STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORLAND HEALTHCARE AND REHABILITATION CENTER	**1901 HOWELL AVENUE WORLAND, WY 82401**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 3/3/25 through 3/6//25. Also reviewed in the course of the survey were complaint intake WY00004178, WY00004203, WY00004207, and WY00004283. The following common abbreviations are used throughout this document: RN: Registered Nurse DON: Director of Nursing CNA: Certified Nursing Assistant MDS: Minimum Data Set OT: Occupational Therapist Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609		4/4/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/25/2025

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F 609	Continued From page 1 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interview, facility incident investigation review, state survey agency incident database review, and policy review, the facility failed to report allegations of misappropriation of resident property for 1 of 3 sample residents (#59) reviewed for abuse, neglect, and misappropriation. The findings were: 1. Review of the annual MDS assessment dated 11/17/24 showed resident #59 had a brief interview for mental status score of 14 out of 15 which indicated the resident was cognitively intact. The following concerns were identified: a. Interview with the resident on 3/4/25 at 11:23 AM revealed s/he had $200 which was missing and had told a housekeeper about it. The resident revealed the money went missing "about 3 weeks ago" and the money had not been found, returned, or replaced. b. Review of the state survey agency incident database review showed no evidence the allegation of missing money was reported. c. Review of an "Investigator Interview Form" dated 2/10/25 showed the resident told the social services director s/he was missing $200 from a	F 609	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported to the Administrator of the facility and to the State Survey Agency.	

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F 609	Continued From page 2 bank envelope that was on his/her bedside table. The resident was unable to say what happened to the money or when it went missing. d. Interview with the social services director on 3/5/25 at 3:29 PM revealed she was aware the resident was missing money and an investigation was completed. Interview with the social services director on 3/5/25 at 4:52 PM confirmed the allegation of missing money and investigation were not reported to the state survey agency. 2. Review of the facility policy titled "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating" last revised September 2024 showed "...1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility...3. "Immediately" is defined as: a. within two hours of an allegation involving abuse or result [sic] in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury..."	F 609	Corrective Action: The incident was reported to the State Survey Agency and Ombudsman on 3/17/25. Identification: All residents that choose to keep cash funds on their person have the potential to be affected by the alleged deficiency. Systematic Changes: On March17, 2025, the Social Services Director was re-educated on all alleged violations, specifically misappropriation of resident property (cash money), reported to the Administrator and the State Survey Agency. Review of facility policy Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating. Monitoring: The Administrator/Designee will monitor all grievances and investigations no less than weekly and PRN to ensure that the correct reporting procedures are followed. Issues identified will be corrected immediately. The systematic changes will be monitored by the NHA/Designee monthly for 3 months and as needed at the monthly QAPI meeting to ensure compliance.	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on	F 679		4/4/25

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F 679	Continued From page 3 the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, facility activities calendar review and policy and procedure review, the facility failed to provide an activities program designed to support residents in their choice of activities for 1 of 2 sample residents (#48) with activity concerns. The findings were: 1. Review of the admission MDS assessment dated 6/19/24 showed resident #48 had a diagnosis of dementia with behavioral symptoms such as hitting, kicking and wandering. Further review showed it was very important to the resident to do things with groups of people, very important to go outside when the weather was good, and somewhat important to do his/her favorite activities. The resident had a brief interview for mental status score of 5 out of 15, which indicated severe cognitive impairment. Review of the care plan last revised on 2/26/25 showed "[the resident is] dependent on staff for meeting emotional, intellectual, physical, spiritual and social needs" interventions which included "Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility. Please invite me to scheduled activities ... Engage in simple, structured activities	F 679	The facility will provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, psychosocial well-being of each resident, encouraging both independence and interaction in the community. Corrective Action: On March 24, 2025 Resident #48 began wiping of tables after meals and wiping down handrails when up and pacing in hallway. Identification: All residents that reside on the Special Care Unit have the potential to be affected by the alleged deficiency. Systematic Changes: On March 17, 2025 and March 20, 2025 all staff were in-serviced on the structural activities, group activities, and	

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F 679	Continued From page 4 such as small cognitive games. I like to go for walks to get a snack and soda. I like to be helpful and clean around the building when I am able to. I was a janitor for several years, and I enjoy being helpful." In addition, the resident's plan showed "I like to be kept busy with activities and exercise. I like to be busy, and I do not like to be cooped up. I will bang on the SCU [secure care unit] doors and try to exit...Resident is an elopement risk [due to history] of exit seeking and wandering." Interventions included "Ask resident if [s/he] would help clean up after meals...Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, play games, games that challenge [his/her] memory and cognition. Exercise, resident likes to walk. Resident has a history of being a school janitor, [s/he] likes to clean. Allow [him/her] to assist with clearing tables, wiping hand rails." The following concerns were identified: a. Review of the activities calendar for the SCU showed the activities for 3/4/25 were 10 AM puzzles, 11 AM music, 2 PM matching game, and 4 PM Storytime with [staff name]. Further review showed activities planned for 3/5/25 were 10 AM chair exercise, 11 AM funny videos, and 4:30 PM wet Wednesday. b. Observation on 3/4/25 from 9:49 AM to 10:20 AM showed the resident was pacing with his/her walker up and down the hallway and around the dining room. At 10:11 AM, the social services director entered the secure unit and told resident #48 they would be going to play balloon tennis soon. The staff member left the secure unit, and the resident remained in the unit. Further observation showed the resident was not assisted to the activity, and the s/he continued to pace.	F 679	engaging residents on the special care unit in activities. Those unable to attend will be provided 1:1 re-education. Monitoring: The Social Service Director/Designee will monitor five activities per week for one month then weekly for one month as needed to ensure structured activities are being held and appropriately engaging. Issues identified will be corrected immediately. The systematic changes will be monitored by the NHA/Designee monthly for 3 months and as needed at the monthly QAPI meeting to ensure compliance.	

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F 679	Continued From page 5	F 679		

c. Observation on 3/5/25 from 8:55 AM to 11:20 AM showed the resident was pacing around the dining room. A CNA encouraged him/her to sit down and watch TV, which s/he did. At 8:59 AM, the resident got up and began pacing up and down the hallway. S/he continued pacing up and down the hallway until 9:54 AM when s/he sat down to have a snack. At 10:37 AM, the resident left the unit with an aide for a shower. At 11:20 AM, the resident was again walking up and down the hallway and followed a staff member into another resident's room. S/he remained there while the staff member gave medication to the other resident. The resident was not invited to or engaged in activities during the observation.

d. Observation on 3/5/25 from 1:43 PM to 2:55 PM showed the resident was pacing around the dining room and making statements which included "I don't trust that one. She's got a lot of people; she has a network of people. Just between me and you." The resident continued to pace until 1:58 PM when s/he sat and made statements which included "Somebody's watching though. But I didn't do it, so I don't care. I didn't do it, so I don't have nothing to hide. I get upset when somebody blames me for something." and "There's something wrong somewhere." The resident then asked if s/he could use the broom to sweep up. A CNA told him/her that it was already cleaned up. The resident attempted to empty the trash bin in the dining room. The CNA told him/her they would get it later. The resident pulled the trash bin off the medication cart and began to carry it while staff was engaged with other residents. S/he then began using the broom to "mop" the floor, dipping it into the trash can and scrubbing the floor with circular motions.

d. Review of resident's "Life Enrichment Quarterly Review" dated 12/29/24 showed

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F 679	Continued From page 6 "Resident loves social activities" and "Resident continues to be actively engaged in the SNF [skilled nursing facility] community. [S/he] is one of our more outgoing residents in spite of being in the SCU." 2. Interview with the social services director on 3/5/25 at 4:50 PM revealed the facility had one activities staff member on medical leave and one on vacation during the week of the survey. She stated, "This is a bad week for us with activities." The social services director revealed they had a planned activities calendar for the SCU, but it was flexible based on what was going on with the residents. She revealed some residents, like [resident #48], like to do activities with the rest of the residents [outside of the SCU]. She revealed the expectation was for the CNAs in the unit to perform structured activities. 3. Review of facility policy titled "Activity Programs" showed " ...Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident...Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs ..."	F 679		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance;	F 803		4/4/25

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F 803	Continued From page 7 §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to ensure resident diet orders were followed for 1 of 3 sample residents (#50) reviewed for food and nutrition. The findings were: 1. Review of the quarterly MDS assessment dated 12/11/24 showed resident #50 had a brief interview for mental status score of 15 out of 15, which indicated the resident was cognitively intact, and diagnoses which included diabetes mellitus. Further review showed the resident was coded for a therapeutic diet. Review of the resident's physician orders showed the resident was to receive a controlled carbohydrate diet, had fingerstick blood sugar checks before meals and as needed, and received insulin per a sliding scale based on fingerstick blood sugar levels. The following concerns were identified:	F 803	The facility will ensure that resident diet orders are followed for food and nutrition. Corrective Action: Resident #50 meal tray will reflect the correct diet order prior to being served to resident. Identification: All residents residing in the facility on a specialized diet have the potential to be affected by the alleged deficiency. Systematic Changes: On March 17, 2025 and March 20, 2025 all dietary and nursing staff were re-educated by the Dietician/Designee on the importance of following diet orders, specifically controlled carbohydrate diet.	

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F 803	Continued From page 8 a. Observation on 3/4/25 at 8:36 AM showed the resident received a full cinnamon roll with glaze that was visible on top of the roll and on the plate. Review of the diet card provided with the meal showed the resident should have received a half portion of cinnamon roll with no glaze. Interview with the resident at that time revealed the facility did not follow his/her diabetic diet plan. b. Interview with the dietitian on 3/5/25 at 3:48 PM revealed the facility's diabetic diet included smaller portions of carbohydrates and sugar. Further interview revealed diet cards should be followed during meal service, unless a resident requests something different than the diet card. c. Interview with the dietary manager on 3/5/25 at 9:36 AM revealed the diabetic diet portion is a half portion served without a topping. Further interview revealed an aide would usually catch it if a resident was given a regular portion, and they would get approval from the nurse if the resident requested a full portion. d. Interview with the dietary manager on 3/5/25 at 4 PM confirmed the resident's diet card should have been followed and any requests for items different from the diet should be indicated on the card provided with the meal. Further interview confirmed the resident did not request a full cinnamon roll or glaze for the meal.	F 803	Diet Order, Tray Ticket, and actual tray must all match. Re-educated on Food and Nutrition Services Policy. Those unable to attend will be provided 1:1 re-education. Monitoring: The Certified Dietary Manager/Designee will monitor three meals per week for one month then weekly for one month as needed to ensure diet orders are being followed. Issues identified will be corrected immediately. The systematic changes will be monitored by the NHA/Designee monthly for 3 months and as needed at the monthly QAPI meeting to ensure compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		4/4/25

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F 880	Continued From page 9 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 10 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, professional standard review, and policy review, the facility failed to ensure infection prevention practices were implemented for 1 of 2 sample residents (#2) observed during personal care. The findings were: 1. Review of the quarterly MDS assessment dated 12/1/24 showed resident #2 had a brief interview for mental status score of 5 out of 15, which indicated severe cognitive impairment, and diagnoses which included cerebrovascular accident and hemiplegia or hemiparesis. Further review showed the resident was frequently incontinent of bowel and bladder and was dependent on staff for toileting hygiene and personal hygiene. The following concerns were identified: a. Observation on 3/5/25 at 2:22 PM showed	F 880	The facility will establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Corrective Action: On March 5, 2025, CNA #1, was provided 1:1 education by the Infection Preventionist regarding glove use during resident care per Briefs/Underpads Policy and proper handling of soiled laundry per Laundry and Bedding Soiled Policy. Identification: All the residents that are dependent on staff for personal cares have the	

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F 880	Continued From page 11 CNA #1 and OT #1 assisted the resident into bed. The staff members removed the resident's soiled pants and CNA #1 placed the pants on the floor by the bed. The CNA performed incontinence care and, without removing the soiled gloves, the CNA touched the resident's clean brief, clean pants, shirt, left shoe, blanket, television remote, bed remote, call light, and the outside of the wipe container. Prior to leaving the room, the CNA removed the gloves and used hand sanitizing gel. At that time, the CNA obtained the resident's soiled pants from the floor and carried them to the soiled linen room down the hallway, without placing them in a bag. b. Interview with CNA #1 on 3/5/25 at 2:40 PM revealed she knew she was expected to remove her gloves after contamination and prior to touching anything else in the room; however, she was "nervous." In addition, she revealed she should have placed dirty linen items in a bag before exiting the resident's room. c. Interview with the infection preventionist on 3/5/25 at 2:46 PM confirmed contaminated gloves should be removed before touching clean items and staff should were expected to bag soiled items prior to removing them from a resident room. 2. Review of the website "www.cdc.gov/infection-control/hcp/isolation-precautions/appendix-a-table" dated 11/27/23 showed "Remove gloves after contact with a patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination (see Figure). Do not wear the same pair of gloves for the care of more than one patient. Do not wash gloves for the purpose of reuse since this practice has been associated with transmission of	F 880	potential to be affected by this alleged deficiency. Systematic Changes: On March 17, 2025 and March 20, 2025 all nursing staff were re-educated on resident toileting hygiene, personal hygiene as well as proper handling of soiled laundry/linen per the Briefs/Underpads Policy and Laundry and Bedding Soiled Policy. Monitoring: The Infection Preventionist/Designee will monitor three personal cares per week for one month then weekly for one month as needed to ensure proper toileting hygiene, personal hygiene, and the handling soiled laundry/linen procedures are being followed. Issues identified will be corrected immediately. The systematic changes will be monitored by the NHA/Designee monthly for 3 months and as needed at the monthly QAPI meeting to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 12 pathogens...Change gloves during patient care if the hands will move from a contaminated body-site (e.g., perineal area) to a clean body-site (e.g., face) ..." 3. Review of the policy titled "Briefs/Underpads" dated 2001 showed "...12. Perform perineal care [sic] the resident's back side. 13. Remove the underpad from resident by rolling the underpad toward the inside soiled area. Place the underpad in the nearby receptacle/container. 14. Remove gloves, sanitize hands and replace with clean gloves. 15. Place a clean underpad and brief under the resident. 16. Roll the resident on their back. 17. Fasten the brief. 18. Reposition the bed covers. 19. Discard disposable equipment and supplies in designated containers. 20. Remove gloves and perform hand hygiene. 21. Clean the overbed table and return it to its [sic] proper location..." 4. Review of the policy titled "Laundry and Bedding, Soiled" dated 2001 showed "...2. Contaminated Laundry is bagged or contained at the point of collection (i.e., location where it was used)..."	F 880		