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FORM APPROVED
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 _____ | 09/12/2014 |

| 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>Following a State Agency (SA) standard survey conducted from 07/21/2014 to 07/24/2014, a Comparative Federal Monitoring Survey (CFMS) was conducted by the Center for Medicare and Medicaid Services (CMS), Dallas Region VI office, from 09/09/2014 to 09/12/2014.<br>This survey was conducted in accordance with the Code of Federal Regulations, Title 42 Part 483, Subpart B, Requirements for Long Term Care Facilities.<br>According to the CMS 672 signed on 09/09/2014, the facility census was 61 residents.<br>The facility was not in compliance with the Federal requirements for Long Term Care facilities. This report contains those citations.<br>The following abbreviations are used within the context of this report:<br><br>BP - Blood Pressure<br><br>CNA - Certified Nurse Aide<br><br>DON - Director of Nursing<br><br>ADON - Assistant Director of Nursing<br><br>F - Fahrenheit<br><br>LPN- License Practical Nurse<br><br>MDS - Minimum Data Set<br><br>PT - Physical Therapy<br><br>RA - Restorative Aide<br><br>RN - Registered Nurse | F 000 | Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. | |

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.

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| F 000 | Continued From page 1 | F 000 | | |
| F 279 SS=E | ROM - Range of Motion<br>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>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.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>This deficiency was determined by observations, interviews and record reviews. The facility did not develop comprehensive care plans with (1) measureable fluid intake objectives, (2) timetables for evaluating fluid intake and (3) services needed for Residents #1 and #11 to attain the residents' highest practicable physical well-being. | F 279 | F279<br>The facility will use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care.<br>The facility will develop a comprehensive care plan for each resident that include measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>Corrective Action:<br>Resident # 1 - care plan was updated on 10/9/2014, by the DON/Designee to ensure the goal for Hydration is measurable.<br>Resident #11 – care plan was updated on 10/9/2014, by the DON/Designee to ensure the goal for Hydration is measurable.<br><br>Identification:<br>For identification purposes, on or before the allegation of compliance a review of current residents' at risk for Dehydration care plans will be completed by DON/Designee to pinpoint residents at the facility potentially at risk for care plans lacking measurable goals to address hydration. | 10/23/14<br><br>10/23/14 |

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| F 279 | Continued From page 2<br>Residents #1 and #11 fluid intake-related care plan objectives ["Goals"] were not measurable. Residents #1 and #11 fluid intake-related care planned services ["Approaches"] did not enable facility staff to promptly and measurably know if these residents received sufficient fluids.<br><br>This deficient planning had the potential to affect 28 residents identified by the facility on the CMS 802 as needing staff assistance to maintain sufficient fluid intake. Insufficient fluid intake over several days may lead to dehydration. Insufficient fluid intake and dehydration increase the risk of urinary tract infections and respiratory infections. The facility census was 61.<br><br>The findings were:<br><br>FACILITY HYDRATION/FLUID MANAGEMENT POLICY<br>Policy Number CL-NUR-1503 Section 4.1 "Intake/Output Measurements" listed situations in which intake and output measurement "should be considered...." The policy did not require the facility to develop a measurable fluid intake objective for residents at risk of insufficient fluid intake but for whom 24 hour I&O was not needed or was not ordered. The Policy did not require staff to set a timetable for measuring resident fluid intake, unless 24-hour intake and output was measured and recorded.<br><br>RESIDENT #1 - RECORD REVIEW<br>Assessments<br>Resident #1 was an 86 year old female last readmitted to the facility on 03/06/13. Her most recent full comprehensive assessment was completed 07/28/14. The comprehensive assessment included the Minimum Data Set | F 279 | Systemic Changes:<br>Residents will be reviewed upon admission, quarterly, annually, and with significant change of condition utilizing the admission/MDS/RAI/ Care planning process. Care plans will be developed to include services provided to attain or maintain their highest practicable physical, mental, and psychosocial well-being, including ensuring a care plan is in place to address the resident's risk for dehydration that include measurable goals. On or before the allegation of compliance the DON/Designee will in-service the IDT and Nursing staff on care plan preparation to ensure care plans have measurable goals. Nursing staff unable to attend will be provided re-education upon return to work by the DON/Designee.<br>Monitoring:<br>Individual hydration care plans will be reviewed and revised by IDT, to include services provided with measurable goals based on individual need, upon admission and quarterly, annually, and with change of condition. Care plan documentation review will be completed quarterly. Issues identified through this review will be discussed at QA&A for the purpose of process improvement and to ensure plan has been implemented, sustained and evaluated for its effectiveness. | |

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[MDS] assessment and the Resident Assessment Instrument [RAI]. MDS Section G. "Functional Status" assessed Resident #1 as independent eating and drinking and required setup assistance only.

Resident #1's "Nutritional Assessment" dated 07/28/14 calculated Resident #1 needed a daily fluid intake of 2056 to 2300cc [cubic centimeters].

Care Plan
Resident #1's comprehensive care plan included physician's orders for an indwelling catheter. Her physician also ordered 8 ounces of "TwoCal HN" daily at 3pm.

Resident #1's comprehensive care plan was last updated 08/07/14. Resident #1's care plan failed to provide (1) a measurable fluid intake objective or (as planned) a measurable urine output objective, (2) when staff would measure fluid intake or urine output, and (3) one clinical record location to record all fluid intake and/or urine output so nursing staff could efficiently evaluate Resident #1's fluid intake status.

Resident #1's care plan "Problems" which included fluids or oral intake were:

INDWELLING CATHETER
01/03/14- Problem: "I have a foley catheter" [indwelling urinary catheter] that "puts me at risk for UTI's" [urinary tract infection].
04/03/14- Goal: "My catheter will remain patent [drain urine freely] and draining without problems this quarter."
06/05/14- Approach: "monitor intake and record output."

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DENTAL
08/29/13- Problem: "I have had bone receed [sic] from my lower jaw ..."
11/29/13 Goal - "I will be able to tolerate a pureed diet and eat 50-75% of my meals this quarter."
08/29/13 Approach: "Assist me to eat as needed." "Monitor my food and oral intake and record."

CONSTIPATION
08/29/13- Problem: "I have a potential for constipation r/t [related/to] decreased mobility." constipation
11/29/13- Goal: "I will have a BM [bowel movement] q [every] 3 days this quarter."
08/29/13- Approach: "Increase my fluid intake...."

ACTIVITIES OF DAILY LIVING
08/29/13- Problem: "ADL Functional/ Rehabilitation Potential."
11/29/13- Goal: "I will attempt to participate in my ADLs as much as possible during this quarter."
08/29/13- Approach: "Help me with my meals, I sit at an assist table."

Evaluations
The facility "Dietary Flow Sheet" was designed to record meal fluid intake volume and meal supplement fluid intake volume daily. The form is not designed to record fluids taken at another time, fluids taken with medications or fluids that were not oral. The design of the form supplements the care plan fluid intake approaches indicating the plan was to record fluid intake daily.

"Dietary Flow Sheets" for 08/2014 and 09/2014

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were completed for each day in August and September of 2014. None of the shift or daily fluid intakes were totaled.

The 09/2014 "Dietary Flow Sheet" does not show that Resident #1 met the "Nutritional Assessment" minimum recommended daily fluid intake of 2055cc to 2300cc. Total fluid intakes on the Dietary Flow Sheet for 09/2014 were:

| Date | Amount |
|---|---|
| 09/09/14- | 60cc- |
| 09/08/14- | 1060cc |
| 09/07/14- | 820cc |
| 09/06/14- | 620cc |
| 09/05/14- | 580cc |
| 09/04/14- | 1120cc |
| 09/03/14- | 0cc |
| 09/02/14- | 290cc |
| 09/01/14- | 1100cc |

RESIDENT #1 - OBSERVATIONS
09/09/14 at 12pm: Resident #1 in bed. Dark amber urine in collection bag. Urine in drainage tubing was cloudy.
09/09/14 at 12:15pm: Resident #1 fed lunch at assist table. Her eyes were closed. Ate about 25% of solid food. 15% solid intake shown on 09/09/14 "Dietary Flow Sheet."
09/09/14 at 5:00pm: Resident #1 lying in bed on her right side. Bed in low position. Water pitcher across the room on over bed table.
09/10/14 at 8:30am: Resident #1 eating and drinking by herself at assist table. Eyes open.
09/10/14 at 3:30pm: Change of Wound Vac on coccyx pressure ulcer observed. No visible drainage. No signs of dehydration. Urine in drainage tube light and without cloudiness.
09/11/14 at 8:30am: Urine in tubing amber.

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RESIDENT #1 and #11 - INTERVIEW
09/11/14 The Dietary Manager confirmed that the facility "Dietary Flow Sheet" is not designed to record all fluid intake. It does not have fluids taken at other than meal time, fluids taken with medications, or fluids that are not oral.

RESIDENT #11 - RECORD REVIEW
Assessments
Resident #11 was an 98 year old female last readmitted to the facility on 09/08/10. Her most recent full comprehensive assessment was a significant change assessment completed 07/02/14. MDS Section G. "Functional Status" assessed Resident #1 as independent eating and drinking and required setup assistance only.

Resident #11's "Nutritional Assessment" dated 07/02/14 calculated Resident #1 needed a daily fluid intake of 1100 to 1875cc. Resident #11 weighed 98.6 pounds. That is 44.8 kg [kilograms]. The "Nutritional Assessment" form showed that Resident #11's daily fluid intake should be 25cc to 30cc per kg. 44.8kg times 25cc = 1120cc and 44.8kg times 30cc = 1344cc.

Care Plan
Resident #11's comprehensive care plan included physician's orders for Lasix (furosemide) 40 mg [milligram] tablet for edema (no location given). Lasix is a diuretic which stimulates urine output. The use of a diuretic shows that Resident #11 could be at risk for fluid overload.

Resident #11's comprehensive care plan was last updated 08/16/14. Resident #11's care plan failed to provide (1) a measurable fluid intake objective, (2) when staff would measure fluid

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intake, and (3) one clinical record location to record all fluid intake and/or urine output so nursing staff could efficiently evaluate Resident #11's fluid intake status.

Resident #11's care plan "Problems" which included fluids and oral intake were:

URINARY INCONTINENCE
09/10/13- Problem: "I have urinary incontinence R/T [related/to] dementia."
12/10/13 Goal - "I will be free from odor and skin irritation during the quarter."
09/10/13 Approach: "Encourage fluids." "Monitor for s/s [signs/symptoms] of infection: foul odor, cloudy urine etc."

REDUCED CARDIAC OUTPUT
09/10/13- Problem: "I have altered cardiac output r/t Atrial Fibrillation."
12/10/13- Goal: My vital signs will remain within my normal range during the quarter."
09/10/13- Approach: "Monitor for peripheral edema and document."

CONSTIPATION
09/10/13- Problem: "I have difficulty with constipation r/t [related/to] diuretics, TIA [transient ischemic attacks, "mini strokes"] with infarct [blockage of blood flow in the brain] and decreased mobility."
12/10/13- Goal: "I will have a BM [bowel movement] q [every] 3 days during the quarter."
09/10//13- Approach: "Encourage fluids, offer different types of fluids for a variety."

SUFFICENT FLUID INTAKE
09/10/13; updated 01/09/14- Problem: "Dehydration/Fluid Maintenance."

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12/10/13- Goal: "I will not show any s/s [signs/symptoms] of dehydration during the quarter."
09/10/13- Approach: "Monitor for s/s of dehydration such as poor skin turgor and dry mucus membranes. "

ACTIVITIES OF DAILY LIVING
09/10/13; updated 01/09/14- Problem: "ADL Functional/ Rehabilitation Potential."
12/10/13- Goal: "I will attempt to participate in my ADLs as much as possible during the quarter."
09/10/13- Approach: "Eating - set up only, minimal assist as I allow."

HYPOTHYROIDISM
05/15/14- Problem: "I have hypothyroidism [low thyroid stimulating hormone] and I take synthroid [brand name of levothyroxine sodium an artificial thyroid stimulating hormone] for this. This medication has a black box warning."
No date- Goal: "I will remain within the therapeutic range for my TSH [thyroid stimulating hormone] this quarter."
No date- Approach: Monitor for S/S hyperthyroidism including nervousness, tachycardia, weight loss." "Report any changes to MD."

According to the manufacturer, Synthroid has a narrow safe therapeutic range.
(09/19/14 from:
<http://www.rxabbvie.com/pdf/synthroid.pdf>)

The signs and symptoms of overdosage are those of hyperthyroidism. Overdosing may lead to fluid loss. Underdosing undertreats hypothyroidism and may lead to weight gain from

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fluid retention. (09/19/14 from: <https://www.synthroid.com/> )

POOR NUTRITON AND FLUID INTAKE
05/14/14- Problem: "At risk for weight loss due to poor cognition and poor meal intakes."
08/14/14- Problem: "Not able to use utensil any more and is now on liquefied foods to help with wound healing."
05/14/14- Goal: "I will maintain weight at 98# to 100#."
08/14/14- Goal : "Wounds will heal and I will go back up to 96#."
05/14/14- Approach: None for fluid intake.
08/14/14- Approach: None for fluid intake.

Evaluations
"Dietary Flow Sheets" for 08/2014 and 09/2014 were completed for each day in August and September of 2014. None of the shift or daily fluid intakes were totaled.

The 09/2014 "Dietary Flow Sheet" shows that Resident #1 did not meet her minimum "Nutritional Assessment" recommended fluid intake of 1100 - 1875cc on 09/08/14. Total fluid intake on the Dietary Flow Sheet for 09/08/14 was 480cc.

RESIDENT #11 - INTERVIEW
However, the difference in intake between 1875cc and 1100cc is 775cc - 41.3%. A minimum 1100cc daily intake is 58.6% of the maximum 1875cc. On 09/11/14, the Dietary Manager confirmed that the dietician checked Resident #11's 07/02/14 daily fluid intake calculation on 09/10/14. The recommended range was correct at 1100cc to 1875cc.

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| F 282 SS=E | Continued From page 10<br>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, interview and record review, the facility failed to ensure one of 13 sampled residents (Resident #3) received restorative services as outlined in the plan of care.<br>This failure placed Resident #3 at risk for decreased level of physical functioning. The failure had the potential to affect 13 of the facility's 61 residents who were receiving restorative care.<br>Findings:<br>During the initial tour conducted on 09/09/2014 at 9:00 am Resident #3 was observed in her room . The LPN reported the resident fell and broke her hip at the facility and had been receiving Physical Therapy for rehabilitation. Resident #3 was neatly groomed and sitting in a wheelchair. Resident #3 ' s hospital Physical Examination reflected she was hospitalized for repair of an Acute Sub Capital Fractured Left Femur on 08/16/2014.<br>Resident #3 was observed in her room on 09/09/14 at 4:30 pm with CNA #7 and CNA #8. When the resident was observed transferring from the bed to a wheelchair, Resident #3 required extensive assistance of both aides to complete the transfer. Resident #3 was pushed to the bathroom in her wheelchair. CNA #7 | F 282 F 282 | F282<br>The services provided 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>Resident #3 is now being provided restorative services per the plan of care. The DON/designee reeducated the restorative staff on his/her plan of care.<br><br>Identification:<br>Resident's who reside at facility who are receiving Restorative services are at risk. On or before the allegation of compliance the DON/Designee will reeducate the Restorative Aids, Licensed Nurses, and C.N.A's on the importance of following the Resident's plan of care to include ensuring Restorative services are provided per the residents individual plan of care.<br><br>Systemic Changes:<br>The DON/Designee will re-in service the Restorative Team on the facilities Restorative Program Guidelines. This will include review of interventions, clinical performance expectations, documentations, and evaluation. The facility's restorative program will be re-structured to follow the resident's treatment plan. A member from the therapy department will evaluate residents receiving Restorative quarterly and PRN to determine if their program is appropriate and recommend any changes. | 10/23/14 |

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| F 282 | Continued From page 11<br>confirmed to the surveyor the resident was unable to ambulate, even with staff assistance. Physical Therapy Progress Notes reflected Resident #3 was scheduled for therapy aftercare for a broken hip between the dates of 06/20/2014 and 07/18/2014. On 07/25/2014, a PT (Physical Therapy) Daily Progress Note reflected the therapist discharged Resident #3 from skilled PT to RNP (Restorative Nursing Program.)<br>Review of the resident ' s Nursing Restorative Care Flow Sheet for August, 2014, revealed she was scheduled to receive Assisted Active Range of Motion (AAROM) on upper and lower extremities daily for ten repetitions Upper Bilateral Exercises (UBE) for fifteen minutes (no frequency documented) and Ambulation training as tolerated daily with a walker and one staff to assist.<br>The August monthly Care Flow Sheet was blank, indicating the resident did not receive the restorative exercises. An attached sheet used to record the resident ' s progress contained this statement , signed by Restorative Aide (RA) #2 and dated 08/17/2014,: " [Resident #] started restorative program on 08/17/14. We are doing ROM as well as working with UBE for 15 minutes and working also on ambulating to improve her mobility again. "<br>The only other progress note on the form, also signed by RA #2 and dated 08/31/2014, stated , " [Resident #3] didn ' t work with restorative this month due to restorative aids [sic] being on the floor. "<br>RA #1 was interviewed on 09/10/2014 at 9:15 am. She reported Resident #3 had not been started on the Restorative Program that was recommended by the PT at the end of July. RA #1 said when a CNA called in sick or did not show up to work, either she or RA #2 were told not to complete their restorative job duties and were " | F 282 | Monitoring:<br>The DON/Designee will meet bi-monthly and PRN with the Restorative Nurse and aids to review residents on the Restorative Program to ensure interventions are in place per individual resident care plans. Issues identified will be corrected at that time and the DON/designee will review trends in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness. | |

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| F 282 | Continued From page 12<br>pulled to work the floor."<br>Physical Therapist #1 was interviewed by phone on 09/12/2014 at 10:00 am. He stated when he worked with Resident #3 in therapy she was able to transfer with minimal assistance and ambulate with a walker for short distances. The therapist stated, generally, if residents could initiate restorative care immediately after physical therapy ends, the resident would be more likely to "carry over" the skills learned in therapy. | F 282 | | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews, the facility failed to store all food under sanitary conditions. This failed practice had the potential to affect all 61 residents in the facility. Census of 61.<br><br>Findings were:<br><br>INITIAL KITCHEN TOUR<br>09/09/2014 at 8:45 am:<br>Cold Storage<br>Kitchen freezers and refrigerators: Some food cartons stored close to and/or against the sides | F 371 | F371<br>The facility will procure food from sources approved or considered satisfactory by Federal, State, or local authorities and store, prepare, distribute, and serve food under sanitary conditions.<br><br>Corrective Action:<br>The facility will store all food under sanitary conditions.<br>1. A metal divider will be placed in "Central Supply" Stainless steel freezer and in Walk-in Freezer so items do not touch the side or back walls of freezer. 10/23/14<br>2. Food items that are not left in their original packing will be dated as to when they are placed in the freezer. 10/23/14<br>3. New dunage racks will be ordered to replace the current pallets for storing items on so cleaning can be done easily. 10/23/14<br>4. All items in "Dry Storage" and "Central Supply" freezer and coolers that are removed form their original boxes will be dated as to when they were ordered, unless the item has a use by date stamped on each individual package from the supplier. 10/23/14 | |

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| F 371 | Continued From page 13<br>and back walls. This impedes circulation of air and maintaining correct food storage temperatures inside the units.<br><br>Stainless steel freezer in "Central Supply" had unlabeled and undated foods- apparent waffle pieces, bagels, and an unidentified product in an aluminum wrapped package. Hamburger buns on top shelf stacked against the right side wall and back of the freezer.<br><br>Dry Storage<br>Packaged food stored in kitchen dry storage and in Central Supply dry storage on small wooden pallets set against walls. The pallets could not be cleaned behind or under without moving stored food and the pallets. The pallets may hide vermin and pests and provide nesting sites.<br><br>Central Supply dry storage: Unlabeled, undated corn chips. Wire shelves set against walls impaired effective cleaning behind shelves.<br><br>09/09/2014 at 9:45 am: The Hall 200 refrigerator had an unlabeled, undated bowl containing what appeared to be pudding.<br><br>These findings were confirmed by the facility Dietary Manager. | F 371 | 5. "Dry Storage" and "Central Supply" will be arranged to allow cleaning of walls. | 10/23/14 |
| | | | 6. All food will be labeled and dated that are placed in refrigerators and freezers. | 10/23/14 |
| | | | Identification:<br>All residents have the potential to be affected.<br><br>Systems:<br>All Dietary Staff will be in-serviced on October 15, 2014 as to how all items are to be stored, dated, and cleaned. On or before the allegation of compliance the DON/Designee will in-service nursing staff on how all food items placed in refrigerators for each designated hallway are to be dated and what items are appropriate for those refrigerators.<br><br>Monitoring:<br>The Dietary Manager/Designee will monitor compliance weekly for the first quarter then bi-monthly thereafter to ensure all food items are dated and labeled in dry storage, freezers, and refrigerators. The Central Supply Clerk will monitor the designated hall refrigerators weekly to ensure items are labeled, dated, and appropriate. The Dietary Manager/Designee will monitor compliance weekly and prn, kitchen observation rounds utilizing the "Sanitation Check List" form. The Registered Dietitian/Designee will perform a sanitation evaluation monthly utilizing the "Sanitation Check List" form. Issues identified will be reviewed at QA&A to ensure plan has been implemented, sustained, and evaluated for 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. | F 441 | | |

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| F 371 | Continued From page 13<br>and back walls. This impedes circulation of air and maintaining correct food storage temperatures inside the units.<br><br>Stainless steel freezer in "Central Supply" had unlabeled and undated foods- apparent waffle pieces, bagels, and an unidentified product in an aluminum wrapped package. Hamburger buns on top shelf stacked against the right side wall and back of the freezer.<br><br>Dry Storage<br>Packaged food stored in kitchen dry storage and in Central Supply dry storage on small wooden pallets set against walls. The pallets could not be cleaned behind or under without moving stored food and the pallets. The pallets may hide vermin and pests and provide nesting sites.<br><br>Central Supply dry storage: Unlabeled, undated corn chips. Wire shelves set against walls impaired effective cleaning behind shelves.<br><br>09/09/2014 at 9:45 am: The Hall 200 refrigerator had an unlabeled, undated bowl containing what appeared to be pudding.<br><br>These findings were confirmed by the facility Dietary Manager. | F 371 | | |
| 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. | F 441 | F 441<br>The facility will 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. | |



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| F 441 | Continued From page 14<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.<br><br>(c) 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, interview and record review, the facility failed to provide services to prevent the transmission of disease and infection for 4 residents (#s 1, 2, 8 and 11) by:<br><br>1) failing to prevent Resident #1's urine collection | F 441 | Corrective Action:<br>1. Resident # 1 currently has no signs and symptoms of infection. The staff identified in the survey have been reeducated on the facility's Infection Control practices as they pertain to ensuring foley catheter tubing and wound vac tubing does not touch the floor.<br>2. The C.N.A's been reeducated on the facility's Infection Control practices as they pertain to ensuring proper hand washing before and after applying gloves with perineal care and after removing soiled items from a residents room.<br>3. Resident #2, currently has no signs and symptoms of infection. The nurse identified in the survey has been reeducated on the facility's Infection Control practices as they pertain to ensuring proper hand washing before and after applying gloves and "Clean Dressing change."<br>4. Resident # 8 currently has no signs and symptoms of infection. The nurse identified in the survey has been reeducated on the facility's Infection Control practices as they pertain to ensuring proper hand washing before and after providing a finger stick blood glucose.<br><br>Identification:<br>Residents who reside at facility are at risk. | 10/23/14<br>10/23/14<br>10/23/14<br>10/23/14 |

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| F 441 | Continued From page 15<br>bag and tubing from resting on the floor,<br><br>2) discarding Resident #11's soiled brief, gloves and contaminated wound dressing in the resident's trash can,<br><br>3) failing to ensure staff provided pressure ulcer treatment without contaminating supplies and Resident #2's bed linens and,<br>4) failing to ensure the nurse sanitized hands before and after obtaining a blood sample from Resident #8.<br>These failed practices had the potential to affect four residents/61 identified in the CMS-672 to have pressure ulcers, six residents/61 identified to have foley catheters in the CMS-672 and 9/61 residents identified by the DON as residents who received glucometer blood tests.<br>Findings were:<br>RESIDENT #1<br>09/09/2014 at 5:00 pm: Bed in low position. Urine collection bag in cover on floor. Urinary catheter drainage tubing on floor.<br><br>09/10/2014 at 10:40 am: Bed in low position. Urine collection bag in cover on floor. Urinary catheter drainage tubing on floor.<br><br>09/11/2014 at 8:50 am: Bed in low position. Urine collection bag in cover on floor. Urinary catheter drainage tubing on floor.<br><br>RESIDENT #11<br>09/11/2014 at 8:30 am: CNA #2 and CNA #1 provided Resident #11 incontinence care and an incontinence brief change. CNA #1 performed the incontinence care. Both CNAs discarded the soiled brief and their gloves into Resident #11's trash can. | F 441 | Systemic Changes:<br>On or before the allegation of Compliance the DON/ Designee will in-service the RN's, LPN's, and CNA's on the facility's Infection Control practices as they pertain to ensuring foley catheter tubing, foley catheter bag cover, and wound vac tubing are appropriately placed to prevent infection, not touching the floor. Nursing staff unable to attend will be provided re-education upon return to work by the DON/Designee. The DON/Designee will review The Infection Control report to identify trends with the Medical Director during the QA process monthly.<br>On or before the allegation of Compliance the DON/ Designee will in-service the RN's, and LPN's on the facility's Infection Control practices as they pertain to ensuring proper hand washing before and after applying gloves and following the facilities "Clean Dressing Change" policy. Nursing staff unable to attend will be provided re-education upon return to work by the DON/Designee. The DON/Designee will review the Infection Control report to identify trends with the Medical Director during the QA process monthly.<br>On or before the allegation of Compliance the DON/ Designee will in-service the RN's, LPN's, and CNA's on the facility's Infection Control practices as they pertain to ensuring proper hand washing before and after applying gloves before and after incontinent care and after removal of soiled items from residents room. Nursing staff unable to attend will be | |

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While Resident #11 was uncovered, the Hall 200 charge nurse entered the room. She asked CNA #1 to remove Resident #11's soiled sacral wound dressing. CNA #1 discarded the soiled dressing into Resident #11's trash can. The charge nurse applied a new dressing to Resident #11's sacral wound. The charge nurse discarded her gloves into Resident #11's trash can.

CNA #2 picked up Resident #11's trash can bare handed. She removed the plastic bag liner with her bare hands and twirled the bag to close it.

RESIDENT #2

Resident #2 was admitted to the facility on 12/18/2013 with diagnoses that included: urinary tract infection, paranoid, nonorganic psychosis, dementia, pain, agitation, constipation, pressure ulcer to heels, history of pressure ulcer to buttocks, hypertension and Alzheimer ' s disease.

On 09/10/2014 at 10:53 am an observation was made of Registered Nurse (RN) #1 gathering supplies and providing treatment for Resident #2 ' s pressure ulcer. RN #1, after opening the physician ordered treatment supplies (telfa, 2 x 2 gauze, a small bottle of normal saline and wound ointment), walked into the resident ' s room.

On 09/10/2014 at 10: 55 am RN #1, without establishing a barrier or sanitizing the surface for the supplies, placed the wound care supplies on top of the resident ' s television (TV) table.

RN #1 washed her hands before the treatment, gloved both hands and removed Resident #2 ' s soiled Kerlix dressing from the resident ' s left heel. RN #1 removed her gloves and without washing or sanitizing her hands, placed a clean pair of gloves on her hands. RN #1 cleaned the wound on the resident ' s left heel and discarded the used gauze in the resident ' s room trash

provided re-education upon return to work by the DON/Designee. The DON/Designee will review The Infection Control report to identify trends with the Medical Director during the QA process monthly.

On or before the allegation of Compliance the DON/ Designee will in-service the RN's and LPN's, on the facility's Infection Control practices as they pertain to ensuring proper hand washing before and after applying gloves while providing a finger stick blood glucose. Nursing staff unable to attend will be provided re-education upon return to work by the DON/Designee. The DON/Designee will review The Infection Control report to identify trends with the Medical Director during the QA process monthly.

Monitoring:

The DON/Designee will conduct visual observation rounds three times weekly for one month then weekly for one month then monthly and prn thereafter to ensure facility staff are practicing good Infection Control techniques. These rounds will include observing random nurses completing clean dressing changes to ensure staff are washing hands before and after removing gloves, following the "Clean Dressing Change" policy, ensuring foley catheter tubing and/or wound vac tubing, catheter bag cover is not on floor, ensuring nurses are washing hands before and after donning/removing gloves for finger sticks, and

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| F 441 | Continued From page 17 | F 441 | | |

container. RN #1 then moved the already contaminated wound supplies from the TV table and placed them on the resident ' s bed sheets. RN #1 completed the wound care and moved the remaining wound care supplies from the resident ' s bed to the top of the air conditioning unit. RN #1, with the same contaminated gloves, provided wound care, handled the opened contaminated supplies and wrapped the resident's left heel.

On 09/10/2014 at 11:30 am RN #1 was interviewed. RN #1 was asked if there was anything different she would have done during the treatment to Resident #2 ' s left heel. RN #1 stated, " Not really, other than elevate the bed."

On 09/10/2014 at 2:30 pm, the DON was interviewed. When asked about the best practice for wound care dressing changes, the DON stated her expectations were for the nurses who were providing dressing changes to keep their techniques as clean as possible. The clean supplies were to be placed on a table after establishing a barrier. The DON also expected the nurse to remove her contaminated gloves before wrapping the resident ' s wound with clean dressings.

Review of the facility ' s policy and procedure for Clean Dressing Change, provided by the DON on 09/10/2014 at 4:15 pm documented: " Equipment and supplies " to be used were to have, " protective covering for the bed and linens, clean covering for work surface and dressing supplies. " Under the procedure section: step #4: " prepare clean field and place plastic bag within easy reach, but not on floor or within clean field. " Step #7: " Protect linens to prevent soiling during dressing change. " Step #9: " wash hands and put on clean gloves. " Step #12: " remove gloves, wash hands and put on clean gloves. "

ensuring C.N.A's are washing hands after removal of soiled items from room. 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 DON/Designee to ensure plan has been implemented, sustained, and evaluated for its effectiveness.

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

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| F 441 | Continued From page 18<br><br>RESIDENT #8<br>RN#2 was observed collecting a blood sample to check Resident #8's glucose level in his room on 09/09/2014 at 4:30 pm. The nurse entered the room wearing gloves. He collected the blood sample and left the room without washing his hands. The nurse went to the medication cart in the nurses' station, removed his gloves and then began to chart in the medication book. | F 441 | | |
| F 498 SS=E | 483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS<br><br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined that the facility failed to:<br>a) Ensure Certified Nurse Aides (CNAs) provided incontinent care utilizing correct incontinence care technique during incontinent care for Residents #3, #5 and #7.<br>This failed practice had the potential to affect 44/61 residents occasionally/frequently incontinent of bladder and 25/61 residents occasionally/frequently incontinent of bowel identified in the CMS-672 signed by the DON on 09/09/2014.<br>b) Ensure CNAs demonstrated technique that minimized the potential for injury to the residents' axillae anatomical structures during assisted resident transfers for Residents #2, #3, #5, #10 | F 498 | F498<br>The facility will ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>Corrective action:<br>1. Residents #3, #5, & #7 will receive correct incontinence care technique during incontinent care.<br>2. Residents #2, #3, #5, & #10 will be transferred properly minimizing the potential for injury.<br><br>Identification:<br>Residents that reside at the facility are at potential risk. | 10/23/14<br><br>10/23/14 |

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| F 498 | Continued From page 19<br>and #11.<br>This failure had the potential to affect 44/61 residents identified in the CMS-672 as requiring assistance with transfers.<br>Findings:<br>Incontinent Care:<br>RESIDENT #3<br>On 09/09/2014 at 4:00 pm CNA #7 was observed providing incontinent care to Resident #3 in the bathroom of the resident ' s room. The aide instructed the resident to stand and hold on to the grab bar across from the toilet. While the resident was standing, the aide wiped feces from the Resident #3 ' s rectal area two times with a wipe. She then wiped the resident ' s vaginal area one time with a wipe. CNA #7 did not sanitize her hands or don new gloves after wiping the resident ' s anal area and before cleaning the vagina. During this incontinent care, the resident ' s knees were shaking and she appeared to be unsteady on her feet. After the aide completed the care, the aide told the surveyor she was trying to hurry and get the care done because the resident gets tired easily.<br>RESIDENT #5<br>Resident #5 was admitted to the facility on 02/02/2013 with diagnoses that included: urinary tract infection, dehydration, depressive disorder, anemia, pain, anorexia, constipation, history of pressure ulcer to buttock, dementia, hypertension and Alzheimer ' s.<br>On 09/09/2014 beginning at 4:20 pm, the resident was observed in bed. CNA #9, without checking the resident for incontinence, transferred the resident from her bed to her wheelchair and took the resident to the bathroom.<br>During the observation CNA #9 instructed the resident to stand by the toilet and hold on to the grab bar in front of the resident as CNA #9 took | F 498 | Systemic Changes:<br>The facility will ensure that nurse aids are able to demonstrate competency in skills and techniques necessary to care for residents' needs to include resident transfers and incontinence care. On or before the allegation of Compliance the DON/ Designee will re-educate the nurse aids of proper transfers including use of the sit to stand, the maxi lift, and the gait belt ensuring residents are not hoisted back by lifting at the shoulders. If there is any question with the current transfer technique a therapy screen will be completed to ensure the safest possible transfer is performed.<br>On or before the allegation of Compliance the DON/ Designee will re-educate the nurse aids on proper incontinence care. Nursing staff unable to attend will be provided re-education upon return to work by the DON/Designee. Training will also be included in orientation, annually, and prn.<br><br>Monitoring:<br>The DON/Designee will monitor compliance via observation rounds 3 times weekly for 1 month, weekly for 1 month, then monthly and prn. These rounds will include observation of random C.N.A's providing incontinence care and resident transfers. Issues identified will be reviewed at QA&A monthly to ensure plan has been implemented, sustained, and evaluated for effectiveness. | |

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off the resident ' s brief. The resident, as evidenced by her brief, was incontinent of bowel and bladder. While the resident was standing, CNA #9 wiped a large amount of feces from between the resident ' s buttocks. The resident ' s knees were bending and giving way several times during this observation so CNA #9 instructed the resident to sit back down on the toilet. CNA #9 had the resident stand back up and while the resident was standing, wiped the resident ' s buttocks five more times in an attempt to provide incontinence care. CNA #9 did not thoroughly clean observable feces from the resident ' s buttocks. CNA #9 then only wiped the resident ' s perineal area once, in an attempt to provide urinary incontinent care, before placing a clean brief on the resident.
On 09/09/2014 at 4:50 pm CNA #9 was interviewed by this surveyor. When asked if she removed all the feces from Resident #5 ' s buttocks she stated, "I did what I could. "
According to a review of the resident ' s minimum data set assessment (MDS) dated 07/31/2014 the resident required one person assist with transfer and one person assist with personal hygiene. The same MDS coded the resident as frequently incontinent of bowel and bladder.

RESIDENT #7
Resident #7 was admitted to the facility on 05/25/2014 with diagnoses that included: hemorrhage, constipation, urinary tract infections, rhinitis, dysphagia, oxygen dependence, osteoarthritis and Parkinson's.
On 09/10/2014 at 3:30 pm an observation was made of CNA #9 as she provided incontinent (urine) care. The CNA proceeded to use the sit to stand mechanical lift to get Resident #7 off the wheelchair. Once the resident was up the CNA

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began providing incontinent care as the resident was standing with the assistance of the mechanical lift. The CNA used two wet wipes to clean the upper perineal area. The CNA wiped from left to right (Z) and not inside the perineum. After the CNA completed this task she placed a clean adult brief on the resident and lowered the resident back into the wheelchair.
On 09/10/2014 at 3:45 pm CNA #9 was interviewed. The CNA stated that if she had positioned the resident in bed she would have done a better job. When asked if she believed Resident #7 received thorough incontinent care, she replied, "No".
Record review of Resident #7's Care Plan revealed the resident had a history of urinary tract infections. Resident #7's Care Plan approaches, dated 4/17/2014, indicated, "perform good peri care after each incontinence episode."
Record review of the resident's Medication Administration Record revealed Resident #7 had orders for the administration of Amoxicillin 500 milligrams at bedtime for the treatment of urinary tract infections.
The facility policy and procedure for Peri Care, provided by the Director of Nursing (DON) on 09/10/2014, reflected: "expose the perineal area, clean entire perineal area with wipes moving from front to back, turn client onto side and clean buttocks."
On 09/10/2014 at 3:45 pm an interview with the DON was conducted. During the interview the DON stated, "I will have to do an inservice on incontinent care".

Transfers Observations:
RESIDENT #2
Resident #2 was admitted to the facility on 12/18/2013 with diagnoses that included: urinary

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tract infection, paranoid, nonorganic psychosis, dementia, pain, agitation, constipation, pressure ulcer to heels, history of pressure ulcer to buttock, hypertension and Alzheimer ' s.
On 09/09/2014 at 9:45 am an observation of Resident #2 was made as two CNA s (#3 and #4) transferred the resident from his bed to his wheelchair. The resident was transferred using a Hoyer lift. Once Resident #2 was in the wheelchair, CNA #4 walked behind the wheelchair and CNA # 3 stood beside the resident ' s left side. CNA #3 and #4 placed their hands under the resident ' s arms and pulled and lifted him toward the back of the wheelchair in an attempt to reposition the resident. When both CNA s pulled on the resident ' s arms as they lifted the resident back into the wheelchair, the resident ' s shoulders elevated toward his ears.
CNA #3 and #4 were interviewed on 09/09/2014 at 10:00 am. The CNAs were asked about the technique they used to reposition the resident into his wheelchair. CNA # 3 and 4 both stated, " That is the best way to pull him back because he is heavy. "

Record review of Resident #2 ' s Minimum Data Set (MDS) dated 6/17/2014 indicated the resident was 69 inches tall and weighed 163 pounds.
Review of the facility ' s policy and procedure on transfers, provided by the Director of Nursing (DON) on 09/12/2014, documented: " The goals of Training and Skill Practices in Transfers to include: to prevent falls, skin tears and other transfer-related injuries. "
On 09/10/2014 at 1:00 pm the DON was interviewed regarding the observed assisted transfer of Resident #2. The DON stated the technique used by CNA #3 and #4 was an incorrect technique and residents should not be

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lifted or pulled under the arms when transferred.
RESIDENT #3
Resident #3 was observed being transferred in her room on 09/09/14/at 4:30 pm by CNA #7 and CNA #8. The aides did not use a gait belt for the transfer from the bed to a wheelchair. The aides lifted the resident under her arms to transfer her from bed to chair.
Physical Therapist #1 was interviewed by phone on 09/12/2014 at 10:00 am. He stated the aides should be using a gait belt to transfer residents and not be lifting the residents under the arms.

RESIDENT #5:
Resident #5 was admitted to the facility on 02/02/2013 with diagnoses that included: urinary tract infection, dehydration, depressive disorder, anemia, pain, anorexia, constipation, history of pressure ulcer to buttock, dementia, hypertension and Alzheimer ' s.
On 09/09/2014 at 4:20 pm an observation of Resident #5 was made. CNA #9 was observed as she toileted Resident #5. After the CNA completed care, she proceeded to transfer the resident to the wheelchair. Once the resident was sitting in the wheelchair CNA #9 was observed behind the wheelchair. She placed her arms under the resident's arms and pulled the resident to an upright position.
On 09/09/2014 at 4:50 pm an interview with CNA #9 was conducted. When asked about the technique she used to pull Resident #5 up in the wheelchair, the CNA stated, "It's the only way I know because I forgot my gait belt."

RESIDENT #10:
Resident # 10 was observed in the dining room on 09/09/14 at 12:40 pm. She appeared sedated and was not eating. Two aides were observed

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| F 498 | Continued From page 24<br>transferring the resident from a dining room chair to a wheelchair. CNA #3 and CNA #6 placed a gait belt around the resident ' s waist but lifted her under both arms to place her in the wheelchair. The aides re-positioned her in the wheelchair by lifting Resident #10 under her arms totally off the seat. The aides then wheeled the resident to her room and proceeded to transfer her from the wheelchair to her bed. They lifted the resident again by using their arms under her shoulders instead of using the gait belt.<br><br>RESIDENT #11<br><br>On 09/11/201414 at 8:50 am: CNA #1 and CNA #2 lifted Resident #11 from her wheelchair to her bed. Each CNA grasped Resident #11 under one of her armpits. They lifted her straight up, moved the wheelchair back and sat her on the bed. Throughout this maneuver, Resident #11 kept her hips bent at about 90 degrees, her knees bent at about 85 degrees, and her legs clasped tightly together. Neither CNA attempted to support Resident #11's weight underneath her thighs or buttocks. | F 498 | | |