POC approved 5/27/10

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

PRINTED: 05/18/2010
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 04/08/2010

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: DON - director of nursing RN - registered nurse LPN - licensed practical nurse MDS - Minimum Data Set CNA - certified nurse aide cm - centimeter ft - foot 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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. 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).	F 225	F 225 The facility will not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law. The facility will 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. The facility will have evidence that all alleged violations are thoroughly investigated, and will prevent further potential abuse while the investigation is	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Walter Sandell — TITLE: Administrator — (X6) DATE: 5/20/2010

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 approved - Calledon 5/27/10 @ 3:30pm Wyoming Dept of Health Message given

MAY 20 2010

To Heidi Salaz, Business Office manager since Administrator and DON out of building.

Janelle Collins 10:15

Office of Healthcare Licensing and Surveys

JC 5/17/10

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of internal investigations, the facility failed to investigate 1 of 10 incidents involving possible abuse (resident #62). The findings were: Review of the care plan for resident #62 showed the resident had required the assistance of one employee with wheelchair transportation since 11/27/01. Review of the nursing notes showed the resident was out of the facility on 2/3/10 at 10 AM for a physician's visit. Further review showed the facility received a call from the emergency room on 2/3/10 at 11:30 AM requesting information concerning the resident. The documentation showed the resident fell and hit his/her head and required sutures. At 1:15 PM on 2/3/10, the van driver returned the resident to the facility with family present upon the return. Review of the facility's internal investigations showed this incident was not investigated. During an interview with the DON, social	F 225	in progress. The results of all investigations will 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 will be taken. This requirement will be met as evidenced by: 1. Resident #62 has expired. 2. incidents involving possible abuse, neglect, mistreatment of a resident or misappropriation of resident property will require a full investigation. 5/23/10 3. Social Service Worker, Director of Nursing, or designee will review all reports of possible abuse, neglect, mistreatment of residents and/or misappropriation of resident property. 5/23/10 4. Incidents that require the resident to be seen outside the facility by a physician will require an investigation. 5/23/10 ID of Residents: Residents residing at Worland Health Care have the ability to be affected. Systems: 1. Staff employed at Worland Health	

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F 225	Continued From page 2 services director (SSD), and assistant DON on 4/8/10 at 10:15 AM, it was revealed that the facility administrator transported the resident to the physician visit on 2/3/10. The DON also said the administrator was transporting the resident from the physician's office down a ramp outside the building via a wheelchair when the resident fell out of the wheelchair. The DON then stated that, with assistance from the physician's staff, the administrator placed the resident back into the wheelchair and pushed him/her to an adjacent emergency room for treatment, including x-rays and sutures to the nose. When asked, the DON and SSD stated they did not investigate the incident or report the incident to the appropriate state agency as required. The DON further stated the family was notified by the emergency room staff before the facility could establish contact.	F 225	Care are to be in-serviced at next meeting on 05/17/10 on: a. Abuse Prohibition and Prevention Guidelines – Five Star Policy CL-INTER-0108 b. Incident/Accident Investigation Process - – Five Star Policy CL-INTER-0110a c. Review staff's obligation in reporting possible abuse, neglect, mistreatment of residents and misappropriation of resident property. Monitoring: Administrator, Social Service Worker, Director of Nursing and/or Designee will be notified immediately of suspected abuse, neglect, mistreatment of residents and/or misappropriation of resident property. Incidents will be reviewed by the Interdisciplinary team within twenty-four hours and investigations initiated as warranted. Any issues noted will be addressed immediately. Quality Assurance: Director of Nursing will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	
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:	F 274		

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F 225	Continued From page 2 services director (SSD), and assistant DON on 4/8/10 at 10:15 AM, it was revealed that the facility administrator transported the resident to the physician visit on 2/3/10. The DON also said the administrator was transporting the resident from the physician's office down a ramp outside the building via a wheelchair when the resident fell out of the wheelchair. The DON then stated that, with assistance from the physician's staff, the administrator placed the resident back into the wheelchair and pushed him/her to an adjacent emergency room for treatment, including x-rays and sutures to the nose. When asked, the DON and SSD stated they did not investigate the incident or report the incident to the appropriate state agency as required. The DON further stated the family was notified by the emergency room staff before the facility could establish contact.	F 225		
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:	F 274	F 274 The 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. This will be met as evidenced by: 1. A significant change was initiated on 04/09/10 for resident #8 to reflect accuracy for condition of skin. ID of Residents: Residents who reside at Worland Health Care have the ability to be affected. Systems: 1. Licensed Personnel will be in-serviced at next meeting on 05/17/10 on:	5/23/10

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5/27/10

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F 274	Continued From page 3 Based on observation, medical record review and staff interview, the facility failed to complete a significant change MDS assessment for 1 of 11 sample residents (#8) who required that assessment. The findings were: Observation on 4/7/10 at 2:30 PM showed resident #8 had an area of black eschar approximately 2.5 cm by 1.5 cm on the right heel. Review of nursing documentation dated 3/16/10 showed the resident had a "7 cm circular fluid filled blister" on the right heel which ruptured when the resident kicked the blankets. Review of the 3/17/10 wound care progress notes showed there was a 3 cm by 2 cm black and blue area on the bottom of the resident's heel inside the blister. This area was identified by the facility as an unstaged pressure ulcer on 3/21/10. Medical record review showed no evidence a significant change MDS assessment had been completed by 4/7/10. Interview with the MDS coordinator on 4/8/10 at 8:10 AM confirmed the assessment was not completed.	F 274	a. Five Star Policy/Procedure CL-AL-RS314 on Significant Change in Resident Condition. b. Need to notify Director of Nursing/Assistant Director of Nursing, and Minimum Data Set Coordinator of change in resident condition and ensure on twenty-four hour report. c. Minimum Data Set Coordinator to initiate Significant Change of Condition. Monitoring: Director of Nursing and Assistant Director of Nursing will conduct audits no less than two times per week and as necessary to ensure all systems are in place. a. Change of Condition are listed on twenty-four hour reports. b. Minimum Data Set Change of Condition initiated as warranted. c. Documentation in place d. Referrals made as necessary i.e. Dietician, Pharmacist, Physician, Therapists, and any other referral that may be necessary. e. Plan of Correction reflects change f. Ensure Interdisciplinary team is aware of significant change in condition g. Any other issues discovered will be addressed immediately.	
F 279 SS=E	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. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279		

5/7/10

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F 274	Continued From page 3 Based on observation, medical record review and staff interview, the facility failed to complete a significant change MDS assessment for 1 of 11 sample residents (#8) who required that assessment. The findings were: Observation on 4/7/10 at 2:30 PM showed resident #8 had an area of black eschar approximately 2.5 cm by 1.5 cm on the right heel. Review of nursing documentation dated 3/16/10 showed the resident had a "7 cm circular fluid filled blister" on the right heel which ruptured when the resident kicked the blankets. Review of the 3/17/10 wound care progress notes showed there was a 3 cm by 2 cm black and blue area on the bottom of the resident's heel inside the blister. This area was identified by the facility as an unstaged pressure ulcer on 3/21/10. Medical record review showed no evidence a significant change MDS assessment had been completed by 4/7/10. Interview with the MDS coordinator on 4/8/10 at 8:10 AM confirmed the assessment was not completed.	F 274	Quality Assurance: Director of Nursing will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	
F 279 SS=E	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. The care plan must describe the services that are to be furnished to attain or maintain the resident's	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. This will be met as evidenced by: 1. An appropriate plan of care reflecting skin issues was developed and/or updated for resident #8 on 04/07/10 to include identification of risk, treatment plan, preventative measures, and nutritional status.	5/23/10

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F 279	Continued From page 4 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 medical record review, staff interview, and review of the facility's "Skin and Wound Management Program Overview," the facility failed to provide an appropriate plan of care for 3 of 3 sample residents (#8, #15, #35), who were at risk for or had developed pressure sores. The findings were: 1. According to the 2/23/10 significant change MDS assessment, resident #8 was at risk for developing pressure ulcers. Review of the Braden Risk Assessment scores (tool used for predicting pressure ulcer risk) dated 3/4/10 and 3/12/10 showed the resident was at moderate risk (13) for development of pressure ulcers. On the reverse side of the forms were interventions which could be used on an interim basis prior to the development of a comprehensive assessment and care plan for pressure ulcer prevention. Observation on 4/7/10 at 2:30 PM with RN #4 revealed the resident had an area of black eschar on the right heel. The RN stated the eschar was approximately 2.5 cm long and 1.5 cm wide. An area of pink granulation tissue approximately 0.5 cm wide surrounded the eschar. Review of nursing documentation dated 3/16/10 showed the resident had a "7 cm circular fluid filled blister" on the right heel which ruptured	F 279	2. An appropriate plan of care reflecting skin issues was developed and/or updated for resident #15 on 04/10/10 to include identification of risk, treatment plan, and preventative measures, and nutritional status. 3. An appropriate plan of care reflecting skin issues was updated for resident #35 on 04/06/10 to include identification of risk, treatment plan, preventative measures, and nutritional status. ID of Residents: Residents who reside at Worland Health care have the ability to be affected. Systems: 1. Licensed personnel in-serviced 04/19/10 on: Needing to update plan of care to reflect any/all changes in resident condition. 2. Licensed personnel will be in-serviced at next meeting on 05/17/10 on: A. Five Star Policy CL-INTER-0115 on Process for Care Plan Development and Communication. B. Five Star Quality Care, Care Plan Development. 3. Residents will be reviewed upon admissions, quarterly, annually, and with significant change of condition. 4. Plan of Care will be developed	5/23/10 5/23/10

5/20/10

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F 279	Continued From page 5 when the resident kicked at the blankets. The nursing notes and the "Wound Care Progress Notes," both dated 3/17/10, showed there was a 3 cm by 2 cm black and blue area inside the blister on the resident's heel. Even though the resident was identified by the facility as being at risk for developing pressure ulcers, a comprehensive care plan with time lines and measurable objectives had not been developed. This was confirmed by RN #4 on 4/7/10 at 4:15 PM. According to the "Skin and Wound Management Program Overview," last revised 6/1/07, "Residents identified at risk for development of pressure ulcers (Braden Risk Assessment score of less than 18) will have a care plan developed and documented to minimize the risk of developing a pressure ulcer." 2. According to the 8/27/09 significant change MDS assessment, resident #35 was at risk for developing pressure ulcers. Also, the corresponding 9/1/09 Resident Assessment Protocol (RAP) for pressure ulcers showed a referral to the care plan. Review of the Braden Risk Assessment score for the resident dated 12/1/09 showed s/he was at risk (18) for developing pressure ulcers. On the reverse side of the form were interim interventions which could be used prior to the development of a comprehensive care plan to address the resident's skin issues. Observation on 4/7/10 at 11:45 AM with RN #3 showed the resident currently had a stage II pressure ulcer at the left central inner buttocks fold area. The pressure ulcer measured approximately 1 cm long and 0.75 cm wide. The area was clean and dry with pinkish granulation tissue. The RN completed the appropriate treatment and reapplied a dressing as ordered.	F 279	to ensure services are provided to attain or maintain the residents' highest functional, physical, mental, and psychosocial well-being. Monitoring: The interdisciplinary team will review weekly all skin issues and chart to ensure appropriate plan of care has been developed to ensure that any/all services are provided to attain or maintain the residents' highest functional, physical, mental, or psychosocial well-being. The Director of Nursing and/or the Assistant Director of Nursing will conduct random audit no less than two times per week to ensure comprehensive care plans are developed and/or updated as warranted by residents condition. Any issues discovered will be addressed immediately. Quality Assurance: Director of Nursing will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	

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F 279	Continued From page 6 During an interview on 4/6/10 at 2:50 PM, the MDS coordinator stated the 9/1/09 RAP referred to a care plan for prevention of pressure ulcers that should have been completed at that time. Record review failed to show an individualized, comprehensive care plan was developed specific to this resident's pressure ulcer until 4/7/10. 3. Review of nursing documentation dated 3/11/10 showed resident #15 had a 6.5 cm circular open area on the left buttock. Review of the care plan during that time period showed interventions addressing this particular pressure ulcer had not been developed as part of the comprehensive care plan. Interview with the DON on 4/7/10 at 3 PM confirmed a comprehensive care plan for pressure ulcers on this resident's buttocks was not developed. According to the "Skin and Wound Management Program Overview," last revised 6/1/06, "Residents identified at risk for development of pressure ulcers (Braden Risk Assessment Score of less than 18) will have a care plan developed and documented to minimize the risk of developing a pressure ulcer."	F 279		
F 281 SS=F	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of professional standards of practice, the facility failed to secure and account for medications in 3 of 4 medication carts. The findings were:	F 281	F 281 The services provide or arranged by the facility will meet professional standards of quality. This requirement will be met as evidenced by: 1. Medication carts will be secured at all times and especially when out of sight of Licensed Personnel.	5/23/10

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F 281	Continued From page 7 According to the Smith, Duell and Martin in "Clinical Nursing Skills Basic to Advanced Skills," 7th Edition, 2008, staff should "Keep all medications in locked carts or cabinets...Keep narcotics in double-locked cabinets...Sign out for the narcotic on the narcotic sheet after taking narcotic out of the drawer." Failure to follow these professional standards of practice was identified in the following instances: a. Observation on 4/5/10 at 5:05 PM revealed an unlocked medication cart sitting in the dining room of the special care unit. There were four residents from the special care unit sitting in the dining room at that time, but no staff were in the area. Two minutes later, LPN #10 came out of a resident's room where the door had been closed and went to the medication cart. Interview with the LPN at that time revealed all residents in the special care unit were cognitively impaired. b. Observation on 4/6/10 at 7:32 AM showed the medication cart for Hall 3 was placed just outside the doorway to the dining room. Although the locking mechanism was pushed in, further observation showed RN #1 just pulled out the lock for the cart without using a key to unlock the mechanism. When the RN finished setting up the medications, she pushed the lock in, but it failed to engage as she was able to pull it out to set up medications for the next resident. Continued observation at 7:38 AM revealed the narcotic drawer inside the cart was also unlocked when the RN left the cart outside the dining room to administer medications. She was gone four minutes and was out of sight of the medication cart; during that time several unidentified staff and residents walked by the cart to enter the dining room. Twenty four residents resided on Halls 3 and 4 and could have entered the dining	F 281	2. Licensed Personnel in-serviced on 04/23/10 that medication card and the narcotic box are to be kept locked at all times. ID: Residents residing at Worland Health Care have the ability to be affected. Systems: 1. Licensed personnel in-serviced on 04/23/10 on need to secure medication care as well as narcotic lock box at all times. 2. Defective Narcotic lock box was replaced on cart for Hall #1 on 04/09/10. 3. Licensed Personnel will be in-serviced on 05/17/10 on Five Star Policy CL-NUR-1600, Medication Management Guidelines. 4. Licensed Personnel in-serviced 04/23/10 on the need to sign out all medications as given and this includes narcotics and per necessary medications. Will re-in-service on 05/17/10. Monitoring: 1. Consulting pharmacist to conduct system checks on all medication carts to ensure all locking mechanisms are in prime working order. Defective mechanisms to be replaced as necessary.	5/23/10

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	535048	A. BUILDING _____ B. WING _____	C 04/08/2010

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 281	Continued From page 8 room through that door. On 4/8/10 at 9:25 AM the RN demonstrated that the narcotic drawer remained unlocked while the lock was pushed in but not engaged. She also demonstrated, by only pushing the lock partially in, that the locking mechanism on the cart could be manipulated so the lock was not engaged. The RN confirmed the medication cart should be locked when unattended, and narcotics should be double locked. c. Observation on 4/7/10 at 4:45 PM revealed the narcotic box on the medication cart in Hall 1 was not locked. Interview with RN #4 revealed she had been unable to lock the narcotic box since she started work at the facility the first week in March 2010. In addition, a random narcotic count at that time revealed resident #8 had a medication card that contained 18 Darvocet-N tablets. According to the narcotic count book, there should have been 19 tablets at that time. Interview with the RN revealed she had given the resident a Darvocet-N tablet at 2 PM, 2 hours and 45 minutes earlier, but had not yet signed out the narcotic. Interview with the DON on 4/8/10 at 8 AM revealed narcotics were to be signed out when they were given.	F 281	2. Director of Nursing and/or Assistant Director of Nursing to conduct cart checks no less than two times per week and as necessary to ensure carts are locked at all times. These checks will include the narcotic lock box. 3. Director of Nursing and/or Assistant Director of Nursing to conduct random audits no less than two times per week and as necessary to ensure that all medications signed out as given to resident and to include signing out narcotics on narcotic count sheet and any/all per necessary medications. 4. Any issues noted will be addressed immediately. Quality Assurance: Director of Nursing will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review	F 312	F 312 The facility will ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal, and oral hygiene. This requirement will be met as evidenced by:	

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F 312	Continued From page 9 of policies and procedures and monitoring documentation, the facility failed to ensure staff provided appropriate perineal care for 2 of 6 sample residents (#38 an d#45) observed during the provision of incontinence care. The findings were: Review of the facility's policy and procedure for routine perineal (incontinence) care revealed, "...Clean the genitalia (peri area) with a clean washcloth or wipe using a downward motion from the pubis (front) to the anus (back). Use a different section of the washcloth with each wipe or discard wipe after each stroke to avoid contamination..." The following concerns were noted: a. Observation on 4/6/10 at 9:10 AM revealed resident #45 had been incontinent of bowel and bladder. When CNA #8 provided perineal care to the resident, she wiped from back to front several times and repeatedly used the same area of the wipes, which had been contaminated with feces. When the CNA was asked about the correct procedure for providing perineal care, she stated she cleaned the residents thoroughly, checked the skin, and reported any concerns to the nurse. b. Observation on 4/6/10 at 10:15 AM showed resident #38 had smears of feces on the perineal area and disposable brief. When providing perineal care, CNA #8 cleansed the resident from back to front. Review of the completed checklist for monitoring perineal care showed the CNA had been taught to cleanse the perineal area from front to back.	F 312	The facility will ensure that staff provides appropriate perineal care. Residents #38 and #45 will receive proper perineal care. 1. The Infection Control Nurse will provide one on one in-servicing to Certified Nursing Assistant #8 each week for four weeks to ensure the appropriate perineal care is provided to residents. 5/23/10 2. Infection Control Nurse and or Charge Nurse will provide one on one in-servicing on proper peri-care to certified nursing assistants. 5/23/10 3. Nursing staff to be in-serviced on 05/17/10 on appropriate perineal care. 5/23/10 4. Review of Five Star Policy CL-NUR-1716: Routine Perineal Care and Licensed and unlicensed nursing personnel on 05/17/10. 5/23/10 Systems: In-service on peri-care will be provided to all Certified Nursing Assistants bi-annually and as necessary by the Staff Development Coordinator or designee. Monitoring: Assistant Director of Nursing will conduct random checks to ensure appropriate peri-care is provided no less than one time a week and no less than one Certified Nursing Assistant every week. Assistant Director of	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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F 312	Continued From page 9 of policies and procedures and monitoring documentation, the facility failed to ensure staff provided appropriate perineal care for 2 of 6 sample residents (#38 an d#45) observed during the provision of incontinence care. The findings were: Review of the facility's policy and procedure for routine perineal (incontinence) care revealed, "...Clean the genitalia (peri area) with a clean washcloth or wipe using a downward motion from the pubis (front) to the anus (back). Use a different section of the washcloth with each wipe or discard wipe after each stroke to avoid contamination..." The following concerns were noted: a. Observation on 4/6/10 at 9:10 AM revealed resident #45 had been incontinent of bowel and bladder. When CNA #8 provided perineal care to the resident, she wiped from back to front several times and repeatedly used the same area of the wipes, which had been contaminated with feces. When the CNA was asked about the correct procedure for providing perineal care, she stated she cleaned the residents thoroughly, checked the skin, and reported any concerns to the nurse. b. Observation on 4/6/10 at 10:15 AM showed resident #38 had smears of feces on the perineal area and disposable brief. When providing perineal care, CNA #8 cleansed the resident from back to front. Review of the completed checklist for monitoring perineal care showed the CNA had been taught to cleanse the perineal area from front to back.	F 312	Nursing or designee to provide one on one in-servicing as necessary. Any issues noted will be addressed immediately. Quality Assurance: Director of Nursing will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	F 323 The facility will ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and	

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F 323	Continued From page 10 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe environment for residents, guests and staff in 2 of 4 corridors. The findings were: Periodic observation from 4/5/10 at 4:30 PM through 4/8/10 at 8:48 AM revealed the following concerns: 1. The metallic 2 ft. by 3 ft. louver in the bottom of the corridor door to the bathroom in Hall 4 was bent and dented and no longer fit into the frame. As a result, the metal edges of the louver projected into the corridor and represented a potential hazard. 2. Two 1 inch vertical strips of door frame molding to resident rooms #307 and #308 were not attached to the wall. As a result, the sharp edges of the molding represented a potential hazard. 3. Interview with the administrator on 4/8/10 at 8:48 AM confirmed the above two observations represented a safety hazard.	F 323	assistance devices to prevent accidents. This requirement will be met as evidenced by: a. The bent metallic two foot by three foot louver in the bottom of the corridor door to the bathroom in hall 4 was removed and replaced with plywood and stained and sealed on 04/12/10. b. Two one inch vertical strips of door frame molding on resident rooms #307 and #308 were re-attached to the wall on 04/12/10. ID of Residents: Residents residing at Worland Health Care have the ability to be affected. Monitoring: The director of maintenance or designee will monitor doors no less than monthly. Any issues noted will be addressed immediately. Quality Assurance: Director of Maintenance will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	5/23/10 5/23/10
F 371 SS=E	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	F 371	F 371 The facility will ensure: 1) procure food from sources	

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F 371	Continued From page 11 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the 2009 Food Code, the facility failed to prevent possible food contamination. The findings were: Periodic observation in the kitchen and main dining area from 4/5/10 at 3:30 PM through 4/8/10 at 8:48 AM revealed the following concerns: a. A 2 ft. wide metal shelf over the range was dirty and greasy to the touch. Cooking utensils and supplies were placed on the shelf during the cooking process. A 2 ft. wide metal spice storage shelf over a food preparation counter was also dirty with spilled powders and spices. b. The top of the Hobart convection oven was dirty and greasy to the touch. c. The motor on the back of the Hobart convection oven was not enclosed. Observation on 4/6/10 at 10:48 AM revealed a food cart containing uncovered, individual resident servings of Boston Cream Pie parked next to the oven motor. The motor was running and dirty with accumulated dust and grease, resulting in potential contamination of the food. d. A 3 ft. high radiator directly under the food distribution window in the dining room had dried food crumbs and dust visible through the vents on the top of the radiator. Heat rising from the radiator could spread dust and potentially	F 371	approved or considered satisfactory by Federal, State, or local authorities 2) Store, prepare, distribute, and serve food under sanitary conditions This requirement will be met as evidenced by: a. The metal shelf over the range was cleaned on 04/08/10and the metal spice storage shelf was also cleaned on 04/08/10. b. The top of the Hobart convection oven was cleaned on 04/08/10. c. The motor on the back of the Hobart convection oven was cleaned 04/08/10. A plastic cover will be used to cover the food cart when servings of food are on it. d. The three foot high radiator directly under the food distribution window in the dining room was cleaned 04/12/10. e. The moldy bell peppers and heads of lettuce were disposed of on 04/07/10. ID of Residents: Residents residing at Worland Health Care have the ability to be affected. Systems: a. Staff education will be provided regarding proper storage,	5/23/10 5/23/10 5/23/10 5/23/10 5/23/10

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F 371	Continued From page 12 contaminate meals placed in the window above it. According to Food Code, U.S. Public Health Service, 2009, 4-601.11, Equipment, Nonfood-Contact Surfaces. "(C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris." 5. Observation on 4/5/10 at 4:30 PM and on 4/6/10 at 5:10 PM revealed a box of approximately 15 bell peppers with visible mold growing on the majority of peppers. In addition, a plastic sack of 4 heads of lettuce was also observed at this time. Each of the heads was turning brown, and an accumulation of brown liquid was apparent in the bottom of the bag. According to Food Code, U.S. Public Health Service, 2009, 3-302.11, "(A) Food shall be protected from cross contamination by: (7) Storing damaged, spoiled, or recalled food being held in the food establishment as specified under 6-404.11." Interview with the facility kitchen manager on 4/8/10 at 10:48 AM confirmed the above observations.	F 371	preparation, and distribution of food under sanitary conditions. b. A cleaning schedule will be put into place so each area is cleaned regularly. c. Sanitation audits will be conducted weekly by Registered Dietician and/or Dietary Manager. d. Dietary staff will check radiator weekly and give work order to maintenance for cleaning of radiator. e. Dietary staff will check vegetable and fruit cooler no less than twice a week to ensure all vegetables and fruits are in good serving condition. Monitoring: The Registered Dietician and/or Dietary Manager will do random checks no less than one time a week to ensure proper cleaning of the kitchen. Will also check the cleaning lists to make sure cleaning is being completed. Any issues noted will be addressed immediately.	
F 385 SS=D	483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of	F 385	Quality Assurance: Dietary Manager will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	

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F 371	Continued From page 12 contaminate meals placed in the window above it. According to Food Code, U.S. Public Health Service, 2009, 4-601.11, Equipment, Nonfood-Contact Surfaces, "(C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris." 5. Observation on 4/6/10 at 4:30 PM and on 4/6/10 at 5:10 PM revealed a box of approximately 15 bell peppers with visible mold growing on the majority of peppers. In addition, a plastic sack of 4 heads of lettuce was also observed at this time. Each of the heads was turning brown, and an accumulation of brown liquid was apparent in the bottom of the bag. According to Food Code, U.S. Public Health Service, 2009, 3-302.11, "(A) Food shall be protected from cross contamination by: (7) Storing damaged, spoiled, or recalled food being held in the food establishment as specified under 6-404.11." Interview with the facility kitchen manager on 4/6/10 at 10:48 AM confirmed the above observations.	F 371		
F 385 SS=D	483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of	F 385	F 385 The facility will ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. The requirement will be met as evidenced by:	

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F 385	Continued From page 13 residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to obtain complete re-admission orders for 2 of 3 sample residents (#8, #9) who were re-admitted to the facility within the last two months. The findings were: 1. Medical record review showed resident #9 went to the hospital for a surgical procedure on 3/19/10 and was re-admitted to the facility on 3/26/10. Further review showed there were no signed physician orders from 3/26/10 through 4/6/10. Interview with the DON on 4/6/10 at 4:45 PM revealed she reviewed the proposed orders with the physician. However, she did not write a verbal order to that effect; nor were verbal orders written for the medications the resident had received since 3/26/10. The DON confirmed the written orders remained unsigned by the physician eleven days after the resident's readmission to the facility. 2. Review of the hospital's transfer and discharge instructions showed resident #8 was re-admitted to the long term care facility on 3/12/10. Both of these forms had been signed by the physician on 3/12/10. However, the discharge medication reconciliation instructions failed to indicate the type, amount, and frequency of insulin the resident was to receive. Review of the medication administration records prior to the resident's hospitalization showed the resident received Humalog regular insulin on a sliding scale basis after his/her blood sugar levels were checked four	F 385	The facility will ensure to obtain complete admission and/or re-admission orders from the admitting physician and orders clarified as warranted. All orders received from out of town physicians will be reviewed with primary physician before admission or re-admission to facility. a. Complete re-admission orders were obtained for resident #9 on 04/06/10 by admitting primary physician.	5/23/10
			b. Re-admission orders were for les # 8 received and re-typed and sent to admitting physician on 03/12/10. Clarification sent on 04/15/10 with specific orders for the sliding scale insulin as previously ordered.	5/23/10
			ID of Residents: Residents residing at Worland Health Care have the ability to be affected. Systems: 1. Director of Nursing/Assistant Director of Nursing or designee to review all information for potential admission/readmission to facility. 2. Discharge orders and admission orders received from physician who is not primary physician will be sent to primary physician for review before	

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F 385	Continued From page 14 times daily. Upon the resident's re-admission, this regimen was continued from the order dated 3/4/10. There was no evidence the order was clarified and approved by the physician after the resident's re-admission on 3/12/10. Faxed information received from the DON on 4/15/10 at 12 PM confirmed the 3/12/10 re-admission order was incomplete.	F 385	readmitted/admitted to facility. 3. Request will be submitted in writing by Director of Nursing/Assistant Director of Nursing or designee asking primary physician if they will accept admission/readmission to the facility. 4. Orders will be clarified with primary physician unless otherwise indicated. 5. Telephone orders will be written to admission/re-admission as appropriate from primary/admitting physician. 6. Licensed Personnel in-serviced 4/19/10 and 05/17/10 on the above.	
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 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 remove expired medications from 2 of 7 medication storage areas. The findings were:	F 425	Monitoring: Director of Nursing/Assistant Director of Nursing or designee will review all admission/re-admission orders prior to admission and with random audits no less than one time a week to ensure: 1. Admitting physician has agreed to admit to facility. 2. Orders are signed by admitting primary physician 3. Orders will be clarified prior to the resident's admission. 4. Orders signed by admitting primary physician. 5. Any issues noted will be addressed immediately.	

5/27/10

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	535048	A. BUILDING _____ B. WING _____	C 04/08/2010

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 385	Continued From page 14 times daily. Upon the resident's re-admission, this regimen was continued from the order dated 3/4/10. There was no evidence the order was clarified and approved by the physician after the resident's re-admission on 3/12/10. Faxed information received from the DON on 4/15/10 at 12 PM confirmed the 3/12/10 re-admission order was incomplete.	F 385	Quality Assurance: Director of Nursing will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	
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 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 remove expired medications from 2 of 7 medication storage areas. The findings were:	F 425	F 425 The facility will provide routine and emergency drugs and biologicals to its residents, or obtain then under and agreement described. 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. This requirement will be met as evidenced by: The facility will ensure that expired medications are removed from medication storage areas: a. Medication storage rooms b. Medication carts c. Central supply storage area	5/23/10

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F 425	Continued From page 15 Observation revealed medications were stored in four medication carts, two medication rooms, and in locked cabinets in the central supply area. The following concerns were noted: a. Observation of the Hall 1 medication cart on 4/7/10 at 4:45 PM revealed a bottle of magnesium oxide 400 milligrams (mg). The bottle originally contained 120 tablets but was approximately half full. The cart also contained a bottle, also approximately half full, of aspirin 325 mg; the original amount in the bottle was 100 tablets. Each bottle of medication expired on March 31, 2010. b. Observation of the medications stored in the central supply area revealed an unopened bottle of acetaminophen 500 mg; the bottle contained 100 tablets and expired on 3/31/10. c. Interview with RN #4 during the observations revealed she did not check expiration dates on stock medication bottles when administering medications. On 4/8/10 at 8 AM the DON stated the pharmacist was to check monthly and remove expired medications; she stated she was unaware this had not been done at the end of March 2010.	F 425	Licensed personnel will check bottle of medication for expiration date when administering medications. ID of Residents: Residents residing at Worland Health Care have the ability to be affected. Systems: a. Licensed Personnel in-serviced 04/19/10 on importance to check medication bottles for expiration dates when administering medications. b. Licensed personnel to make routine checks on all medications for expiration dates. c. At first of each month, the Night nurse will check the bottles of medications and pull from medication cart any medication bottle that expired previous month. d. Central supply person to check medication storage areas one time a week. i. Medication carts ii. Medication storage room iii. Central supply storage area e. Central supply person will use a highlighting marker to mark any bottle that would expire in current month. These marked bottles will be placed in a special basket in medication cupboard in nurses medication storage area.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

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F 425	Continued From page 15 Observation revealed medications were stored in four medication carts, two medication rooms, and in locked cabinets in the central supply area. The following concerns were noted: a. Observation of the Hall 1 medication cart on 4/7/10 at 4:45 PM revealed a bottle of magnesium oxide 400 milligrams (mg). The bottle originally contained 120 tablets but was approximately half full. The cart also contained a bottle, also approximately half full, of aspirin 325 mg; the original amount in the bottle was 100 tablets. Each bottle of medication expired on March 31, 2010. b. Observation of the medications stored in the central supply area revealed an unopened bottle of acetaminophen 500 mg; the bottle contained 100 tablets and expired on 3/31/10. c. Interview with RN #4 during the observations revealed she did not check expiration dates on stock medication bottles when administering medications. On 4/8/10 at 8 AM the DON stated the pharmacist was to check monthly and remove expired medications; she stated she was unaware this had not been done at the end of March 2010.	F 425	f. Licensed personnel will be in-serviced on 04/19/10, 04/23/10, & 05/17/10 on the highlighting system. g. Consulting pharmacist to check storage area for expired medications on routine monthly facility visits. Monitoring: 1. Director of Nursing, Assistant Director of Nursing, or designee to do random checks no less than one time a week on medication bottles to check expiration dates and ensure expired medications are pulled from storage areas. 2. Director of Nursing and Assistant Director of Nursing to do random checks no less than one time a week to ensure Licensed personnel check bottles for expiration date as medication administered. 3. Any issues noted will be addressed immediately.	
F 431 S5=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	Quality Assurance: Director of Nursing will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	

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F 425	Continued From page 15 Observation revealed medications were stored in four medication carts, two medication rooms, and in locked cabinets in the central supply area. The following concerns were noted: a. Observation of the Hall 1 medication cart on 4/7/10 at 4:45 PM revealed a bottle of magnesium oxide 400 milligrams (mg). The bottle originally contained 120 tablets but was approximately half full. The cart also contained a bottle, also approximately half full, of aspirin 325 mg; the original amount in the bottle was 100 tablets. Each bottle of medication expired on March 31, 2010. b. Observation of the medications stored in the central supply area revealed an unopened bottle of acetaminophen 500 mg; the bottle contained 100 tablets and expired on 3/31/10. c. Interview with RN #4 during the observations revealed she did not check expiration dates on stock medication bottles when administering medications. On 4/8/10 at 8 AM the DON stated the pharmacist was to check monthly and remove expired medications; she stated she was unaware this had not been done at the end of March 2010.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	F 431 The facility will employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and	

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F 431	Continued From page 16 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to ensure multi-dose vials of medications stored in 1 of 4 medication carts were appropriately labeled when opened and were not expired while still available for use. The findings were: During an observation of the Hall 3 medication cart on 4/7/10 at 4:40 PM, two multi-dose vials of Lantus Insulin had been opened, but the date they were opened was not documented on the label. Both vials were	F 431	periodically reconciled. Drugs and biologicals used in the facility will be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility will store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility will provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This requirement will be met as evidenced by: 1. Multi dose vials of medication will have date on bottle when opened. 5/23/10 2. Bottles discovered to not have date when opened will be immediately given to Director of Nursing for proper disposal. 5/23/10 3. Multi dose vials will be disposed of properly thirty days after opened. 5/23/10	

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F 431	Continued From page 17 available for use. During an interview immediately after the observation, RN #6 confirmed both vials lacked the date they were opened. Furthermore, she could not determine how long the vials had been opened or if they exceeded the expiration date after opening. She confirmed both insulins were still available for use. Review of the facility's policy and procedure entitled, "Vials and Ampules of Injectable Medications," revealed "Medication in multi-dose vials may be used for a period of one (1) month following its opening, if inspection reveals no signs of deterioration at that time."	F 431	4. Multi dose vials to include a. Eye drops b. Insulin vials c. Injectable medications such as normal saline, etc. ID of Residents: Residents residing at Worland Health Care the ability to be affected. Systems: Licensed personnel to be in-serviced 04/23/10 and 05/17/10 or need to: 1. Date all multi dose vials at time opened. 2. Dispose of multi dose vials after thirty days 3. If discover multi dose vial not dated, do not use, give to Director of Nursing for proper disposal. Monitoring: 1. Director of Nursing, Assistant Director of Nursing, or designee to conduct random checks on multi dose medications no less than one time a week to ensure all multi dose medications are: a. Properly dated when opened b. Used no more than thirty days as per facility policy c. Removed from use thirty days after opened	5/23/10

5/17/10

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F 431	Continued From page 17 available for use. During an interview immediately after the observation, RN #6 confirmed both vials lacked the date they were opened. Furthermore, she could not determine how long the vials had been opened or if they exceeded the expiration date after opening. She confirmed both insulins were still available for use. Review of the facility's policy and procedure entitled, "Vials and Ampules of Injectable Medications," revealed "Medication in multi-dose vials may be used for a period of one (1) month following its opening, if inspection reveals no signs of deterioration at that time."	F 431	2. Central supply person to check medication carts one time a week for expired medications and will also check to ensure multi dose medication bottles dated when opened. If not dated will pull from area immediately and give to Director of Nursing for proper disposal. 3. Any issues noted will be addressed immediately. Quality Assurance: Director of Nursing will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	

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