dated 5/5/26 showed resident #17 reported " [DON#2] came to the room to check on [his/her] roommate, [resident #3], in a rude demeanor regarding [resident #3] wearing a mask and insisting she wear one without making known who she was". The form was filled out by the activities staff and reviewed by the administrator with the resolution being "DON will identify herself to roommate before assessing the roommate." a. Interview with resident #17 on 7/1/26 at 1:15 PM revealed that DON #2 could be rude when talking to residents and "nothing ever happened with it.' b. Interview with the activities staff #1 on 7/2/26 at 8:16 AM revealed she had helped resident #17 with the grievance on DON #2. She stated DON #2 told her she was going to handle the grievance, and she responded to her that it was inappropriate for her to be the one to manage the grievance. She then stated she and DON #2 had a meeting with the administrator where she was asked to re-write the grievance with the pertinent information, which she did not want to do. She stated she and the administrator were headed to speak with the resident when the administrator got called away. She continued to the resident's room and where she found the DON #2 "in resident #17's face" telling the resident she "did not say" the things she accused her of. She reported the administrator walked into resident #17's room after the interaction had started. She stated the administrator told her she would address DON #2's behavior. She stated she also reported this interaction to the social worker. c. Interview with the social services director on 7/2/26 at 8:42 AM revealed she had written a grievance on resident #17's behalf and resident #3's behalf.There was no evidence of those grievances and they were not provided by the administrator. d. Interview with the administrator on 7/2/26 at 12:30 PM revealed she had only received the first grievance from resident #17 and she stated she did not rewrite grievances. She interviewed resident #17 to figure out what happened and the resident didn't know the name of the employee because she did not introduce herself. She reported she took DON #2 to the resident's room for identification and the resident confirmed it was DON #2 who had spoken	F0585		07/10/2026

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 07/07/2026

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
F0585 SS = E	Continued from page 18 to her in a rude manner. She confirmed she did not address the DON's behavior on the grievance form and did not interview any witnesses to the grievance. 3. Interview with the social services director on 6/30/26 at 5:20 PM revealed she had been approached by CNA #1 about about a mask that had been forced on resident #3, and the resident's request that s/he wanted to go to the hospital. She states she asked the resident's nurse to assess her/him, and call an ambulance if the resident wanted to be transferred to the hospital. She reported she filed a grievance for this. a. Interview with CNA #1 on 7/2/26 at 9:23 AM revealed resident #3 had stated s/he wasn't feeling well, and asked to go in the hallway. She reported DON #2 said the resident couldn't leave his/her room, and she heard resident #3 say s/he wanted to leave to go to the hospital and DON #2 told him/her "no" and yelled, "this is your house for the rest of your life so you'll follow our rules." She reported DON #2 argued back and forth with the resident about it being her house and everyone had to listen to her. She reported DON #2 forced the mask on resident #3, and stated it was "not even on properly and very forcefully." Resident #3 then tried to take off the mask but was physically unable to on his/her own. CNA #1 reported that she had told the primary nurse the the resident wasn't feeling well earlier in the day before the incident with DON #2 but did not chart it as DON #2 told her CNAs were writing too much in the charts. She then went to the social worker and told her about what happened and filled out a grievance for resident #3, and asked if she could help get the resident sent to the hospital or at least assessed. She reports she had never been asked about the situation by the administrator. b. Interview with the administrator on 7/2/26 at 12:30 PM revealed she had not received a grievance for resident #3 and did not know about the situation. 4. Interview with the social services director on 6/30/26 at 5:20 PM revealed she had been contacted by resident #1's family about not getting his/her medications and no vital signs being taken, and she had filled out a grievance. She stated DON #2 had been aware of the grievances. She stated she also contacted the regional manager and was told to tell the family that DON #2 had it handled. She stated she filed a complaint to the corporate CEO and operations. a. Interview with the administrator on 7/2/26 at	F0585		07/10/2026

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 07/07/2026

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
F0585 SS = E	Continued from page 19 12:30 PM revealed she had not received a grievance for resident #1 and denied knowing about the situation. 5. Interview with the social services director on 6/30/26 at 5:20 PM revealed she had at least 3 grievances that had gone “missing” after she gave them to DON #2. Further interview on 7/2/26 confirmed none of the grievances that were provided had been ones she had written for any of the grievances listed above. 6. Interview with CNA #3 on 7/2/26 at 10:11 AM revealed that DON #2 requested all the staff for a “pow wow” on 3rd hall and she had been standing in the hallway waiting for a resident who was in the bathroom. She stated she told DON #2 that she couldn’t leave the resident alone and the DON insisted. The resident’s family then found her/him alone in the bathroom and was upset. She reported she filled out a grievance form. This grievance could not be provided by the facility that resembled this situation. 7. Review of a grievance form dated 5/28/26 from the family of residents #18 and #19 showed they complained of unethical behaviors by the facility that included residents had been told not to report things, had been told not to talk to the State, grievances had been changed or missing, and family members had not been told the “whole truth” about the state of the facility and family’s care. The resolution had been listed as “verbal education with staff on 5/27/26 and 5/28/26 regarding professionalism, reporting grievances and given the compliance hotline number.” 8. Interview with the administrator on 7/2/26 at 12:30 PM revealed she took over the grievances and made sure they were investigated. She stated grievances had been getting lost and she knew they had an issue, and she had started a Plan of Improvement (PIP). The facility acquired a locked box to submit grievances. 9. Review of the facility policy titled “Grievance Procedures Policy” last updated March 2025 showed “...2. The administrator oversees the grievance procedure and coordinates the center system for collecting, tracking and responding to grievances…6. Grievances are resolved immediately, when possible, by the individual receiving the grievance…7. When immediate resolution is not possible, the grievance is routed to the Grievance Official promptly…8. If the grievance involves abuse, neglect, exploitation, or misappropriation of resident property, the	F0585		07/10/2026

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 07/07/2026

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
F0585 SS = E	Continued from page 20 administrator is notified immediately, and an investigation begins…9. The Administrator/designee routes the Grievance Form to the appropriate department manager who reviews the grievance, respond within five business days, and returns the Grievance Form to the Administrator. 10. The person with the grievance has the right to a written decision regarding his/her grievance…14. Grievance forms/investigations are maintained for a minimum of 3 years.	F0585		07/10/2026
F0628 SS = E	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §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. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language	F0628	F0628 Discharge Process Bed Hold /Transfers Residents #2, #4, #5, #7 no longer reside in the facility. Residents #3 and #6 reviewed and have been corrected to meet the federal and state requirements for this deficiency. DNS/designee completed an audit of hospital transfers with the previous 7 days to validate that bed hold notices, and the transfer/discharge notices were in place. Any resident affected by this deficiency will be addressed and corrected to meet the federal and state requirements. DNS/designee provided educated License Nurses on federal and state requirements regarding bed hold policies, transfer documentation and required notifications. DNS/Designee will conduct audit of hospital transfers weekly for 4 weeks, a minimum of 5 transfer records weekly for 8 weeks to validate bed hold, and transfer/discharge notice are in place. 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: 7/10/26	07/10/2026

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 07/07/2026

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
F0628 SS = E	Continued from page 21 and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights,	F0628		07/10/2026

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 07/07/2026

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
F0628 SS = E	Continued from page 22 including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing	F0628		07/10/2026

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 07/07/2026

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
F0628 SS = E	Continued from page 23 facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §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: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on staff interview and medical record review, the facility failed to ensure written bed hold and transfer notices were given to 6 of 7 (#2, #3, #4, #5, #6, #7) residents reviewed for transfers. The findings were:	F0628		07/10/2026

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 07/07/2026

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
F0628 SS = E	Continued from page 24 1. Review of a quarterly MDS assessment dated 2/7/26 showed resident #4 had a BIMS score of 15 out of 15 which indicated the resident was cognitively intact, and diagnoses which included stroke, anemia, hypertension, renal disease, hemiplegia, and seizure disorder. The following concerns were identified: a. Review of a transfer note dated 4/30/26 showed the resident had a syncopal episode with black tarry stools and was sent to the emergency department. Further review showed no evidence a bed hold or transfer notice had been provided. 2. Review of a quarterly MDS assessment dated 3/6/26 showed resident #5 had a cognitive assessment of 3 which indicated severe impairment for daily decision making, and diagnoses which included vascular dementia, hypertension, diabetes, cerebral vascular accident, depression and need for assistance with personal care.The following concerns were identified: a. Review of a progress note dated 5/7/26 and timed 10:02 PM showed the nurse had followed up with the hospital to get the resident's status. There was no evidence that the resident had been transferred to the hospital and no documentation of the resident's condition prior to the transfer. Further review showed no evidence a bed hold or transfer notice had been provided. 3. Review of a quarterly MDS assessment dated 5/30/26 showed resident #6 had a BIMS score of 14 out of 15 which indicated the resident was cognitively intact, and had diagnoses which included chronic obstructive pulmonary disorder, anemia, hypertension, acute on chronic respiratory failure with hypoxia, malnutrition, and pulmonary fibrosis. The following concerns were identified: a. Review of a progress note dated 4/30/26 and timed 6:45 AM showed the resident was transferred to the hospital for low oxygen saturation readings. Further review showed the bed hold was incomplete and there was no evidence a transfer notice had been provided. 4. Review of a quarterly MDS assessment dated 6/16/26 showed resident #3 had a BIMS score of 13 out of 15 which indicated the resident was cognitively intact, and diagnoses which included right sided hemiplegia, hypertension, peripheral vascular disease, respiratory failure with hypoxia, dysphagia, and encephalopathy. The following concerns were identified:	F0628		07/10/2026

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 07/07/2026

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
F0628 SS = E	Continued from page 25 a. Review of a progress note dated 5/5/26 and timed 5:46 PM showed the resident had been sent to the hospital for shortness of breath. Further review showed no evidence a bed hold or transfer notice had been provided. b. Review of a progress note dated 5/13/26 and timed 10:14 AM showed the resident had been sent to the hospital for vomiting and diarrhea. Further review showed no evidence a bed hold or transfer notice had been provided. 5. Review of a quarterly MDS assessment dated 4/16/26 showed resident #7 had a BIMS score of 9 out of 15 which indicated moderate cognitive impairment, and diagnoses which included obstructive and reflux uropathy, urine retention, and seizure disorder. The following concerns were identified: a. Review of a progress note dated 6/28/26 and timed 7:15 AM showed the resident was sent to the hospital for abdominal pain and foley catheter issues. Further review showed no evidence a bed hold or transfer notice had been provided. 6. Review of an admission MDS assessment dated 5/7/26 showed resident #2 had a BIMS score of 99 which indicated the resident had been unable to complete the assessment, and diagnoses which included stroke, hemiplegia, aphasia, apraxia, atrial fibrillation, and hypertension. The following concerns were identified: a. Review of a progress note dated 5/07/26 at 3:07 PM showed the resident was sent to the hospital for low oxygen saturation readings. Further review showed no evidence a bed hold or transfer notice had been provided. 7. Interview with the regional nurse manager and DON #2 on 7/1/26 at 4 PM confirmed no bed holds or transfer notices had been provided to the residents or their representatives.	F0628		07/10/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care,	F0695	F0695 Respiratory/Tracheostomy Care and Suctioning Resident # 1 no longer resides in the facility. 2. DNS/designee completed an audit on the current residents who require BIPAP or oxygen to validate equipment is available,	07/10/2026

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 07/07/2026

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
F0695 SS = D	Continued from page 26 consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on resident representative interview, staff interview and record review, the facility failed to ensure that residents received necessary respiratory care for 1 of 3 (#1) residents reviewed for respiratory care. The findings were: 1. Review of the discharge MDS assessment dated 5/8/26 showed resident #1 had a BIMS score of 13 out of 15 which indicated the resident was cognitively intact, and diagnoses which included acute on chronic respiratory failure with hypercapnia and hypoxia, congestive heart failure, pneumonia, pulmonary hypertension, pleural effusion and obstructive sleep apnea. The following concerns were identified: a. Review of the admission assessment dated 5/4/26 and timed 1:02 PM showed the resident arrived on 6 liters per minute (LPM) of oxygen via nasal cannula (NC). b. Review of an order placed on 5/5/26 showed “oxygen @ 6 L/Min via nasal cannula. May titrate oxygen flow to maintain oxygen saturation above 90%. every shift related to ACUTE AND CHRONIC RESPIRATORY FAILURE WITH HYPERCAPNIA (J96.22).” There was no evidence of oxygen placement or assessment on 5/4/26 or the morning of 5/5/26. c. Review of an order placed on 5/5/26 showed “Bipap at NOC at bedtime”. There was no evidence of Bipap placement or assessment on 5/4/26. d. Review of an order placed on 5/6/26 showed “Rinse Mask with H2O in the morning Rinse with H20 and air dry.” There was no evidence that the task had been completed on 5/5/26. e. Review of the order placed on 5/5/26 showed “Does resident become short of breath when laying flat OR avoid laying flat to prevent shortness of breath? Y/N every shift”. There was no evidence of assessment on 5/4/26 or morning of 5/5/26. f. Review of a progress note dated 5/5/26 and timed 7:34 PM showed “Resident came to our facility on 5/4/2026 as a new resident. Resident's med orders were put into PCC for pharmacy to process and	F0695	Continued from page 26 functioning properly and being used as ordered. No other residents were affected by this deficiency. 3. DNS/designee provides education to the nursing staff on verification of respiratory care order including BIPAP, oxygen, is present, functioning and available before or immediately upon admission. 4. DNS/designee will conduct an audit of new admissions requiring respiratory care order 5 days a week for 4 weeks, weekly audits of new admission for an additional 8 weeks. 5. 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: 7/10/26	07/10/2026

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 07/07/2026

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
F0695 SS = D	Continued from page 27 meds were stuck in queue…. Therefore, meds were not process by pharmacy until today. Meanwhile, resident did not receive [his/her] medication last night or this morning…" g. Interview with the resident's representative on 6/30/26 at 10:03 AM revealed she had been told the resident arrived at the facility around 11:30 AM on 5/4/26. She reported she visited the resident at 4 PM on 5/4/26 and noticed s/he did not have a Bipap available. She had not been told she needed to bring the resident's personal Bipap. She reported she obtained the resident's Bipap and had to move furniture around the room to set the machine up for him/her as they were not able to get any staff to help them. h. Interview with the social services director on 6/30/26 at 5:20 PM revealed that on 5/5/26 in the evening she was contacted by resident #1's family about not getting his/her respiratory orders. She reviewed the resident's chart and did not see any documentation that anything had been done for the resident. She then spoke to DON #2 to get resolution on her/his orders not being started. i. Interview with the regional nurse manager and DON #1 on 7/1/26 at 4 PM confirmed the resident was without respiratory assessment and assistance from the time he arrived at the facility until the evening of 5/5/26 where assistance and assessment was first documented.	F0695		07/10/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F0755	F0755 Pharmacy Services Resident #1 is no longer resides in the facility at time of the deficiency. DNS/designee completed an audit of current resident medication orders for the last 14 days to validate the medication orders are active, and medication is available to administer per prescriber ordered. No other residents were affected by this deficiency. DNS/designee provides education to the nursing staff on how to enter and activate order on eMAR in pointclickcare, emergency medication access, physician notification and documentation expectations. DNS/designee will conduct an audit on the current	07/10/2026

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 07/07/2026

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
F0755 SS = D	Continued from page 28 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, and resident representative and staff interview, the facility failed to ensure a pharmaceutical services procedure related to accurate acquiring, receiving, dispensing and administration of medications for 1 of 4 sample residents (#1) reviewed for medication availability. The findings were: 1. Review of a discharge MDS assessment dated 5/8/26 showed resident #1 had a BIMS score of 13 out of 15 which indicated the resident was cognitively intact, and diagnoses which included acute on chronic respiratory failure with hypercapnia and hypoxia, congestive heart failure, pneumonia, pulmonary hypertension, pleural effusion, urine retention and obstructive sleep apnea. Review of the physician orders showed the resident was to receive sildenafil citrate oral tablet 20 mg by mouth three times a day for pulmonary hypertension, tamsulosin HCL oral capsule 0.4 mg by mouth in the morning related to urine retention, apixaban oral tablet 2.5 mg by mouth two times per day for atrial fibrillation, metoprolol tartrate oral table 12.5 mg by mouth two times a day for pulmonary hypertension, and pantoprazole sodium oral tablet delayed release 40 mg by mouth in the morning for gastro-esophageal reflux disease without esophagitis. The following concerns were identified: a. Review of a progress note dated 5/5/26 and timed 7:34 PM showed “Resident came to our facility on 5/4/2026 as a new resident. Resident's med orders were put into PCC for pharmacy to process and meds were stuck in queue. Therefore, meds were not processed by the pharmacy until today. Meanwhile, resident did not receive [his/her] medication last night or this morning. This writer administered	F0755	Continued from page 28 medication orders on eMAR to validate medications order is active, medication is available to administer as prescriber ordered of 5 resident charts per week for 4 weeks, 3 resident chart audits per week for the following 8 weeks. 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: 7/10/26	07/10/2026

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 07/07/2026

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
F0755 SS = D	Continued from page 29 medication according to physician's orders. This writer took Meds out of the pixel and administered the meds to the resident. The resident's v/s were taken before meds were given. (B/P 140/70HR 119 O2 91% Temp 98.0 R 19) Resident was assessed. Md notified. Family [name] notified. New Orders implemented. V/S were taken." b. Review of the medication administration record (MAR) for May 2026 showed no evidence the resident had been administered the sildenafil evening dose on 5/4/26 or the morning, midday or evening dose on 5/5/26. c. Review of the MAR for May 2026 showed no evidence the resident had been administered the tamsulosin on 5/5/26. d. Review of the MAR for May 2026 showed no evidence the resident had been administered the apixaban evening dose on 5/4/26 or the morning dose on 5/5/26. c. Review of the MAR for May 2026 showed no evidence the resident had been administered the metoprolol evening dose on 5/4/26 or the morning dose on 5/5/26. d. Review of the MAR for May 2026 showed no evidence the resident had been administered the pantoprazole dose on 5/5/26. e. Interview with the resident's representative on 6/30/26 at 10:03 AM revealed she was told by staff that the resident arrived at the facility on 5/4/26 at 11:30 AM and the resident did not receive any medications until late in the evening on 5/5/26. f. Interview with the social services director on 6/30/26 at 5:20 PM confirmed on 5/5/26 she was contacted in the evening by resident #1's family about not getting his/her medication as ordered. She revealed when she reviewed the resident's chart and did not see any documentation that anything had been done for the resident, she notified the DON to get resolution on his/her orders not being started. g. Interview with the regional nurse manager and DON #1 on 7/1/26 at 4 PM confirmed the resident was without medications from the time s/he arrived at the facility on 5/4/26 until the evening of 5/5/26 where s/he received some of his/her medications, and then s/he received the rest of his/her medications on 5/6/26. Further interview revealed they would expect residents to receive all	F0755		07/10/2026

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 07/07/2026

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
F0755 SS = D	Continued from page 30 medications available upon arrival to the facility.	F0755		07/10/2026
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on resident representative and staff interview, medical record review, and manufacturer's recommendation review, the facility failed to ensure residents were free from significant medication error for 1 of 4 (#1) residents reviewed for medication administration. The findings were: 1. Review of a discharge MDS assessment dated 5/8/26 showed resident #1 had a BIMS score of 13 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included acute on chronic respiratory failure with hypercapnia and hypoxia, congestive heart failure, pneumonia, pulmonary hypertension, pleural effusion, urine retention, and obstructive sleep apnea. Review of the physician's orders dated 5/5/26 showed the resident was to receive sildenafil citrate oral tablet (sildenafil Citrate) give 20 mg by mouth three times a day related to pulmonary hypertension , tamsulosin HCl oral capsule (tamsulosin HCl) and metoprolol tartrate oral tablet (metoprolol tartrate) give 12.5 mg by mouth two times a day related to pulmonary hypertension. The following concerns were identified: a. Review of a progress note dated 5/5/26 and timed 7:34 PM showed the medications were not put into the system until 5/5/26 and the first administration did not occur until the medications were logged into the system. Further review showed the resident had an elevated pulse of 119 beats per minute and there was no evidence the resident's pulse was reassessed. b. Review of the medication administration record for May 2026 showed no evidence the resident received the sildenafil as ordered on 5/4/26 at 6 PM and on 5/5/26 at 8 AM, 12 PM, or 6 PM. Further review showed no evidence the resident received metoprolol as ordered on 5/4/26 at 6 PM and on 5/5/26 at 8 AM. c. Interview with the social services director on	F0760	Resident #1 is no longer reside at the facility Licensed nurses were educated on timely order entry, ensuring all entered orders are activated to the pharmacy through the EMAR, and that physician notification, and required reassessment is completed when medications are delayed or pending delivery. The Director of Nursing (or Designee) audited all residents, from 6/24/26 - 7/8/26 to ensure any new admission orders were entered timely, activated, and given promptly as ordered. No deficient practice found. The Director of Nursing (or Designee) will audit all new admissions, during clinical morning meeting, to ensure all orders are entered, activated timely, and administered for 90 days. DNS/Designee will track, trend date, and report findings at the monthly QAPI committee meeting for 90 days to demonstrate continued compliance. Date of compliance: 7/10/26	07/10/2026

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 07/07/2026

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
F0760 SS = D	Continued from page 31 6/30/26 at 5:20 PM revealed on 5/5/26 she was contacted in the evening by resident #1's family related to the resident not receiving his/her medications as ordered. She revealed she had reviewed the resident's chart and did not see any documentation that anything had been done for the resident and she notified the DON for resolution. d. Interview with the occupational therapist on 7/1/26 at 2:02 PM revealed she had done an initial evaluation and bed mobility assessment on the resident on 5/5/26 and remembered him/her having shortness of breath during the exams. e. Interview with the resident's representative on 6//30/26 at 10:03 AM confirmed she had contacted the facility on 5/5/26 related to the resident's medications. Further she revealed the resident reported having a headache and the representative requested tylenol for the resident. f. Interview with the regional nurse manager and DON #1 on 7/1/26 at 4 PM confirmed the resident was without medications from the time s/he arrived at the facility on 5/4/26 at 11:30 AM until the evening of 5/5/26 where s/he received some of his/her medications, and then s/he received the rest of his/her medications on 5/6/26. Further interview confirmed they would expect residents to receive all medications available upon arrival to the facility. g. Review of the manufacturer's recommendations for metoprolol dated 7/2023 showed "… 5.1 Abrupt Cessation of Therapy: Following abrupt cessation of therapy with certain beta-blocking agents, exacerbations of angina pectoris and, in some cases, myocardial infarction have occurred. When discontinuing chronically administered LOPRESSOR, particularly in patients with ischemic heart disease, gradually reduce the dosage over a period of 1 to 2 weeks and monitor the patient…Warn patients not to interrupt therapy without their physician's advice…" h. Review of "Clinical deterioration after sildenafil cessation in patients with pulmonary hypertension" dated 2008 showed "...short-term effects of a missed dose could include increased shortness of breath with everyday activity, fatigue or low energy as blood flow resistance in the lungs temporarily rises, dizziness or lightheadedness from reduced exercise tolerance..."	F0760		07/10/2026