DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035048	A. BUILDING _____ B. WING _____	05/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORLAND HEALTHCARE AND REHABILITATION CENTER	1901 HOWELL AVENUE WORLAND, WY 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
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ARD Assessment Reference Date CDM Certified Dietary Manager CNA Certified Nurse Aide DON Director of Nursing MAR Medication Administration Record MDS Minimum Data Set RN Registered Nurse Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	Preparation and execution of this plan of correction does not constitute an admission or agreement by this provides of the truth of the facts alleged or conclusions set forth in statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposed and correlate with the most recently contemplated or accomplished corrective action and do not necessarily correspond chronologically to date the facility is of the opinion it was in compliance with requirements of participation or that corrective action was necessary.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and family and staff interview, the facility failed to ensure dignity was maintained for 1 of 13 sample residents (#52). The findings were: 1. Observation on 5/21/12 at 4:45 PM revealed resident #52 wore a soft torso support (vest that attached in the back of the wheelchair) while in the wheelchair. A brown stain approximately 1.5 by 0.5 inches was visible on the front of the support. Further observations during the survey on 5/21/12, 5/22/12, and 5/23/12 revealed the stain remained. During an interview on 5/23/12 at	F 241	F241 The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

POC accepted. Call to Dee Cozzens, WHA on 6/25/12 @ 1:50pm.
Janelle Corlis, QPI/L

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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 241	Continued From page 1 5:15 PM, RN #1 stated the facility had plenty of other clean torso supports that could have been used while staff laundered the dirty one. 2. During an interview on 5/23/12 at 7 PM, a family member stated s/he had concerns with residents being left in soiled clothing.	F 241	Correction: 1. On May 24, 2012 prior to the surveyors exiting the nurse assigned to Resident #52 removed his soiled torso support. The staff responsible for this dignity concern were re-educated by the Director of Nursing/Designee on May 24, 2012. On June 11, 2012 the Director of Nursing /Designee initiated re-education of staff regarding assure residents were wearing clean, unsoiled clothing/torso supports etc and that if clothing became soiled that it be changed at that time.	7/8/12
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on random observations and staff and resident interviews, the facility failed to ensure adequate maintenance and repair of two resident wheelchairs (#7, #54) and the walls in two resident hallways. The findings were: 1. Observations on 5/22/12 at 10:48 AM, on 5/23/12 at 3:22 PM and again on 5/24/12 at 8:48 AM revealed the plastic covering on both arms of two resident wheelchairs (#7, #54) was cracked. In addition, pieces of plastic were missing from all four arms exposing the foam material underneath. Interview with resident #7 on 5/23/12 at 3:22 PM revealed s/he was aware the edges of the plastic "sometimes scratched my arms." Interview with the maintenance manager on 5/24/12 at 8:48 AM confirmed the arms needed to be replaced. 2. Periodic observation throughout the survey revealed pieces of wallpaper in the 100 and 400	F 253	Identification: Residents who reside at facility are at potential risk. On June 13, 2012 the Director of Nursing /Designee completed visual rounds to identify other residents who may have had soiled clothing and/ or soiled attached to them ie: torso supports, blankets etc. No other residents were identified during this review Systemic Changes: The facility will provide care for residents in a manner that respects and enhances each residents dignity, individuality, and right to personal privacy. "Dignity" means that interacting with residents, staff carries out activities that assist the resident in maintaining and enhancing self-esteem and self-worth. Care for residents in a manner that maintains dignity and individuality includes assuring they are clean, dry, and well kept. Their clothing is not soiled nor are items next to them such as torso supports soiled. When the staff identifies any issues regarding soiled clothing or other, it is addressed at that time. Staff will be educated on Resident Dignity on hire, annually, and prn. Beginning May 24, 2012 and continuing up until the allegation of compliance the Director of	

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F 241	Continued From page 1 5:16 PM, RN #1 stated the facility had plenty of other clean torso supports that could have been used while staff laundered the dirty one. 2. During an interview on 5/23/12 at 7 PM, a family member stated s/he had concerns with residents being left in soiled clothing.	F 241	Nursing /Designee in-serviced the staff on dignity, specifically assuring that residents are clean, dry, and well kept and that clothing is not soiled. An attendance sheet is kept and reconciled with the active staff roster and staff who were unable to attend will be provided 1:1 education.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on random observations and staff and resident interviews, the facility failed to ensure adequate maintenance and repair of two resident wheelchairs (#7, #54) and the walls in two resident hallways. The findings were: 1. Observations on 5/22/12 at 10:48 AM, on 5/23/12 at 3:22 PM and again on 5/24/12 at 8:48 AM revealed the plastic covering on both arms of two resident wheelchairs (#7, #54) was cracked. In addition, pieces of plastic were missing from all four arms exposing the foam material underneath. Interview with resident #7 on 5/23/12 at 3:22 PM revealed s/he was aware the edges of the plastic "sometimes scratched my arms." Interview with the maintenance manager on 5/24/12 at 8:48 AM confirmed the arms needed to be replaced. 2. Periodic observation throughout the survey revealed pieces of wallpaper in the 100 and 400	F 253	Monitoring: Managers will monitor to ensure resident's dignity is maintained through care rounds weekly and prn. They will utilize the Quality of Care rounds observation tool. Results will be tracked/trended for any issues. Issues identified will be reviewed in QA&A for process improvement to ensure the system is maintained and evaluated for its effectiveness.	

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F 253	Continued From page 2 resident hallways were either missing or had come away from the wall at the wallpaper seams. The following areas in the 100 hall were affected: near resident rooms 106, 103 and 102. In the 400 hall, the areas affected were near resident rooms 402, 407, 410, 403, the bathing room and the corner nurses' station. Interview with the maintenance manager on 5/24/12 at 8:48 AM confirmed the wall paper "needed to be repaired or it would continue to get worse".	F 253	Systemic Changes: Facility management staff will conduct visual rounds weekly to ensure that wheelchair arms are maintained on a regular basis. On or before the allegation of compliance the Maintenance Director and/ or designee will in-service facility staff on communication of maintenance issues such as torn wheelchair arms and torn wallpaper via maintenance repair request and/or the 24 hour report. The Nursing Home Administrator will provide oversight to ensure identified issues have been resolved. Monitoring; The Maintenance Director, Housekeeping Director and the Nursing Home Administrator, or designee, will conduct monthly environmental rounds in order to identify outstanding housekeeping and maintenance issues such as torn wheelchair arms and/ or torn wallpaper with overall oversight provide by the Nursing Home Administrator. Findings to be presented to QA&A monthly as needed.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a significant change MDS assessment when required for 1 of 10 sample residents (#51) who required a significant change assessment. The findings were:	F 274		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORLAND HEALTHCARE AND REHABILITATION CENTER	1661 HOWELL AVENUE WORLAND, WY 82401

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F 274	Continued From page 3 According to the 8/5/11 annual MDS assessment, resident #51 required limited assistance with bed mobility and transfers. Review of the following MDS assessment, a quarterly dated 11/5/11, showed the resident declined and now required extensive assistance with bed mobility and transfers. On 5/24/12 at 8:45 AM, the MDS coordinator confirmed a significant change should have been done, but was not. According to the Centers for Medicare & Medicaid Services: Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, April 2012, Chapter 2: "Some Guidelines to Assist In Deciding if a Change is Significant or Not...Decline in two or more of the following ...Any decline in an ADL physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment."	F 274	System Changes: The Interdisciplinary Team will complete the Minimum Data Sheet on admission, quarterly, annually, and with significant changes in status. Each Minimum Data Sheet completed will be compared to the prior Minimum Data Sheet to identify changes. If the Inter Disciplinary Team determines that the Resident has had changes in two or more areas that are not self limiting, then a significant change in status assessment will be completed. On or before the allegation of compliance the Director of Nursing /Designee will in-service The Interdisciplinary Team with regards to this process. The Director of Nursing/Designee will oversee this process. Monitoring: Quarterly the Minimum Data Sheet Nurse/designee will compare each resident's Minimum Data Sheet to the prior Minimum Data Sheet to identify if a significant change assessment is required. The Minimum Data Sheet Nurse will review 6 random records per month comparing the most recent Minimum Data Sheet to the prior Minimum Data Sheet to determine if a significant change assessment should have been completed. Issues identified will be corrected at that time and trends will be presented by the Minimum Data Sheet Nurse/ designee in QAA to ensure plan has been implemented, sustained, evaluated for its effectiveness.	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure quarterly MDS assessments were completed timely for 2 of 13 sample residents (#34, #48). The findings were: According to the Centers for Medicare & Medicaid	F 276		

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F 274	Continued From page 3 According to the 8/5/11 annual MDS assessment, resident #51 required limited assistance with bed mobility and transfers. Review of the following MDS assessment, a quarterly dated 11/5/11, showed the resident declined and now required extensive assistance with bed mobility and transfers. On 5/24/12 at 8:45 AM, the MDS coordinator confirmed a significant change should have been done, but was not. According to the Centers for Medicare & Medicaid Services: Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, April 2012, Chapter 2: "Some Guidelines to Assist in Deciding if a Change is Significant or Not...Decline in two or more of the following ...Any decline in an ADL physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment."	F 274		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure quarterly MDS assessments were completed timely for 2 of 13 sample residents (#34, #48). The findings were: According to the Centers for Medicare & Medicaid	F 276	F276 The facility will assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Corrective Action: 1. A quarterly assessment has been completed on resident #48. 2. A quarterly assessment has been completed on resident #34. Identification of other residents potentially affected: Residents residing at the facility are found to be potentially affected by the deficient practice. On or before July 8, 2012 the Inter Disciplinary Team will review records of residents residing at facility to determine if the quarterly assessment has been completed. If it was determined a quarterly assessment has not been completed it will be completed at that time.	7/8/12 7/8/12

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F 276	Continued From page 4 Services: Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, April 2012, Chapter 2, the ARD of a quarterly MDS assessment should be no later than the ARD of the previous assessment plus 92 calendar days. The following concerns were identified: 1. Review of the 1/15/12 significant change MDS assessment for resident #48 showed the ARD was 1/9/12. The ARD of the next quarterly assessment was 4/22/12, 104 days from the ARD of the previous assessment. On 5/23/12 at 5:25 PM, the MDS coordinator stated they were having a hard time keeping up with assessments, and therefore some were late. 2. Review of the 1/15/12 significant change MDS assessment for resident #34 showed the ARD was 1/9/12. When asked for the subsequent MDS assessment on 5/23/12 at 5:25 PM, the MDS coordinator stated the quarterly assessment was not complete yet, because they were still waiting for one staff person to complete their portion.	F 276	System Changes: The Interdisciplinary Team will complete the Minimum Data Sheet on admission, quarterly, annually, and with significant changes in status per the required regulatory time frames. A tickler will be pulled each week which shows the assessments due and the Minimum Data Sheet Nurse/ designee will review this list each week with Inter Disciplinary Team. On or before the allegation of compliance the Director of Nursing /Designee will in-service The Interdisciplinary Team with regards to this process and the required time frames specific to completion of the quarterly assessment. The Director of Nursing/Designee will oversee this process. Monitoring: The Minimum Data Sheet Nurse/designee will review 6 random records per month comparing the date of the most recent quarterly Minimum Data Sheet to the prior quarterly Minimum Data Sheet to determine if the quarterly assessments have been completed timely. A tickler will be pulled from the system each month also. Issues identified will be corrected at that time and trends will be presented by the Minimum Data Sheet Nurse/ designee in QAA to ensure plan has been implemented, sustained, evaluated for its effectiveness.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		

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F 276	Continued From page 4 Services: Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, April 2012, Chapter 2, the ARD of a quarterly MDS assessment should be no later than the ARD of the previous assessment plus 92 calendar days. The following concerns were identified: 1. Review of the 1/15/12 significant change MDS assessment for resident #48 showed the ARD was 1/9/12. The ARD of the next quarterly assessment was 4/22/12, 104 days from the ARD of the previous assessment. On 5/23/12 at 5:25 PM, the MDS coordinator stated they were having a hard time keeping up with assessments, and therefore some were late. 2. Review of the 1/15/12 significant change MDS assessment for resident #34 showed the ARD was 1/9/12. When asked for the subsequent MDS assessment on 5/23/12 at 5:25 PM, the MDS coordinator stated the quarterly assessment was not complete yet, because they were still waiting for one staff person to complete their portion.	F 276		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	F 279 A facility will use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care. The facility will develop a comprehensive care plan for each resident that includes measurable objective and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.	

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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 _____	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORLAND HEALTHCARE AND REHABILITATION CENTER	1001 HOWELL AVENUE WORLAND, WY 82401

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F 279	Continued From page 5 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop an individualized care plan for all needed areas for 1 of 13 sample residents (#48). The findings were: Review of the 1/15/12 significant change and 4/26/12 quarterly MDS assessments revealed resident #48 was frequently incontinent of bladder and occasionally to frequently incontinent of bowel. Review of the 4/26/12 care plan showed staff were instructed to "assist with toileting"; however, an individualized toileting schedule was not provided. Review of the May 2012 CNA Care Plan Flow Sheet showed staff were instructed to "check and change" the resident, but specific timeframes were not included. Observation on 5/22/12 at 11:40 AM revealed CNAs #1 and #2 assisted the resident to the bathroom. When asked what the toileting plan was for the resident, both CNAs stated they usually did not work with the resident. They stated residents were usually toileted before and after meals. On 5/24/12 at 8:25 AM, LPN #1 looked at the care plan and confirmed it was not specific for toileting.	F 279	Corrective Action: 1. An individualized plan of care for all needed areas has been developed for resident #48 specific to toileting. Identification of Other Residents Potentially Affected: For identification purposes, a review of current residents' toileting care plans will be completed to pinpoint residents at the facility potentially at risk for care plans lacking specific details regarding their toileting needs. Systemic Changes: Residents will be reviewed upon admission, quarterly, annually, and with significant change of condition utilizing the admission data collection tool/ Minimum Data Sheet /RAI/ Care planning process. Incontinent residents will be further evaluated by utilizing the 3 day bowel and bladder flow sheet as well as the bladder evaluation. Through this process the resident's toileting and/ or incontinent care needs will be identified and care plans will be developed to include services provided to attain or maintain their highest practicable physical, mental, and psychosocial well-being. On or before the allegation of compliance the Director of Nursing/Designee will in-service the Inter Disciplinary Team on developing the plan of care specific to the resident. An attendance sheet will be utilized and reconciled with the current active staff roster. Nursing staff unable to attend will be provided with one on one in-servicing.	7/8/12
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 279	Continued From page 5 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop an individualized care plan for all needed areas for 1 of 13 sample residents (#48). The findings were: Review of the 1/15/12 significant change and 4/28/12 quarterly MDS assessments revealed resident #48 was frequently incontinent of bladder and occasionally to frequently incontinent of bowel. Review of the 4/26/12 care plan showed staff were instructed to "assist with toileting"; however, an individualized toileting schedule was not provided. Review of the May 2012 CNA Care Plan Flow Sheet showed staff were instructed to "check and change" the resident, but specific timeframes were not included. Observation on 5/22/12 at 11:40 AM revealed CNAs #1 and #2 assisted the resident to the bathroom. When asked what the toileting plan was for the resident, both CNAs stated they usually did not work with the resident. They stated residents were usually toileted before and after meals. On 5/24/12 at 8:25 AM, LPN #1 looked at the care plan and confirmed it was not specific for toileting.	F 279	Monitoring Individual care plans to be reviewed and revised, to include services provided based on individual need, upon admission and quarterly, annually and with change of condition. Care plan documentation review will be completed quarterly. Issues identified through this review will be discussed at QA&A for the purpose of process improvement and to ensure plan has been implemented, sustained and evaluated for its effectiveness.	
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309	F309 Each resident will receive and the facility will provide the necessary care and	

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F 309 SS=D	Continued From page 6 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide timely interventions to treat pain for 1 of 7 sample residents (#48) with pain. In addition, the facility failed to ensure care was provided to promote continence for 1 of 9 sample residents (#48) with bowel incontinence. The findings were: 1. Review of the medical record showed resident #48 had diagnoses including osteoarthritis and pain. Review of physician orders showed an order dated 5/17/12 for Tramadol 50 milligrams (mg) every 6 hours as needed for pain. Review of nursing notes showed on 5/18/12, 5/19/12, and 5/21/12 the resident was given the pain medication for complaints of shoulder pain. Observation on 5/22/12 at 8:45 AM revealed occupational therapist (OT) #1 and CNA #2 transferred the resident from the wheelchair to a recliner. During the observation, the resident grimaced, cried out, and said "ouch" during the entire transfer, especially when the left shoulder was moved. The OT and CNA told the resident "I know it hurts." The OT commented that the resident had severe arthritis. The following	F 309	services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Corrective action: 1. On May 24, 2012 the nurse assigned to Resident #48 contacted the primary physician and received an order for routine Ultram 50mg Three Times Daily. The Occupational Therapist and Certified Nursing Assistant involved in the deficient practice were re-educated on the importance of reporting when residents experience pain. 2. Resident #48 – Care Plan has been updated to read "check & change" before and after meals, at bedtime, and every two hours during the night to ensure services are provided to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Identification of other residents who may be at risk: On or before July 8, 2012 the Director of Nursing /Designee will review each resident's current pain management regimen for its effectiveness. Issues identified will be corrected at that time to ensure resident's who have the potential for pain do not have delays in treatment.	7/8/12 7/8/12

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	535040	A. BUILDING _____ B. WING _____	05/24/2012

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WORLAND HEALTHCARE AND REHABILITATION CENTER	1901 HOWELL AVENUE WORLAND, WY 82401

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F 309	Continued From page 7 concerns were identified: a. Continued observation of the OT and CNA showed neither reported the resident's pain to the nurse. b. At 9:55 AM RN #1 went into the resident's room to perform another task. The RN asked the resident, who was resting in the recliner, if s/he was having pain. The resident replied yes. When asked if s/he needed a pain pill, the resident said "uh huh." At 10 AM the RN returned and gave the resident pain medication, 1 hour 15 minutes after the observation of the transfer. c. Review of the May 2012 MAR confirmed the resident did not receive pain medication until 10 AM on 5/22/12. d. During an interview on 5/23/12 at 2:30 PM, OT #1 confirmed the resident had pain. The OT stated usually when a resident had signs/symptoms of pain, she would report it to the nurse, but "I don't think I did yesterday." e. On 5/23/12 at 4:25 PM, RN #1 stated that the resident didn't always report pain; staff should look for signs/symptoms and report to the nurse. The RN confirmed that staff had not reported the resident's pain on 5/22/12 to her. 2. Review of the 1/15/12 significant change and 4/28/12 quarterly MDS assessments revealed resident #48 was occasionally to frequently incontinent of bowel. The following concerns were identified: a. Review of the 4/26/12 care plan showed staff were instructed to "assist with toileting"; however, an individualized toileting schedule was not provided. Review of the May 2012 CNA Care Plan Flow Sheet showed staff were instructed to "check and change" the resident, but specific timeframes were not included. During an	F 309	Residents who require assistance with toileting are at potential risk. The facility will do a record review of those residents residing at facility to identify residents who require assistance with toileting. The resident identified will be evaluated to ensure an effective bowel management program is in place, including toileting times when appropriate, issues identified will be corrected at that time. Systemic changes: On or before the allegation of compliance the Director of Nursing /Designee will in-service licensed nursing staff and therapy staff on the importance of communicating resident's pain so that their pain can been treated. Residents will be assessed for pain on admission, quarterly, annually, and with significant changes in status which can include new reports of pain. An attendance sheet will be kept and reconciled with the nursing and therapy active staff roster and those nursing and therapy staff unable to attend will be provided 1:1 education. On or before the allegation of compliance the staff development coordinator/designee will in-service staff on toileting residents per their plan of care in order to ensure services are provided to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Residents will be assessed on admission, quarterly, annually and with significant changes in condition for their normal bowel habits and their toileting schedules. A 3-day bowel evaluation will be completed on admission and prn to establish normal bowel patterns.	

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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 309	Continued From page 8 interview on 5/24/12 at 8:25 AM, the LPN (#1) who was responsible for the care plan confirmed an individualized plan for toileting was not included. b. Observation on 5/22/12 from 7:40 AM until 11:40 AM (four hours) revealed staff did not check the resident for incontinence, nor offer toileting. At 11:40 AM CNAs #1 and #2 assisted the resident to the bathroom. The resident was incontinent of bowel. When asked what the toileting plan was for the resident, both CNAs stated they usually did not work with the resident. They stated residents were usually toileted before and after meals.	F 309	A care plan will be initiated to include interventions individualized to each resident based of his/ her normal bowel and toileting times will be identified. Licensed staff will monitor daily that residents who are able are toileted through random observations of Certified Nursing Assistants performing Activities of Daily Living cares. An attendance sheet will be kept and reconciled with the nursing active staff roster and those nursing staff unable to attend will be provided 1:1 education Monitoring: The Director of Nursing/Designee will monitor via review of the 24 hour report each business day as well as quality of care rounds weekly and prn. These rounds will include random observations of therapy sessions and Activities of Daily Living cares provided by staff to identify residents that may be experiencing pain that has not been addressed. Issues identified will be corrected immediately and then trended to be reviewed by the Director of Nursing each month in QAA to ensure plan has been implemented, sustained, and evaluated for its effectiveness. Licensed staff will monitor daily that residents who are able are toileted through random observations of Certified Nursing Assistants performing Activities of Daily Living cares. Director of Nursing/Assistant Director of Nursing will monitor every month via random observation of Certified Nursing Assistants providing Activities of Daily Living cares. Issues identified will be tracked and corrected at that time, trends will be presented in QA&A by the Director of Nursing /Designee to ensure plan has been implemented, sustained, and evaluated for its effectiveness.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide care to promote continence for 1 of 8 sample residents (#48) with urinary incontinence. The findings were:	F 315		

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F 309	Continued From page 8 interview on 5/24/12 at 8:25 AM, the LPN (#1) who was responsible for the care plan confirmed an individualized plan for toileting was not included. b. Observation on 5/22/12 from 7:40 AM until 11:40 AM (four hours) revealed staff did not check the resident for incontinence, nor offer toileting. At 11:40 AM CNAs #1 and #2 assisted the resident to the bathroom. The resident was incontinent of bowel. When asked what the toileting plan was for the resident, both CNAs stated they usually did not work with the resident. They stated residents were usually toileted before and after meals.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide care to promote continence for 1 of 6 sample residents (#48) with urinary incontinence. The findings were:	F 315	F 315 Based on the resident's comprehensive assessment, the facility will ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Corrective action: For resident #48 her toileting needs are addressed in the Care plan and on the Certified Nursing Assistant assignment sheet and the Certified Nursing Assistant have been educated on toileting residents per the care plan.	7/8/12

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORLAND HEALTHCARE AND REHABILITATION CENTER	1601 HOWELL AVENUE WORLAND, WY 82401

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F 315	Continued From page 9 Review of the 1/16/12 significant change and 4/28/12 quarterly MDS assessments revealed resident #48 was frequently incontinent of bladder. The following concerns were identified: a. Review of the 4/26/12 care plan showed staff were instructed to "assist with toileting"; however, an individualized toileting schedule was not provided. Review of the May 2012 CNA Care Plan Flow Sheet showed staff were instructed to "check and change" the resident, but specific timeframes were not included. During an interview on 5/24/12 at 8:26 AM, the LPN (#1) who was responsible for the care plan confirmed an individualized plan for toileting was not included. b. Observation on 5/22/12 from 7:40 AM until 11:40 AM (four hours) revealed staff did not check the resident for incontinence, nor offer toileting. At 11:40 AM CNAs #1 and #2 assisted the resident to the bathroom. The resident was incontinent of urine. When asked what the toileting plan was for the resident, both CNAs stated they usually did not work with the resident. They stated residents were usually toileted before and after meals.	F 315	Identification: Residents who require assistance with toileting are at risk. Residents who are incontinent will be evaluated to ensure toileting and/ or incontinence care needs are addressed and to ensure services are provided to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Care plans will be reviewed/ revised at that time. Certified Nursing Assistant assignment sheets will be reviewed/revised at that time if indicated. Systemic changes: Upon admission residents are assessed for incontinence as well as level of Activities of Daily Living assistance required utilizing the nurses comprehensive data collection review. Residents will be assessed continually through the RAI process. When a resident is identified as incontinent and/ or requires assistance with toileting he/ she will be evaluated by a licensed nurse in order to determine the reason for incontinence and, if appropriate, a bladder retraining program will be initiated. The care plan will address the resident's toileting/incontinence care needs. The Inter Disciplinary Team will update the plan of care and communicate to the nursing staff the suggested toileting plan/ incontinent care plan. On or before the date of alleged compliance, the Director of Nursing/Designee will in-service the nursing staff on the urinary management practice guidelines as it relates to toileting vs incontinent care.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 315	Continued From page 9 Review of the 1/16/12 significant change and 4/28/12 quarterly MDS assessments revealed resident #48 was frequently incontinent of bladder. The following concerns were identified: a. Review of the 4/26/12 care plan showed staff were instructed to "assist with toileting"; however, an individualized toileting schedule was not provided. Review of the May 2012 CNA Care Plan Flow Sheet showed staff were instructed to "check and change" the resident, but specific timeframes were not included. During an interview on 5/24/12 at 8:25 AM, the LPN (#1) who was responsible for the care plan confirmed an individualized plan for toileting was not included. b. Observation on 5/22/12 from 7:40 AM until 11:40 AM (four hours) revealed staff did not check the resident for incontinence, nor offer toileting. At 11:40 AM CNAs #1 and #2 assisted the resident to the bathroom. The resident was incontinent of urine. When asked what the toileting plan was for the resident, both CNAs stated they usually did not work with the resident. They stated residents were usually toileted before and after meals.	F 315	Monitoring: Licensed staff will monitor daily that residents are being toileted via random reviews with the Certified Nursing Assistant's while they provide Activities of Daily Living cares. Director of Nursing or designee with monitor the licensed staff and Certified Nursing Assistant's by frequently reviewing daily Certified Nursing Assistant worksheets/checklists, Certified Nursing Assistant charting, and random observation until an acceptable patter has been identified, then periodically to assess continued compliance. Identified issues will be reviewed in QA&A by the Director of Nursing /Designee to ensure plan is implemented, sustained and evaluated for its effectiveness.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 The facility will procure food from sources approved or considered satisfactory by Federal, State, or local authorities; Store, prepare, distribute and serve food under sanitary conditions. Corrective action: 1. No specific resident was identified. The cook identified in the deficient practice was re-educated by the Dietary manager on May 30, 2012.	7/8/12

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	536046	A. BUILDING _____ B. WING _____	05/24/2012

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WORLAND HEALTHCARE AND REHABILITATION CENTER	1901 HOWELL AVENUE WORLAND, WY 82401

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F 371	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that staff utilized appropriate handwashing, that surfaces in the kitchen were sanitized, and that ceiling vents and fire suppression system nozzles were free of dust and dirt. The findings were: 1. Observation in the kitchen on 5/23/12 from 10:12 AM until 12:25 PM revealed cook #1 performed meal preparation and tray line service. At no time during the observation did the cook wash her hands. The cook changed her gloves occasionally, but did not wash her hands upon removing the gloves. Specific concerns included: a. The cook donned gloves, and then touched the oven door and handled a bottle of oil. The cook then used the same gloved hand to put raw chicken into a pan. b. After handling raw chicken with gloved hands, the cook removed the gloves (and without handwashing) and then touched a clean bucket and scoop to be used for ice. c. The cook returned from a smoking break and did not wash her hands. She then handled clean plate covers with her bare hands. She put on gloves and started tray line service. d. The cook removed gloves, used the telephone, and then without washing her hands, put on a new pair of gloves to continue with tray line service. e. The cook used her gloved hands to pour a can of soup into a bowl, and then use the microwave. The cook then used the same gloved hands to handle bread, cheese, and potato chips. During an interview on 5/23/12 at 2:35 PM the	F 371	2. No specific resident was identified. The cook identified in the deficient practice was re-educated by the Dietary manager on May 30, 2012. 3. The fire nozzles above the stove hood and the ceiling fan were cleaned prior to the surveyor exiting the facility. Identification: Residents that reside at the facility are at potential risk. Systemic Changes: On or before the allegation of compliance the Dietary Manager/designee in-serviced the dietary staff on procedures for sanitation to include, ensuring a clean environment through adhering to the cleaning schedule, utilization of an appropriate sanitizer, and proper hand washing and gloving techniques. An attendance sheet will be kept and reconciled with the dietary staff roster, and dietary staff unable to attend will be provided 1:1 education. Monitoring: The Dietary Manager/Designee will monitor compliance through weekly and pm kitchen observation rounds. Issues identified will be reviewed by the Dietary manager/designee at QA & A monthly to ensure plan has been implemented, sustained and evaluated for effectiveness. Follow up will be the responsibility of the Dietary manager.	7/8/12 7/8/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535046	A. BUILDING _____ B. WING _____	05/24/2012

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 371	Continued From page 11 CDM stated staff were instructed to wash their hands when they changed tasks. According to Food Code 2009, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... Immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE SERVICE and SINGLE-USE ARTICLES and...(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands. 2. Observation in the kitchen from 10:12 AM until 12:26 PM revealed cook #1 wiped the prep table surfaces with a cloth that was held in water in the three compartment sink. At 11:15 AM the cook stated the water contained Dawn dishwashing soap. The cook stated she liked to use Dawn because it "cuts the grease better." At 11:15 AM the cook drained the sink, and then filled it back up with water and Dawn dishwashing soap. She then used a cloth in that water to wipe the prep tables and the base of the Robot Coupe (mixer to puree foods). During an interview on 5/23/12 at 2:35 PM the CDM stated staff were instructed to use a bleach solution to wipe tables. She stated staff could use Dawn first, to get rid of grease, but then needed to sanitize using the bleach solution. According to Food Code 2009, U.S. Public Health Service: 4-702.11, "Utensils and food-contact surfaces of equipment shall be sanitized before use after cleaning." In addition, according to	F 371		

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F 371	Continued From page 12 3-304.14: "(B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114;" 3. Observation during the initial tour on 5/21/12 at 3:40 PM revealed a ceiling vent located near the steam table was visibly soiled with dust and dirt. In addition, 2 of the 3 nozzles for the fire suppression system located above the range had strands of dust hanging from them. Observation again on 5/23/12 at 10:12 AM revealed the ceiling vent and nozzles were in the same unclean condition. On 5/23/12 at 2:35 PM, the CDM stated the maintenance department was responsible for cleaning the vents. In addition, she stated she assumed the nozzles were cleaned when the filter was cleaned, but confirmed the nozzles were not part of the cleaning schedule. According to Food Code 2009, U.S. Public Health Service 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 425	F 425 The facility will provide routine and emergency drugs and biologicals to its residents. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. The facility will provide pharmaceutical services to meet the needs of each resident. The facility will employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	

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	535048	A. BUILDING _____ B. WING _____	05/24/2012

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WORLAND HEALTHCARE AND REHABILITATION CENTER	1901 HOWELL AVENUE WORLAND, WY 82401

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F 426	Continued From page 13 supervision of a licensed nurse. 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medications in 3 of 3 areas where medications were stored were not expired. The findings were: 1. Observation on 5/23/12 at 3 PM revealed medications were stored in the medication room between the 100 and 200 hall. Interview at that time with RN #2 revealed the medication stored in the medication room were available for use. Random observation of these medications revealed a plastic sack containing 3 Phenergan suppositories with the expiration date of March 20, 2012. RN #2 confirmed the suppositories were outdated. 2. Observation on 5/23/12 at 3:15 PM revealed medications were stored in the medication room between the 300 and 400 hall. Interview at that time with RN #1 confirmed the medications	F 425	Corrective action: The expired medications identified by the surveyor were removed and set aside for destruction prior to the surveyors exiting the facility. Identification of other residents potentially at risk: Residents that reside at facility are at risk. Systemic changes: The medications will be stored appropriately and will be removed from the cart on or before the expiration date. The Central Supply Coordinator will review each medication cart, medication rooms, medication storage areas, and refrigerators monthly to identify any medications that may be expired and/or close to the expiration date. The expired medication and/or medications close to the expiration date will be removed from the cart and set aside for destruction. On or before the allegation of compliance the Director of Nursing /Designee will in-service licensed nurses and Central Supply Coordinator on the Storage and Labeling of medication requirements which includes removing medications prior to the expiration date. An attendance sheet will be utilized and reconciled with the active nurse staff roster and those nurses unable to attend will be provided 1:1 education. Monitoring: The Director of Nursing /Designee will review medication carts, medication rooms, refrigerators, and the medication storage area once each month. Expired medications will be removed if found and staff re-educated at that time.	7/2/12

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	530043	A. BUILDING _____ B. WING _____	06/24/2012

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 425	Continued From page 14 stored in the medication room were available for use. Random observation of these medications revealed a 16 ounce bottle of mineral oil with the expiration date of March 2012. RN #1 confirmed the mineral oil was expired. 3. Observation on 5/23/12 at 3:30 PM revealed over the counter medications were stored in a locked area in the central supply room. Interview at that time with RN #1 revealed these medications were available for use. Random observation of the medications revealed a bottle of 100 tablets of aspirin 325 milligrams (mg) with an expiration date of March 2012. RN #1 confirmed the bottle of aspirin was expired.	F 425	Issues identified will be tracked and trended then reviewed through the monthly QA&A committee as needed to ensure plan has been implemented, sustained and evaluated for its effectiveness.	