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

PRINTED: 06/27/2013
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 |
|---|---|---|---|
| | 535048 | A. BUILDING _____ B. WING _____ | C 06/13/2013 |

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

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| F 000 | INITIAL COMMENTS<br><br>The following common abbreviations are used throughout this document:<br><br>CNA- Certified Nurse Aide<br>DON- Director of Nursing<br>LPN- Licensed Practical Nurse<br>MDS- Minimum Data Set<br>RN- Registered Nurse<br><br>Less commonly used abbreviations will be annotated in each deficiency. | 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 225 SS=E | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged | F 225 | **F225**<br>The facility will ensure that the abuse registry is checked for all Certified Nursing Assistants hired. The facility will ensure that allegations of mistreatment will be thoroughly investigated and the results of the investigation will be provided to the State.<br><br>Corrective action:<br>Staff involved in ensuring that the abuse Registry has been checked for all newly hired Certified Nursing Assistants have been reeducated by the NHA/ Designee on the importance of ensuring this is done for all newly hired Certified Nursing Assistants. The results of the | 8/1/13 8/9/13 |

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. Change made for phone call with Dee Correnti, Administrator on 7/11/13 Sen.



POC accepted. Janelle Cook, OXLC

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| F 225 | Continued From page 1<br>violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on review of personnel files, staff interview, and policy and procedure review, the facility failed to ensure the nurse aide registry was checked for findings of abuse for 1 of 2 CNAs reviewed. In addition, the facility failed to report the results of the investigation within 5 working days to the state survey agency for 1 of 3 allegations of abuse or injuries of unknown origin reviewed. The finding were:<br><br>1. Review of the personnel file for CNA #1, hired 5/17/13, revealed no evidence the nurse aide registry was checked for findings of abuse. During an interview on 6/12/13 at 3:55 PM, the staff development coordinator (SDC) stated she did not check the nurse aide registry because she erroneously thought the employee was a nurse aide (NA), and not a CNA. After she reviewed the personnel file, the SDC acknowledged the employee did have a CNA license at the time of hire, and the registry should have been checked. According to the facility's "Abuse Prohibition and | F 225 | Investigation of the allegation identified in the survey were reviewed with the surveyor at the time it was identified. The NHA/Designee will reeducate the Director of Nursing and Social Service Director on ensuring that the results of any abuse investigation are sent into the State with in the five days specified by the State.<br><br>Identification of other residents:<br>Residents who reside at facility are potentially affected by this deficient practice.<br><br>System changes:<br>Unusual occurrences, concerns and grievances will be documented on the 24-hour report. The Interdisciplinary Team will review the 24 hour report during the morning leadership meeting and will identify any concerns that may indicate abuse. The facility will also monitor for patterns/trends that may indicate abuse or neglect through investigation of unusual occurrences. The facility will also monitor through feedback from Resident Council, Resident and Family feedback and through feedback from the Ombudsman. Abuse Issues identified will be investigated immediately and the investigation results reported to the State. On or before the allegation of compliance the Facility leadership have been trained by NHA/Designee on the investigation and follow-up requirements of alleged abuse or neglect, specifically ensuring | |

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| F 225 | Continued From page 2<br>Prevention Program" policy (revised 10/20/08), "...employees will be checked for a history of abuse through the state Nurse Aide Registry."<br><br>2. Review of facility documentation showed an investigation of resident to resident abuse dated 11/30/12. There lacked evidence the state survey agency was notified of the results of the investigation. On 6/13/13 at 9:40 AM the DON confirmed the results of the investigation were not reported. She stated she was out of town during that time. According to the facility's "Abuse Prohibition and Prevention Program" policy (revised 10/20/08), "The Administrator or designee will submit a report of the investigation to the appropriate state agency within 5 working days of the incident..." | F 225 | that the results of the investigation are submitted to the State. On or before the allegation of compliance the staff involved in the hiring of new Certified Nursing Assistants have been in-serviced by the Director of Nursing/Designee regarding ensuring that the abuse registry is checked on all newly hire Certified Nursing Assistants. Facility staff will be in-serviced by the Staff Development Coordinator/Designee on the abuse/neglect prohibition policy as part of the hiring process, annually and as necessary.<br><br>Monitoring:<br>The Director of Nursing/Designee will review the reported investigation each month for three months then quarterly thereafter to ensure the results of the abuse investigations are reported to the States. Issues identified will be presented by the Director of Nursing to the QA&A committee to ensure the plan has been implemented, sustained, and evaluated for its effectiveness.<br><br>The NHA will oversee these processes. | |
| F 274 SS=D | 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE<br><br>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.)<br><br>This REQUIREMENT is not met as evidenced by: | F 274 | | |

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| F 225 | Continued From page 2<br>Prevention Program" policy (revised 10/20/08), "...employees will be checked for a history of abuse through the state Nurse Aide Registry."<br><br>2. Review of facility documentation showed an investigation of resident to resident abuse dated 11/30/12. There lacked evidence the state survey agency was notified of the results of the investigation. On 6/13/13 at 9:40 AM the DON confirmed the results of the investigation were not reported. She stated she was out of town during that time. According to the facility's "Abuse Prohibition and Prevention Program" policy (revised 10/20/08), "The Administrator or designee will submit a report of the investigation to the appropriate state agency within 5 working days of the incident..." | F 225 | | |
| F 274 SS=D | 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE<br><br>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.)<br><br>This REQUIREMENT is not met as evidenced by: | F 274 | **F 274**<br>A facility will 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.<br><br>Corrective Action:<br>A significant change in status assessment has been completed on resident #48.<br><br>Identification of other residents potentially affected:<br>Residents residing at the facility are found to be potentially affected by the deficient practice. Beginning June 13, | 8/1/13 8/9/13 |



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| F 274 | Continued From page 3<br>Based on medical record review and staff interview, the facility failed to complete a significant change assessment for 1 of 5 sample residents (#48) who required that type of assessment. The findings were:<br><br>Review of the 12/15/12 quarterly MDS assessment revealed resident #48 required limited assistance (coded as "2") in dressing, toileting, and hygiene. A comparison of the subsequent 3/17/13 quarterly MDS assessment revealed the resident declined and required extensive assistance (coded "3") for dressing, toileting and hygiene. During an interview on 6/11/12 at 4:10 PM the MDS coordinator confirmed the resident declined in more than two areas and a significant change assessment should have been done. | F 274 | 2013 up until the allegation of compliance the Inter Disciplinary Team will review records of residents residing at facility to determine if a significant change in the resident's physical status has occurred. This review will include the comparison between the most recent Minimum Data Sheet to the prior Minimum Data Sheet. If a significant change in status was determined a significant change in status assessment has been completed.<br><br>System Changes:<br>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.<br><br>Monitoring:<br>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 | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and medical record review, the facility failed to ensure staff followed the care plan for 2 of 13 sample residents (#44, #46). The findings were:<br><br>1. Review of the 3/3/13 quarterly MDS assessment for resident #44 showed the resident was cognitively impaired, frequently incontinent of urine, able to ambulate independently with a | F 282 | | |

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| F 274 | Continued From page 3<br>Based on medical record review and staff interview, the facility failed to complete a significant change assessment for 1 of 5 sample residents (#46) who required that type of assessment. The findings were:<br><br>Review of the 12/15/12 quarterly MDS assessment revealed resident #46 required limited assistance (coded as "2") in dressing, toileting, and hygiene. A comparison of the subsequent 3/17/13 quarterly MDS assessment revealed the resident declined and required extensive assistance (coded "3") for dressing, toileting and hygiene. During an interview on 6/11/12 at 4:10 PM the MDS coordinator confirmed the resident declined in more than two areas and a significant change assessment should have been done. | F 274 | 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 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and medical record review, the facility failed to ensure staff followed the care plan for 2 of 13 sample residents (#44, #46). The findings were:<br><br>1. Review of the 3/3/13 quarterly MDS assessment for resident #44 showed the resident was cognitively impaired, frequently incontinent of urine, able to ambulate independently with a | F 282 | **F282**<br><br>The services proved or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care.<br><br>Corrective Action:<br>1. Resident #44 is now being toileted per his/her plan of care. The Director of Nursing/ designee re educated the staff on her plan of care specific to his/her toileting needs.<br>2. Resident #46 is now using a different wheelchair cushion. She has agreed to leave the cushion in the wheelchair stating that it does not bother her and is comfortable. | 8/11/13 8/9/13<br><br>8/11/13 8/9/13 |



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| F 282 | Continued From page 4<br>walker, and required limited assistance with toileting. Review of the care plan, revised 6/6/13, showed staff needed to monitor the resident because at times, s/he was unable to perform proper pericare or continued to wear urine soaked disposable briefs after toileting him/herself without staff assistance. Further review of the care plan showed staff were directed to assist the resident with toileting before and after meals, at bedtime and every two hours at night. Continuous observation on 6/11/13 from 7:50 AM until 12:30 PM revealed staff did not assist the resident to the toilet, nor did they check for incontinence. At 9:20 AM CNA #2 was observed as she entered the resident's room and departed without checking the resident for incontinence or providing assistance with toileting. At 11:55 AM CNA #3 was observed as she assisted the resident to the dining room for lunch, but the CNA did not check the resident for incontinence or assist him/her to the toilet. From 11:55 AM until 12:30 PM, the resident sat in the dining room eating lunch. In an interview on 6/12/13 at 10:50 AM CNA #2 stated when she was in the resident's room on 6/11/13 at 9:20 AM, the CNA saw urine in the toilet and assumed the resident had gone to the bathroom without staff assistance. The CNA further stated this was the reason she did not assist the resident to the toilet at that time. The CNA did not explain why she had not checked the resident for proper peri-care or dry disposal brief as directed by the care plan.<br><br>2. Review of the medical record for resident #46 revealed the resident was at risk for developing pressure ulcers because s/he had developed pressure ulcers in the past that healed. Review of the 3/17/13 significant change MDS assessment | F 282 | Identification:<br>Resident's who reside at facility are at risk. On or before the allegation of compliance the Director of Nursing/Designee will re educate the Licensed Nursing Staff and the Certified Nursing Assistants on the importance of following the Resident's plan of care to include and toileting per the resident individual care plan and ensure interventions to reduce pressure ulcer risk are in place per the plan of care.<br><br>Systemic Changes:<br>The Resident's individual Toileting Plan and pressure ulcer prevention interventions if indicated will be included on the Certified Nursing Assistants plan of care. The Certified Nursing Assistants plan of care is updated by the MDS Coordinator/ designee when indicated. On or before the allegation of compliance the Director of Nursing /Designee will re educate the Licensed Nursing Staff and the Certified Nursing Assistants on the Certified Nursing Assistants care plan and the importance of following the Resident's plan of care to include ensuring pressure ulcer prevention interventions are in place and toileting per the resident individual care plan. An attendance sheet will be utilized and reconciled with the Certified Nursing Assistants and the Licensed Nursing Staff and those staff unable to attend will be provided 1:1 education. | |

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| F 282 | Continued From page 5<br>revealed the resident was assessed as needing a pressure reducing cushion in his/her wheelchair. According to the corresponding care plan, a pressure reducing cushion was to be positioned in the resident's wheelchair. On 6/11/13 at 11:05 AM, LPN #1 was observed as she applied a dressing to the reopened pressure sore on the resident's left hip. Further observation revealed the open area was a small, red, and moist stage II pressure ulcer. At that time the LPN stated this was a healed pressure ulcer that had reopened and it was first noted on 6/10/13. Periodic observations of the resident on 6/10/13, 6/11/13 and 6/12/13 revealed the resident sat in his/her wheelchair without a pressure reducing cushion. In an interview on 6/12/13 at 12:25 PM, the LPN confirmed the pressure reducing cushion had not been in the resident's wheelchair. The LPN stated the resident removed the cushion due to discomfort and staff had not began the process of finding a more suitable cushion for the resident because they had not known the current cushion was not comfortable.<br><br>3. An interview with LPN #1 on 6/12/13 at 10:10 AM revealed the care plan interventions for residents #44 and #46 were current, and staff were expected to follow the care plan for both residents. | F 282 | Monitoring:<br>The Director of Nursing /Designee will do facility rounds 3 times weekly and as necessary observing care to ensure staff are following the resident's toileting plan of care and pressure ulcer interventions are in place per individual resident care plans. Issues identified will be corrected at that time and the Director of Nursing/designee will review trends in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness. | |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having | F 314 | F314<br><br>Based on the comprehensive assessment of a resident, the facility will ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were | |

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| F 282 | Continued From page 6<br>revealed the resident was assessed as needing a pressure reducing cushion in his/her wheelchair. According to the corresponding care plan, a pressure reducing cushion was to be positioned in the resident's wheelchair. On 6/11/13 at 11:05 AM, LPN #1 was observed as she applied a dressing to the reopened pressure sore on the resident's left hip. Further observation revealed the open area was a small, red, and moist stage II pressure ulcer. At that time the LPN stated this was a healed pressure ulcer that had reopened and it was first noted on 6/10/13. Periodic observations of the resident on 6/10/13, 6/11/13 and 6/12/13 revealed the resident sat in his/her wheelchair without a pressure reducing cushion. In an interview on 6/12/13 at 12:25 PM, the LPN confirmed the pressure reducing cushion had not been in the resident's wheelchair. The LPN stated the resident removed the cushion due to discomfort and staff had not began the process of finding a more suitable cushion for the resident because they had not known the current cushion was not comfortable.<br><br>3. An interview with LPN #1 on 6/12/13 at 10:10 AM revealed the care plan interventions for residents #44 and #46 were current, and staff were expected to follow the care plan for both residents. | F 282 | unavoidable; and a resident having pressure sores received necessary treatment and service to promote healing prevent infection, and prevent new sores from developing.<br><br>Corrective Action:<br>1. Resident 3# is receiving wound care per policy and is free from infection. The nurse identified in the survey as not providing wound care with good infection control techniques has been reeducated by the Director of Nursing.<br>2. Resident #46 now has a new wheelchair cushion in place. She has agreed to leave the cushion in place, stating that it is comfortable.<br><br>Identification:<br>Residents who reside at facility and require wound care and or pressure ulcer prevention interventions.<br><br>Systemic Changes:<br>Wound Care will be provided per policy. On or before the allegation of compliance the Director of Nursing/Designee will reeducate Licensed Nursing staff on the "Clean Dressing change" and ensuring good infection control when providing wound care. Licensed Nursing staff and the Certified Nursing Assistants on Pressure Ulcer Prevention to include ensuring wheelchair cushions are in place. An attendance sheet will be utilized and reconciled with the C.N.A and the | 8/1/13 8/9/13<br>8/1/13 8/9/13 |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having | F 314 | | |

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

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| F 314 | Continued From page 6<br>pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure preventative measures were consistently implemented and adequate wound care was performed in a manner to prevent infection and promote healing for 2 of 5 sample residents (#3, #46) who had pressure ulcers. The findings were:<br><br>1. Review of the 5/16/13 Braden Scale for resident #3 showed s/he was scored at 16 (mild risk) for pressure ulcers. However, according to the resident's 3/28/13 significant change MDS assessment, the resident had two stage IV pressure ulcers. Review of the resident's 3/25/13 medical consult showed s/he had two stage IV pressure ulcers, one on each heel, that were debrided on that day. Observation on 6/11/13 at 9:35 AM showed the resident had a debrided pressure ulcer on each heel. The following concerns with pressure ulcer care for resident #3 were identified at that time:<br>a. RN #1 picked up the resident's trash can and removed the contents. However, the RN did not wash her hands afterward, and was not wearing gloves.<br>b. RN #1 donned gloves without washing hands, picked up the trash can, and placed it on the resident's bed under the resident's left lower leg. She placed a towel between the resident and the trash can, but failed to place a barrier | F 314 | Licensed Nursing Staff Roster and those staff unable to attend will be provided 1:1 education.<br><br>Monitoring:<br>The Director of Nursing/Designee will observe wound care being provided three times weekly and as necessary. The Director of Nursing/Designee will do facility Rounds Three times weekly and as necessary to ensure the wheelchairs cushion are in place Issues identified will be corrected at that time and the Director of Nursing/Designee will reports issues in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness. | |

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| F 314 | Continued From page 7<br>between the trash can and the resident's bed.<br>c. RN #1 then performed wound care with a four-by-four gauze pad soaked with normal saline. The RN dropped the four-by-four on the bed, picked it up, and continued wound care.<br>d. RN #1 finished wound care on the left heel, then slid the trash can from the resident's left lower leg to support the resident's right leg, and proceeded to treat the right heel. However, she failed to place a barrier between the trash can and the resident's bed.<br>e. RN #1 changed gloves between wounds, but failed to wash or sanitize her hands between care on the resident's left and right heels, or at any time during the observation until all tasks were completed.<br>f. During an interview with RN #1 on 6/11/13 at 9:55 AM, she acknowledged she should have washed her hands between tasks, and should not have placed the trash can on the resident's bed.<br><br>According to the 6/1/07 facility policy and procedure titled, "Clean Dressing Change" the procedure included, "...9. Wash hands and put on clean gloves. 10. Clean wound as ordered. Carefully dry skin around wound....12. Remove gloves, wash hands and put on clean gloves. 13. Apply dressing and secure as ordered. If appropriate, lightly pack all dead space, i.e., undermining, tunneling, etc., to prevent abscess formation."<br><br>2. Review of the medical record for resident #46 revealed the resident was at risk for developing pressure ulcers because s/he had developed pressure ulcers in the past that healed. Review of the 3/17/13 significant change MDS assessment revealed the resident was assessed as needing a | F 314 | | |

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| F 314 | Continued From page 8<br>pressure reducing cushion in his/her wheelchair. According to the corresponding care plan, a pressure reducing cushion was to be positioned in the resident's wheelchair. On 6/11/13 at 11:05 AM, LPN #1 was observed as she applied a dressing to the reopened pressure sore on the resident's left hip. Further observation revealed the open area was a small, red, and moist stage II pressure ulcer. At that time the LPN stated this was a healed pressure ulcer that had reopened and it was first noted on 6/10/13. Periodic observations of the resident on 6/10/13, 6/11/13 and 6/12/13 revealed the resident sat in his/her wheelchair without a pressure reducing cushion. In an interview on 6/12/13 at 12:25 PM, the LPN confirmed the pressure reducing cushion had not been in the resident's wheelchair. The LPN stated the resident removed the cushion due to discomfort and staff had not began the process of finding a more suitable cushion for the resident because they had not known the current cushion was not comfortable. | F 314 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>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.<br><br>This REQUIREMENT is not met as evidenced | F 315 | F315<br><br>Based on a 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 cauterization 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. | |

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| F 315 | Continued From page 9<br>by:<br>Based on observation, medical record review, and staff interview, the facility failed to ensure toileting assistance and appropriate incontinence care were provided for 1 of 7 sample residents (#44) who required this type of assistance. The findings were:<br><br>Review of the 3/3/13 quarterly MDS assessment for resident #44 showed the resident was cognitively impaired, frequently incontinent of urine, able to ambulate independently with a walker, and required limited assistance with toileting. Review of the care plan, revised 6/6/13, showed staff needed to monitor the resident because at times, s/he was unable to perform proper perlcare or continued to wear urine soaked disposable briefs after toileting him/herself without staff assistance. Further review of the care plan showed staff were directed to assist the resident with toileting before and after meals, at bedtime and every two hours at night. Continuous observation on 6/11/13 from 7:50 AM until 12:30 PM revealed staff did not assist the resident to the toilet, nor did they check for incontinence. At 9:20 AM CNA #2 was observed as she entered the resident's room and departed without checking the resident for incontinence or providing assistance with toileting. At 11:55 AM CNA #3 was observed as she assisted the resident to the dining room for lunch, but the CNA did not check the resident for incontinence or assist him/her to the toilet. From 11:55 AM until 12:30 PM, the resident was observed sitting in the dining room eating lunch. In an interview on 6/12/13 at 10:50 AM CNA #2 stated when she was in the resident's room on 6/11/13 at 9:20 AM, the CNA saw urine in the | F 315 | Corrective Action:<br>Resident #44 is now assisted with toileting and/or perl care before and after meals, HS, and as necessary per her plan of care The Director of Nursing/ designee re educated the staff on her specific plan of care.<br><br>Identification:<br>Resident's who reside at facility are at risk. On or before the allegation of compliance the Director of Nursing/Designee will re educate the Licensed Nursing Staff and the Certified Nursing Assistants on the importance of following the Resident's plan of care to include providing incontinent care and/or toileting per the plan of care.<br><br>Systemic Changes:<br>The Resident's individual Toileting Plan will be included on the Certified Nursing Assistants plan of care. The Certified Nursing Assistants plan of care is updated by the MDS Coordinator/ designee when indicated. On or before the allegation of compliance the Director of Nursing/Designee will re educate the Licensed Nursing Staff and the Certified Nursing Assistants on the Certified Nursing Assistants care plan and the importance of following the Resident's plan of care: specifically toileting per the resident individual care plan. An attendance sheet will be utilized and reconciled with the Certified Nursing Assistants and the Licensed Nursing Staff | 8/1/13<br>8/9/13 |

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| F 315 | Continued From page 10<br>toilet and assumed the resident had gone to the bathroom without staff assistance. The CNA further stated this was the reason she did not assist the resident to the toilet at that time. The CNA did not explain why she had not checked the resident for proper peri-care or dry disposal brief | F 315 | and those staff unable to attend will be provided 1:1 education.<br><br>Monitoring:<br>The Director of Nursing Designee will do facility rounds 3 times weekly and as necessary observing care to ensure staff are following the resident's toileting plan of care. Issues identified will be corrected at that time and the Director of Nursing/designee will review trends in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness. | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. | F 441 | | |

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| F 315 | Continued From page 10<br>toilet and assumed the resident had gone to the bathroom without staff assistance. The CNA further stated this was the reason she did not assist the resident to the toilet at that time. The CNA did not explain why she had not checked the resident for proper peri-care or dry disposal brief | F 315 | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. | F 441 | F 441<br><br>The facility will establish and maintain and Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>Corrective Action:<br>The Infection Control program is established in the facility. The Infection Control nurse has been reeducated regarding her need to continue to track the resident's infection each month until resolved. The infections noted on the Infection control logs during the last 3 months for Resident's #3, 66, 23, 5, 13, 54, 8, and 58 have since resolved. The RN observed during survey providing in proper wound care and placing trash can on the residents bed without a barrier and using the 4x4 after dropping it onto the bed has be reeducated on the proper way to provide wound care to prevent cross contamination. The Certified Nursing | 8/1/13<br>~~8/9/13~~ |



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| F 441 | Continued From page 11<br><br>(p) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and review of project plans and infection control logs, the facility failed to ensure staff followed appropriate infection control practices during 3 random observations of resident care (#3, #38, #59). In addition, the infection control program failed to include clinical resolution and monitoring for 8 residents (#3, #66, #23, #5, #13, #54, #8, #58) who received antibiotic therapy. Finally, the infection prevention activities failed to include an infection control risk assessment (ICRA) and a plan for continued monitoring during work on the facility ceilings. The findings were:<br><br>1. Interview with the infection control practitioner (ICP) on 6/12/13 at 3:25 PM and review of the December 2012 to June 2013 infection control surveillance logs revealed the lack of a final clinical resolution for eight residents (#3, #66, #23, #5, #13, #54, #8, #58) documented as receiving antibiotic therapy. The ICP also revealed she tracked each patient for a month and if there was not a resolution during that month she did not continue to track them or include them in her data analysis.<br><br>2. During the tour of the facility on 6/10/13 and again on 6/11/13 workers were observed drilling | F 441 | Assistants observed during survey providing in peri care and then failing to do proper hand hygiene after removal of gloves and before dressing the resident have been reeducated on the ensuring hand hygiene is completed before and after removal of gloves to prevent cross contamination. The ICRA (for the work being completed at the facility that including drilling holes in the ceiling and removal of ceiling tiles) was completed prior to the surveyors exiting the facility<br><br>Identification:<br>Residents that reside at facility are at potential risk<br><br>Systemic Changes:<br>On or before the allegation of Compliance the Director of Nursing will in service to the Infection control nurse on the facility's Infection Control program to include surveillance, complete data collection, isolation implementation, and preventing the spread of infections specifically continuing to track resident's infections each month until resolved<br><br>The RN's LPN's were re educated on the proper way to perform wound care to prevent cross contamination<br><br>The Certified Nursing Assistants were reeducated on the importance of hand washing before and after removal of gloves when providing peri care | |

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| F 441 | Continued From page 12<br>holes in the ceiling and cutting ceiling tiles in one area of the 100 hall and one area of the 200 Hall. Further observation revealed dust abatement measures had been implemented and residents were not observed to be at risk. Review of the facility work project plan showed on the 200 Hall holes in the ceiling were being drilled out for the sprinkler system placement. Review of the plan also showed on the 100 hall ceiling tiles were being cut for placement where dust migration could be controlled. However, interviews with the ICP on 6/12/13 at 3:25 PM and the DON on 6/12/13 at 4:20 PM revealed they had not completed an ICRA for this project, nor had they implemented a system for ongoing monitoring to ensure safe infection prevention practices for the residents who resided on the two halls.<br><br>3. Observation on 6/11/13 at 7:50 AM revealed the pillow that had been placed behind resident #59's back to facilitate proper positioning in the wheelchair had fallen from the wheelchair to the floor. At that time ants were also observed on the floor near the pillow. Continuous observation revealed RN #1 removed the pillow from the floor and placed it in a nearby empty chair at 8:10 AM. At 8:20 AM, dietary aide #1 moved the pillow from the chair and positioned it behind the resident's back. Interview with the ICP on 6/12/13 at 3:25 PM revealed using a pillow that had been on the floor was not an acceptable standard of infection prevention practices.<br><br>4. On 6/11/13 at 9:05 AM, CNA #4 and CNA #2 were observed providing fecal incontinence care for resident #38. The CNAs removed their gloves after cleansing the resident's skin. Then, without performing hand hygiene, they proceeded to | F 441 | Monitoring:<br>According to company protocol, infections will be tracked and trended through surveillance, complete data collection, isolation implementation, and preventing the spread of infections. The resident infections will be tracked until resolved. The infection control logs will be reviewed by the Director of Nursing/Designee to ensure resident infections are tracked until resolved and Trends, outbreaks and/ or issues concerning infection control program including ensuring ICRA's are completed when construction work is being completed in the facility. This will be reviewed by the Director of Nursing/Designee in the monthly QA process to ensure plan has been implemented, sustained, and evaluated for its effectiveness. Director of Nursing/Assistant Director of Nursing will monitor every month via random observation of Certified Nursing Assistants providing peri care to ensure hand washing is occurring before and after removal of gloves. Issues identified will be tracked and corrected at that time, trends as well as infection control reports will be presented in QA&A by the Director of Nursing/Designee to ensure plan has been implemented, sustained, and evaluated for its effectiveness. | |

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| F 441 | Continued From page 13<br>dress the resident, using their ungloved hands to dress his/her upper torso and lower extremity clothing. Interview with the ICP on 6/12/13 at 3:25 PM revealed the failure to perform hand hygiene after glove removal was not an acceptable standard of infection prevention practices.<br><br>5. The following infection control concerns were identified during pressure ulcer care for resident #3 on 6/11/13 at 9:35 AM:<br>a. RN #1 picked up the resident's trash can and removed the contents. However, the RN did not wash her hands afterward, and was not wearing gloves.<br>b. RN #1 donned gloves without washing hands, picked up the trash can, and placed it on the resident's bed under the resident's left lower leg. She placed a towel between the resident and the trash can, but failed to place a barrier between the trash can and the resident's bed.<br>c. RN #1 then performed wound care with a four-by-four gauze pad soaked with normal saline. The RN dropped the four-by-four on the bed, picked it up, and continued wound care.<br>d. RN #1 finished wound care on the left heel, then slid the trash can from the resident's left lower leg to support the resident's right leg, and proceeded to treat the right heel. However, she failed to place a barrier between the trash can and the resident's bed.<br>e. RN#1 changed gloves between wounds, but failed to wash or sanitize her hands between care on the resident's left and right heels, or at any time during the observation until all tasks were completed.<br>f. During an interview with RN #1 on 6/11/13 at 9:55 AM, she acknowledged she should have washed her hands between tasks, and should not | F 441 | | |

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OMB NO. 0938-0391

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

| 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 06/13/2013 |

| 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 441 | Continued From page 14<br>have placed the trash can on the resident's bed. | F 441 | | |