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

PRINTED: 09/16/2016
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 ______ PS 10/14/16 B. WING ______	09/01/2016

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

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 8/29/16 through 9/1/16. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nurse Aide DON: Director of Nursing ADON: Assistant Director of Nursing MDS: Minimum Data Set LPN: Licensed Practical Nurse RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	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.	
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview, the facility failed to ensure survey	F 167	F167 The facility will make the results available for examination and will post in a place readily accessible to residents and will post a notice of their availability. This REGULATION will be met as evidenced by: Correction: The survey book was placed in the lobby and is accessible for anyone to view. Identification: Residents residing in the facility may be subject to this deficiency. Systemic changes: The facility will ensure that measures	10/16/16 10/28/16

Revised 10/13/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heidi Gainz | TITLE: Administrator | (X6) DATE: 9/30/16

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.

10/14/16 10:35 POC accepted, spoke with Kristen Scheurman, DON, facility will re-type and send original to SA office.
11/4/16 2:45pm - spoke c Heidi administrator [illegible] State surveyor

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F 167	Continued From page 1 results were posted in a location readily accessible to all residents. The census was 62. The findings were: 1. Observation on 8/30/16 at 11:30 AM showed survey results were in a binder located in the facility "nook." Further observation showed the binder was in a plastic holder mounted on the wall beside a chair, with a shelf and antique radio placed in front of the mounted holder, which obstructed access. 2. Group interview with 8 residents on 8/30/16 at 10 AM revealed none of the residents participating were able to verify the location of the survey results, and they were not aware they had the right to review survey results. 3. Interview with the administrator, DON, and ADON on 8/31/16 at 7:10 PM confirmed the survey results were not easily accessible to the residents.	F 167	and/or systemic changes are put into place will include but not be limited to ensuring that all survey results and approved plan of correction if applicable, are available in a readable form, such as a binder or notebook and have not been altered by the facility unless authorized by the State agency, and are available to residents without having to ask a staff person. The survey results have been placed in the lobby next to the receptionist area. The Nursing Home Administrator will ensure the binder always has the most recent survey results. Monitoring: The Nursing Home Administrator or designee will monitor monthly to ensure the survey book is visible to all residents and visitors and the most recent survey results are in the binder and accessible. Issues identified will be corrected at that time. On a quarterly basis, will identify any patterns and if necessary, a report will be developed and submitted to the Quality Improvement/Quality Management Committee. The facility Quality Assurance Program under the guidance of the Administrator will review the report, and if necessary, will direct an improvement plan.	
F 225 SS=E	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.	F 225		

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F 225 SS=E	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.	F 225	F225 This REGULATION will be met as evidenced by: Corrective Action: The staff members responsible for not reporting the abuse allegations related to resident # (30, 31, 34, 35, 39, 46) have been reeducated on ensuring the results of all investigations are reported to officials in accordance with State Law including to the State survey and certification agency. On or before the date of compliance the incidents between residents 46 & 39 on 7-22-16 & 8-1-16, & 8-16-16 and residents 34 & 35 on 8-8-16 incident will be reported to the Wyoming Office of Healthcare Licensing & Survey. On or before the date of compliance the incidents involving residents #39, 46, 30, 31, 34, & 35 will be reviewed and interventions will be in place to ensure resident safety.	10/14/16 10/14/16 by the Regional Director of Health Service PS 10/14/16

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F 225	Continued From page 2 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). 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 and resident interview, review of incident reports, review of policy and procedures, and review of the State survey and certification agency incident log, the facility failed to thoroughly investigate 7 of 8 incidents reviewed (involving residents #30, #31, #34, #39, #46). Additionally, the facility failed to report 5 of 8 incidents reviewed to the State survey and certification agency. The findings were: 1. Review of four incidents which involved verbal altercations between resident #46 and resident	F 225	In addition, the staff members responsible for reporting abuse allegations will complete the facility's investigation checklist for each investigation. Identification: Residents who reside at facility are at potential risk. There have been no further allegations of abuse that were not reported. Systemic changes: Beginning September 19, 2016 and continuing up until the allegation of compliance the Staff employed at Worland Healthcare have been in-serviced regarding the timely and accurate reporting of all abuse allegations to the Interdisciplinary Team. Residents, families and staff will be able to report concerns, incidents and grievances without fear of retribution. Facility supervisors will immediately correct and intervene in reported or identified situations in which abuse, neglect or misappropriation of resident property is at risk for occurring including conducting an investigation of an alleged abuse/neglect, misappropriation of resident property and reporting to appropriate agencies in accordance with state law. The investigation will follow the investigation checklist and will include interviews of other residents as well as staff members and the facility will investigate all patterns, trends or incidents that suggest the possible presence of abuse, neglect to	

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F 225	Continued From page 3 #39 between 7/22/16 and 8/16/16 were not investigated thoroughly. The following concerns were identified: a. Review of an incident report alleging verbal abuse dated 7/22/16 showed the residents were involved in a verbal altercation. The facility was unable to provide any evidence of an investigation of this incident. Review of a social service progress note dated 7/22/16 showed the social services director (SSD) met with resident #39 concerning his/her verbal threat toward resident #46. Further, the note indicated resident #39 admitted to using inappropriate language towards resident #46 including telling the resident to "shut up" and using profanity. The note did not include any summation, resolution, or any interventions. Further, there was no evidence of resident or staff interviews regarding the incident. Review of the State survey and certification agency incident log showed no evidence the allegation was reported. b. Review of an incident report alleging verbal abuse dated 7/23/16 showed the incident report had no details of the altercation. The facility was unable to provide any evidence of an investigation of the incident. Further, there was no evidence of resident or staff interviews regarding the incident. Review of the State survey and certification agency log showed no evidence the allegation was reported. c. Review of an incident reporting alleging verbal abuse dated 8/1/16 showed the incident report had no details of the altercation. Review of the State survey and certification agency log showed no evidence the allegation was reported. Review of a social service progress note dated 8/6/16 (5 days after the incident) showed the SSD met with resident #39 to discuss what was going on between the resident and resident #46. The	F 225	include bruises of unknown origin or misappropriation of property, identified through analysis conducted by the Quality Assurance and Performance Improvement Committee, with intervention, reporting or policy/procedure modification conducted as appropriate. The Social Service Director or designee will present all current and ongoing investigations including completion of staff and resident interviews, interventions and any summation or resolution regarding each investigation, and completion of reporting to officials in accordance with state law including to the state survey and certification agency. Monitoring: The nurse management team will monitor effectiveness of the system through review of the 24 hour report in the morning stand up meeting, and through investigation of incidents for patterns, or trends that may indicate the presence of possible abuse. The Director of Nursing/Designee will review incident/accident reports and grievances monthly for three months then quarterly thereafter to ensure any incident/grievance that may indicate abuse has been investigated and appropriately reported if indicated. Issues identified will be reviewed by the quality improvement team to ensure the system has been implemented, sustained and evaluated for it's effectiveness.	

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F 225	Continued From page 4 note showed resident #39 told the social services director that resident #46 attempted to engage in conversation with him/her. The social services note showed resident #46 became agitated when resident #39 would not talk to him/her and knocked over a facility ash tray. The facility implemented an intervention of having the residents smoke in different areas; however, no summation or resolution was included in the note. Further, there was no evidence of additional resident or staff interviews regarding the incident. d. Review of an incident dated 8/16/16 showed the police were called by resident #46 because "[the resident] was afraid for [his/her] life." Review of the State survey and certification agency incident log showed no evidence the incident was reported. Review of a social service progress note dated 8/17/16 revealed the SSD met with resident #39 to discuss the incident. Resident #39 was reminded to smoke outside hall 3; however, a summation, resolution, or any interventions to keep the residents safe were not included. Further, there was no evidence of additional resident or staff interviews regarding the incident. e. Interview with resident #46 on 8/30/16 at 11 AM revealed the resident did not feel safe and stated "Why do I have to live somewhere where I am so scared?" 2. Review of an incident between resident #31 and resident #30 dated 7/27/16 showed the two were involved a physical altercation. Resident #30 allegedly grabbed resident #31 and "slammed" him/her into the wall. The incident was reported to the State survey and certification agency. Review of the investigation showed resident #30 and resident #31 were being monitored for safety. A physical assessment was	F 225		

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F 225	Continued From page 5 completed, and monitoring of vital signs was started on resident #31. The investigation did not include any summation, resolution, or interventions. Further, there was no evidence of resident or staff interviews regarding the incident. 3. Review of an incident between resident #46 and a family member dated 7/28/16 revealed the family member "slapped" the back of the resident's head. This incident was reported to the State survey and certification agency; however, review of the investigation showed no interventions were in place to ensure the resident's safety. Further, there was no evidence of resident or staff interviews regarding the incident. 4. Review of an incident between resident #34 and resident #35 dated 8/8/16 showed resident #35 kicked resident #34 and resident #34 kicked resident #35. The facility was unable to provide any evidence an investigation into this incident was complete. Review of the State survey and certification agency log showed no evidence the allegation was reported. 5. Interview with the SSD on 8/31/16 at 5:40 PM confirmed the incidents were not reported to the State survey agency and were not investigated thoroughly. 6. Review of the FiveStar Quality Care, Inc. Abuse Prohibition and Prevention Program policy last revised 10/1/12 revealed "5.1 Reporting Requirements...All employees and Facilities have an obligation to report all allegations of abuse or neglect, injuries of unknown source, and all substantiated incidents to the appropriate state	F 225		

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F 225	Continued From page 6 authorities, including the State Certification Agency and all other agencies as required, immediately, but no later than 24 hours after the allegation or occurrence." Further, "5.6 Investigation...A complete investigation will be conducted for any allegation of abuse, neglect, or any injury of unknown source in accordance with the procedures set forth in the Incident/Accident Investigation Policy. A report of the investigation will be provided to the appropriate state agency with five (5) working days of the incident..."	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to maintain the dignity of 2 of 13 sample residents (#13, #57). The findings were: 1. Review of the 7/8/16 quarterly MDS assessment showed resident #57 was severely cognitively impaired with a BIMS score of 0, was rarely understood, and required the extensive assistance of 1 person for personal hygiene. The following concerns were identified: a. Observation on 8/30/16 at 8:50 AM showed the resident was brought out of the dining room and positioned near a wall by the nurse's station. At that time, the resident had visible nasal drainage dripping down the resident's face onto	F 241	F241 The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Corrective Action: 1. Resident #57 is being provided with assistance with her personal hygiene which includes washing soiled hands and face before and after meals and as needed. 2. Resident #13 no longer resides at the facility. On or before the allegation of compliance, the Director of Nursing and or designee provided re-education to nursing staff regarding treating residents with respect and dignity, specifically	10/12/16 10/26/16 10/12/16 10/26/16

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F 241	Continued From page 7 his/her pants. During the observation, 3 staff members passed the resident and did not provide assistance. The resident received assistance by an unidentified staff member at 9:12 AM, 22 minutes later. b. Observation on 8/30/16 at 7:38 PM showed the resident was seated near a wall by the nurse's station and had finished eating ice cream without assistance. The resident had ice cream on his/her face and clothing. At 7:55 PM, 17 minutes after finishing the ice cream, the activity director assisted the resident in cleaning his/her face and clothing. 2. Review of the 8/23/16 significant change MDS assessment showed resident #13 was severely cognitively impaired with a BIMS score of 01. The resident was completely dependent on the assistance of one staff person for eating and personal hygiene. The following concerns were identified. a. Observation on 8/30/16 from 7:35 PM to 7:50 PM showed the resident was seated in his/her wheelchair in the 100 hallway near the nurse's station. The resident was slouched over with his/her oxygen nasal cannula laying on his/her lap and drool was hanging from the right side of the resident's mouth. Two CNAs and one RN passed by the resident before the resident was taken to his/her room at 7:50 PM. b. Observation on 8/29/16 at 5:45 PM showed the resident was seated in the dining room in his/her wheelchair. There was a small bowl of nectarine slices placed on a tray table in front of him/her. The resident attempted to feed him/herself the nectarine slices with a weighted fork and spilled them onto his/her lap and the side of the wheelchair. RN #1 picked up the spilled nectarines from the resident's lap and wheelchair	F 241	ensuring resident's faces are washed after meals and as needed. Identification Residents who reside at the facility are at potential risk. Systemic Changes: The facility will provide care for residents in a manner that respects and enhances each resident's dignity, individuality, and right to personal privacy. "Dignity" means that interacting with residents during cares, staff carries out activities that assist the resident in maintaining and enhancing self-esteem and self-worth. Care for residents in a manner that maintains dignity and individuality includes ensuring they are in clean clothes/shoes and that they are assisted with grooming before and after meals and as needed. Starting September 19, 2016, and up to the date of compliance, the staff Development Coordinator or designee will in-service staff on resident dignity. Monitoring: Facility managers will monitor to ensure resident's dignity is maintained through the general rounds/observation monitoring program at least 3 times weekly for one month, then weekly for one month and as needed until facility determines substantial compliance has been met. During these rounds, facility	

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F 241	Continued From page 8 and placed them back in the bowl with the resident's fork. The nurse then fed the nectarines to the resident with the fork. 3. Interview with the administrator, DON, and ADON on 8/31/16 at 7:10 PM verified the dining situation for resident #13 was not dignified, and added "staff members should never pick up food off a resident's lap and feed it to them." Further, the expectation was that the staff member obtain new food and utensils for the resident. Continued interview revealed staff were expected to clean resident's faces and hands when they are dirty so the resident does not feel undignified.	F 241	managers will be ensuring care is provided for residents in a manner that maintains dignity and individuality includes ensuring they are in clean clothes and that they are assisted with grooming before and after meals. Further review monitoring will be done through the Resident Council, the facility grievance process, ombudsman, and family feedback. Results through these reviews will be tracked/trended for any issues. Issues identified will be reviewed by Quality Assurance Performance Improvement Committee for process improvement to ensure the system is maintained and evaluated for its effectiveness.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide a sanitary and well-maintained environment in 4 of 6 hallways (100, 200, lobby, service) in the building. The findings were: 1. Observation on 8/31/16 at 3:08 PM showed room 101 had 7 tiles that measured 12 inches by 12 inches and were broken, cracked, or chipped with a black substance in the damaged areas. 2. Observation on 8/31/16 at 3:10 PM showed the carpet outside the clean linen closet had 2 tears. One tear measured 3 1/2 inches by 1/2 inch and	F 253	F253 The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Corrective action: 1. The broken, cracked and chipped tiles in room 101, room 402 and room 407 will be replaced by the maintenance supervisor on or before the date of compliance. 2. A bid will be acquired from a local vendor to replace the thirty-two tiles in room 307 on or before the date of compliance. 3. A bid will be acquired from a local	11/7/16 tolulite 10/28/16 11/7/16 tolulite 10/28/16 11/7/16 tolulite 10/28/16

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	535048	A. BUILDING _____ B. WING _____ PS 10/14/16	09/01/2016

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 253	Continued From page 9 the other tear measured 2 1/2 inches by 1/4 inch. 3. Observation on 8/31/16 at 3:11 PM showed the carpet in front of the "service hallway" had an area that measured 92 inches by 50 inches and had a black discoloration. Further, the carpet was worn near the transition strip and appeared to be smooth and black. 4. Observation on 8/31/16 at 3:12 PM showed the "service hallway" had 103 tiles that measured 12 inches by 12 inches and were broken, cracked, or chipped with a black substance in the damaged areas. 5. Observation on 8/31/16 at 3:13 PM showed the carpet outside of the dish room had an area that measured 34 inches by 7 inches and was worn and discolored. 6. Observation on 8/31/16 at 3:14 PM showed the carpet outside of the main dining room entrance, next to the dish room, had an area that measured 36 inches by 24 inches and was worn and discolored. 7. Observation on 8/31/16 at 3:15 PM showed the carpet in front of the 300/400 nurse's station had an area that measured 132 inches by 55 inches and was stained with an unknown substance. 8. Observation on 8/31/16 at 3:16 PM showed the carpet outside the nursing office had an area that measured 48 inches by 48 inches and was stained with an unknown substance. Further, the carpet in front of the drinking fountain had an area that measured 26 inches by 15 inches that was stained with an unknown substance.	F 253	vendor for replacement of the carpet on Hallways one, two, three, four, and employee offices with carpet squares on or before the date of compliance. 4. A bid will be acquired from a local vendor to replace the flooring in the lobby and the hallway connecting Nurse's Station one and two with Nurses' Station three and four with Luxury vinyl Plank on or before the date of compliance. 5. A bid is being acquired from a local vendor to replace the tiles in the service hallway, kitchen, dry food storage area, therapy gym, the end of hall two and the end of hall four solarium with Luxury vinyl tile. 6. ~~Carpet~~ for repair will be ordered on ~~for~~ before 11/7/16 for repairs. Identification The Nursing Home Administrator and Maintenance Supervisor conducted visual rounds at the time of survey to identify other potential issues. No other issues were identified. Residents residing at the facility are potentially affected. Systemic changes The Nursing Home Administrator, Maintenance Supervisor and facility management team will conduct visual rounds to ensure that the facility maintains a sanitary, orderly, and comfortable interior. Starting at the time of survey and up to the date of compliance the Administrator/designee will in-service facility staff on communication of maintenance and	11/7/16 ~~10/28/16~~ 10/28/16 11/7/16 ~~10/28/16~~ 10/28/16

3:45pm 11/4/16 - Spoke c Heidi-Administrator about reques to change date of compliance for F-253. Change agreed upon c changes for 11/7/16.

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WORLAND HEALTHCARE AND REHABILITATION CENTER	1801 HOWELL AVENUE WORLAND, WY 82401

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F 253	Continued From page 10 9. Observation on 8/31/16 at 3:18 PM showed an area outside of room 402 that measured 10 inches by 1 inch where the carpet was no longer secured to the flooring and was raised 1/2 inch. 10. Observation on 8/31/16 at 3:19 PM showed the carpet outside of room 403 had an area that measured 7 inches by 2 inches and an area that measured 5 inches by 1 inch where the carpet was no longer secured to the flooring and was raised 1/2 inch. 11. Observation on 8/31/16 at 3:22 PM showed the carpet outside of room 405 had 2 areas that measured 12 inches by 1 inch where the carpet was no longer secured to the flooring and was raised 1/2 inch. 12. Observation on 8/31/16 at 3:23 PM showed room 407 had 3 tiles that measured 12 inches by 12 inches and were broken, cracked, or chipped with a black substance in the damaged areas. 13. Observation on 8/31/16 at 3:31 PM showed room 402 had 3 tiles outside the bathroom that measured 12 inches by 12 inches and were broken, cracked, or chipped with a black substance in the damaged areas. 14. Observation on 8/31/16 at 3:34 PM showed the carpet outside the main dining room entrance, on the 300 hall, had a worn area that measured 38 inches by 15 inches and had black discoloration. 15. Observation on 8/31/16 at 3:38 PM showed room 307 had 32 tiles that measured 12 inches by 12 inches and were broken, cracked, or chipped with a black substance in the damaged	F 253	housekeeping concerns via work orders located at the Nurse's Station and on the 24 hour report. The Nursing Home Administrator will provide oversight to ensure identified issues have been resolved. Monitoring The Maintenance Director, Housekeeping Director, and Nursing Home Administrator or designee, will conduct monthly environmental rounds in order to identify outstanding housekeeping and maintenance issues with overall oversight provided by the Nursing Home Administrator or designee. Findings will be presented to the Quality Assurance Performance Improvement Committee monthly for 3 months and as needed.	

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F 253	Continued From page 11 areas. 16. Observation on 8/31/16 at 3:40 PM showed the facility lobby carpet had an area that measured 27 inches by 30 inches and an area that measured 128 inches by 60 inches that were stained with an unknown substance. Further, the carpet had a seam that measured 70 inches and was worn and separated. 17. Observation on 8/31/16 at 4:30 PM showed the 400 activity room had an area on the floor that measured 60 inches by 24 inches and was stained with an unknown substance. 18. Observation on 8/31/16 at 4:32 PM showed the 400 activity room had 10 tiles that measured 12 inches by 12 inches and were broken, cracked, or chipped with a black substance in the damaged areas. 19. Interview with the maintenance director on 9/1/16 at 8:15 AM revealed the carpet in the facility was "very old" and when the facility cleaned it more stains appeared. Further, it was confirmed that the black discoloration on the tiles was because they were broken and they could no longer be effectively cleaned.	F 253		
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	F 274	F274 A facility will conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition.	

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F 274	Continued From page 12 resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and review of the Resident Assessment Instrument User's Manual, the facility failed to ensure a significant change assessment was completed for 2 of 3 residents (#13, #44) who required significant change assessments. The findings were: 1. Review of the medical record showed resident #13 was admitted to the facility on 2/3/14 with diagnoses which included dementia, Parkinson's disease, repeated falls, fatigue, and muscle weakness. Review of the 4/29/16 annual MDS assessment showed the resident required the extensive assistance of 1-2 people with bed mobility, transfers, dressing, toileting, personal hygiene, and bathing; total assistance of 1 person with locomotion on and off the unit; and supervision with eating and no extremity impairment. The assessment further showed the resident had 1 fall without injury since admission. The following concerns were identified: a. Review of nursing progress notes dated 7/23/16 and timed 15:30 PM showed the resident sustained a right hip fracture, with subsequent surgical repair on 7/23/16. The resident was readmitted to the facility on 7/26/16. b. Review of the 8/2/16 quarterly MDS	F 274	Corrective Action: 1. On September 23, 2016 a significant change in status assessment was completed on resident # 13. 2. On September 22, 2016 a significant change in status assessment was completed on resident ~~#7~~ #44. Identification: On or before the date of compliance, all residents will be reviewed to determine if a significant change in the resident's physical or mental status has occurred. If a significant change in status is determined a significant change in status assessment will be completed. All residents who reside in the facility are found to be potentially affected. System Changes: The Interdisciplinary Team will review the status of residents each quarter. If the team determines that a significant change has occurred the assessment will be completed by the 14th calendar day following the determination. The Interdisciplinary Team has been in-serviced with regards to this process. The Director of Nursing or Designee will oversee this process. Monitoring: The Minimum Data Set Nurse or Designee will review 3 records of residents each month to determine if there is a decline or improvement consistently	10/20/16 10/28/16

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F 274	Continued From page 13 assessment showed the resident required the total assistance of 2 or more people with bed mobility, transfers, toileting, and personal hygiene and the extensive assistance of 1 person with eating. c. Further review of the medical record failed to show a significant change MDS assessment was completed. 2. Review of the medical record showed resident #44 was admitted to the facility on 9/10/15 with diagnoses which included depression, cancer, atrial fibrillation, heart failure, hypertension, peripheral vascular disease, gastroesophageal reflux disease (GERD), thyroid disorder and cerebral vascular accident (CVA). Review of the 9/17/15 admission MDS assessment showed the resident with a pain score of "0", indicating no pain presence. This assessment also showed the resident was given a score of "0" for urinary continence, indicating s/he was continent of urine. The following concerns were identified: a. Review of the 6/19/16 quarterly assessment showed the resident had pain which was recorded as frequently present and of moderate intensity. Further, the resident was frequently incontinent of urine. b. Review of a doctor's progress note dated 8/9/16 showed the resident had "DX [diagnosis] of lumbago; the discomfort is most prominent in the lumbar spine. [S/he] characterizes it as constant. This is a chronic problem, with essentially constant pain." c. Further review of the medical record failed to show a significant change MDS assessment was completed. 3. Interview with the MDS coordinator on 8/31/16 at 7:10 PM confirmed significant change	F 274	noted on two or more areas of decline or two or more areas of improvement. Issues identified will be corrected at that time. The Minimum Data Set Nurse or Designee will report her findings to the Interdisciplinary Team at the Daily Leadership Meeting. Negative trends will be action planned and prioritized for process improvement during the monthly Quality Assurance Performance Improvement process.	

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F 274	Continued From page 14 assessments should have been completed. 4. Review of the "CMS RAI version 3.0 manual" showed "...04. Significant change in status assessment (SCSA) (A0310A=04)... other conditions may not be permanent but would have such an impact on the resident's overall status for more than two weeks that they would require a comprehensive assessment and care plan revision. For example, a hip fracture may be viewed as a transient condition but it would generally have a major impact on the resident's functional status in more than one area (e.g., ambulation, toileting, elimination patterns, activity patterns)..." Continued review showed "...Decline in two or more of the following...any decline in an ADL (activities of daily living) physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment." Further, the RAI stated a significant change assessment is appropriate when "...There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments..."	F 274		
F 284 SS=D	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.	F 284	F284 When the facility anticipates discharge a resident will have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which	

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F 284	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a discharge summary and post discharge plan of care was complete for 1 of 2 sample residents (#63) who was discharged from the facility. The findings were: 1. Review of the closed medical record for resident #63 showed s/he was discharged on 8/15/16. Review of the admission history and physical dated 8/1/16 showed the resident lived at home with family and had a caregiver prior to admission. Further, admission orders for the resident included Coumadin (an anti-coagulant) 2 mg (milligrams) by mouth every day, Coumadin 5 mg by mouth every day, and decrease sertraline (an anti-depressant) to 50 mg by mouth every day. Review of a telephone order dated 8/1/16 and timed 12 PM showed the facility was to follow orders in the history and physical dated 8/1/16. The following concerns were identified: a. Review of a telephone order dated 8/1/16 and timed 3:30 PM showed an order clarification for the resident to receive Coumadin 2 mg every other day and alternate with Coumadin 3 mg every other day. b. Review of the physician discharge summary dated 8/15/16 showed the resident was to "continue current nursing home meds [medications]" and the resident was to have a PT/INR (prothrombin time/international normalized ratio) lab test performed in 3 weeks. c. Review of a telephone order dated 8/1/16 and timed 10:10 PM showed the resident was to receive occupational therapy for self-care including ADL retraining, transfers, functional	F 284	will assist the resident to adjust to his or her new living environment. Corrective action: Resident #63 no longer resides at facility. Identification: Residents residing at Worland Healthcare are at risk. Systemic changes: The Social Service Director/Designee will obtain a Discharge Summary from all care plan team members prior to discharge if anticipated or take the Discharge Summary to the next care conference for staff to complete within the week following discharge if discharge not anticipated. On or prior to the allegation of compliance The Nursing Home Administrator and/or Designee will reeducate the Interdisciplinary team members, and Licensed nurses on the Discharge Summary process. An attendance list will be kept and any team members unable to attend will be provided 1:1 re-education. Monitoring The Social Service Director and/or Designee will review each discharge within 7 days after the discharge to ensure discharge summary was complete. Any issues identified will be brought to the Nursing Home Administrator's attention and followed up on accordingly to ensure	10/28/16

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F 284	Continued From page 16 mobility, and upper extremity strengthening. d. Review of a telephone order dated 8/4/16 and untimed showed the resident was to receive physical therapy related to difficulty walking. e. Review of the post-discharge plan of care dated 8/15/16 showed the facility failed to complete the documentation related to community resources and services planning, scheduled appointments, and procedures the resident should know about. Further, the medications section showed the resident was to "continue current meds"; however, there was no evidence that the changes to the resident's medication regimen were communicated at the time of discharge and the facility did not provide contact information for further questions. 2. Interview with the DON and administrator on 8/31/16 at 7:10 PM confirmed the facility did not fully develop the post-discharge plan.	F 284	completion. Identified issues will be trended and presented by the Social Service Director and/or Designee to the Quality Assurance Performance Improvement Committee monthly times 3 months then as needed to ensure plan was implemented, is sustained, and evaluated for its effectiveness.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and medical record review, the facility failed to ensure the services provided maintained the highest practicable physical well-being for 1 of 9 sample	F 309	F309 Each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Corrective Action: Resident #44's pain is being evaluated, treated, and documented appropriately.	10/28/16

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F 309	Continued From page 17 residents (#44) with pain. The findings were: Review of the medical record showed resident #44 was admitted to the facility on 9/10/16 with diagnoses which included depression, skin cancer, atrial fibrillation, heart failure, hypertension, peripheral vascular disease, gastroesophageal reflux disease (GERD), thyroid disorder and cerebral vascular accident (CVA). Review of the 9/17/16 admission MDS assessment showed the resident had a pain score of "0" indicating no pain presence. Review of the 3/19/16 and 6/19/16 quarterly MDS assessments showed the resident had pain which was described as frequently present and of moderate intensity. These assessments showed the resident received no scheduled pain medication, non-scheduled pain medication, or non-medication interventions during the lookback periods reviewed. Review of nurses notes dated 5/2/16 and 5/3/16 showed the resident fell, landing on his/her left side, and had discomfort across his/her left rib area in front. Review of a nurse's note dated 5/10/16 showed the resident complained of pain under the left breast area, had an x-ray completed revealing a non-displaced rib fracture on the left sixth rib, and the resident was encouraged to deep breathe. Review of a nurse's note dated 5/11/16 showed the resident verbalized a pain level of "5" and was encouraged to deep breathe. Review of a physician's progress note dated 8/9/16 showed the resident had a diagnosis of "...lumbago; the discomfort is most prominent in the lumbar spine. [S/he] characterizes it as constant. This is a chronic problem, with essentially constant pain." Further, listed health problems included a closed rib fracture, leg pain, lumbago, hip pain, and urinary tract infection. The following concerns were	F 309	Identification: Beginning September 19th, 2016, an assessment of current residents' pain status will be completed by the Director of Nursing/Designee utilizing the "Pain Review Tool", to ensure that no other residents have been affected by the alleged deficient practice. The resident's current pain management regimen will be evaluated for its effectiveness and care plans will be reviewed and updated by the Director of Nursing/Designee at that time if indicated. Systemic Changes: Licensed nurses are to complete initial full evaluation of pain on all new admissions, current residents with new onset of pain and those residents identified by for pain through the Resident Assessment Instrument process. The Pain Review tool will be completed quarterly, annually, and with significant changes in status. The Director of Nursing will in-service Registered Nurses and Licensed Practical Nurses currently employed with facility on the facility's Pain Management System starting on September 19th, 2016 and up until the date of compliance, specifically ensuring that residents are assessed every shift for pain and interventions are in place and effective for each resident.	

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

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F 309	Continued From page 18 identified: a. Review of the June, July and August 2016 medication administration record (MAR) showed the resident had an order dated 5/10/16 for Ultram (tramadol) 50 mg by mouth every 6 hours as needed for pain. A pain level of 0 out of 10 was charted daily for the months of June, July and August 2016, with the exception of a pain level of 4 out of 10 on 6/26/16 during the day shift. No doses of Ultram were given during this time period including on 6/26/16. b. Interview with resident #44 on 8/30/16 revealed s/he had back and leg pain that worsened with cold temperatures and the resident felt it was "always so cold in here." Further, the resident revealed s/he often left the room because it was too cold. c. Review of the care plan dated 9/16/16 showed the resident was at risk for pain related to a history of knee pain and GERD. However, the resident's rib fracture, lumbago, and leg and hip pain were not addressed. The care plan also did not mention the effects of cold temperatures on the resident's pain. d. Interview with the DON, ADON, and administrator on 8/31/16 at 7:10 PM revealed interventions were not in place to address the resident's pain. Further, the resident's pain medication may need to be scheduled instead of as needed.	F 309	Monitoring: The Director of Nursing/Designee will complete audits of pain management documentation three times a week for accuracy and completeness, including reviewing medication administration records for frequency of as needed medications and to ensure resident's pain regimen is effective. Licensed nurses will be re in-serviced/counseled when documentation requirements are not consistently completed. The Interdisciplinary Team will complete audits of resident's Minimum Data Set, Care Plans and assessment tools, including the quarterly pain assessment tool, to ensure compliance. The Director of Nursing/Designee will trend reviews and present trends in the Facility's Quality Assurance Performance Improvement committee to ensure that this Plan of Care is implemented.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329	F329 Each resident's drug regimen will be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive	

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F 329	Continued From page 19 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review and policy and procedure review the facility failed to ensure the medication regimen for 1 of 9 sample residents (#34) who received psychotropic medications were free of unnecessary medications. The findings were: 1. Review of the August 2016 physician order recapitulation for resident #34 showed Ativan (a sedative/hypnotic) 1 mg (milligram) daily, was ordered on 1/23/14 for anxiety disorder. No evidence was found that a gradual dose reduction (GDR) or risk/benefit evaluation had been attempted. 2. Interview with the DON on 9/1/16 at 8:40 AM	F 329	doses (including duplicate therapy); or for excessive duration; or without monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility will ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Corrective Action: Resident #34 – A risk benefit statement for her Ativan was received on 9/22/16. CNS Identification: Residents receiving psychotropic medication will be reviewed by the Interdisciplinary Team on or before the date of compliance to evaluate if a gradual dose reduction dose is required. Issues identified will be corrected at that time either with attempting the gradual dose reduction or ensuring a risk benefit statement is in place.	10/18/16 10/18/16

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F 329	Continued From page 20 revealed that neither a GDR or risk/benefit evaluation for the resident had been done. 3. Review of the FiveStar Quality Care, Inc. policy and procedure for Psychopharmacological Medication last revised on 4/9/07 revealed "5.0 Gradual Dose Reductions...5.2 Sedatives/Hypnotics For as long as a resident remains on a sedative/hypnotic medications that have been used routinely during the previous quarter, the resident must be evaluated by his/her physician quarterly for tapering of the drugs..."	F 329	System Changes: On September 14, 2016 the Psychotropic Drug Committee was re-educated on the process of evaluating residents receiving psychotropic medications and evaluation of supporting documentation for continued use of the medication. Each resident will be reviewed on admission, quarterly, annually, and with significant change for the use of psychotropic medications for residents who are currently using psychotropic medications, clinical record documentation will be reviewed to ensure: 1). Physician documentation includes; the physician's progress notes, history and physical, and orders to reflect the behavior, the indications for use, when it is used, and required risk benefit statement and/or black box warning information. 2). Nursing/Clinical documentation includes; consent, care plans addressing the antipsychotic drug use and quarterly reviews that reflect the specific condition, indication for use, and evaluation to evaluate continued use as well as the black box information and/or risk benefit statements. 3). If a resident is utilizing an antipsychotic, the Consent Form will be completed and signed by the resident and/or the resident's legal representative. The continued use will be evaluated	by facility Administrator
F 371 S8=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure food was stored and prepared under sanitary conditions in 1 of 1 kitchens. The findings were: Related to cleanliness: 1. Observation on 8/28/16 at 3:35 PM revealed wet wiping cloths on the counter tops in three different locations; the north preparation table, the	F 371		

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F 329	Continued From page 20 revealed that neither a GDR or risk/benefit evaluation for the resident had been done. 3. Review of the FiveStar Quality Care, Inc. policy and procedure for Psychopharmacological Medication last revised on 4/9/07 revealed "6.0 Gradual Dose Reductions...5.2 Sedatives/Hypnotics For as long as a resident remains on a sedative/hypnotic medications that have been used routinely during the previous quarter, the resident must be evaluated by his/her physician quarterly for tapering of the drugs..."	F 329	quarterly by the Psychotropic Drug Committee, Nurses and Interdisciplinary Team. Monitoring: Quarterly, residents utilizing psychotropic medications are reviewed to evaluate the appropriateness of the medication as well as evaluation of supporting documentation for continued use of the medication. Potential reduction attempts will be evaluated at that time if indicated. The documentation audit will be conducted quarterly on resident's utilizing antipsychotics to ensure the medication is being monitored per facility policy and other required documentation is in place. Issues identified will be reviewed by the quality improvement team to ensure the system has been implemented, sustained and evaluated for its effectiveness.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure food was stored and prepared under sanitary conditions in 1 of 1 kitchens. The findings were: Related to cleanliness: 1. Observation on 8/29/16 at 3:35 PM revealed wet wiping cloths on the counter tops in three different locations; the north preparation table, the	F 371		

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F 329	Continued From page 20 revealed that neither a GDR or risk/benefit evaluation for the resident had been done. 3. Review of the FiveStar Quality Care, Inc. policy and procedure for Psychopharmacological Medication last revised on 4/9/07 revealed "5.0 Gradual Dose Reductions...5.2 Sedatives/Hypnotics For as long as a resident remains on a sedative/hypnotic medications that have been used routinely during the previous quarter, the resident must be evaluated by his/her physician quarterly for tapering of the drugs..."	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure food was stored and prepared under sanitary conditions in 1 of 1 kitchens. The findings were: Related to cleanliness: 1. Observation on 8/29/16 at 3:35 PM revealed wet wiping cloths on the counter tops in three different locations; the north preparation table, the	F 371	F371 The facility will – 1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and 2) Store, prepare, distribute and serve food under sanitary conditions. Corrective Action: No residents were named. Food identified as not dated/labeled was immediately thrown away when surveyor brought to the staffs' attention. All cutting boards were visualized and eight were removed from use and replaced on 9/23/16 due to scored and un-cleanable surfaces. Small portable sanitation buckets were ordered on 9/16/16 to be accessible for storing the wiping ~~clothing~~ Clothes between uses. ~~Clothes~~ Cloths PS 10/14/16	10/14/16 10/23/16 10/14/16 10/23/16

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F 371	Continued From page 21 middle preparation table near the steamer, and to the left of the sanitizing sink. The buckets with sanitizing solution were located in the sink. 2. Observation on 8/31/16 at 12:05 PM showed dietary aide #1 used a cloth from the counter and wiped the serving counter between the kitchen and dining room. The cloth had not been stored in the sanitizing solution and was then placed onto a food cart. In addition, at that time another wet wiping cloth was on the middle preparation counter not stored in the sanitizing solution. 3. Interview with the dietary manager on 8/31/16 at 12:14 PM revealed the expectation the wiping cloths stay in the sanitizing bucket until used and then are returned to the bucket. According to Food Code 2013, U. S. Public Service: 3.304.14..."(B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114" 4. Observation on 8/31/16 at 11:30 AM showed 8 of 11 cutting boards were visibly scored creating an uncleanable surface. Interview with the dietary manager on 9/1/16 at 8:20 AM confirmed that the cutting boards were in poor condition and needed to be replaced. According to Food Code 2013, U.S. Public Health Service: 4-501.12 " Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be	F 371	Identification: Residents that reside at the facility are at risk. Systematic changes: Starting on 9/15/16 and up to the date of compliance the Certified Dietary Manager/ Designee will in-service dietary staff on food safety and sanitation program specifically on proper food storage and labeling of transferred food with the date the food was prepared/or put into a container and a use by date, storing wiping cloths in the designated sanitation buckets between use and that cutting boards with scored and un-cleanable surfaces must be removed from use. Monitoring: The Certified Dietary Manager or Designee will complete sanitation rounds 3 times a week for one month, then weekly and as needed to identify concerns regarding food storage and sanitation and until substantial compliance has been met. These issues will also be tracked, trended and the Certified Dietary Manager will present the results in a report to Quality Assurance Performance Improvement Committee monthly for 3 months then as needed for review and suggestions as needed to ensure plan is implemented, sustained and evaluated for its effectiveness.	

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F 371	Continued From page 22 transferred to foods that are prepared on such surfaces. " Related to food storage: 1. Observation on 8/29/16 at 3:35 PM and on 8/30/16 at 8:05 AM showed the walk-in refrigerator contained: a. A one-quart plastic storage container of sweet and sour sauce dated 7/29/16. b. An undated plastic storage container of soy sauce. c. A small plastic storage container of BBQ sauce dated 8/2/16. d. A container of applesauce dated 8/10/16. e. Five bottles of salad dressings which had been transferred from the original containers into individual squirt bottles dated 8/20/16, 8/21/16, one with an unreadable date, and one unlabeled bottle. 2. Interview with dietary aide #1 on 8/31/16 at 9:50 AM confirmed the dates on the containers were the dates when the food was prepared/put into the containers. 3. According to Food Code 2013, U.S. Public Health Service: 3-501.17 "(A)...refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days.	F 371		
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431	F431 The facility will employ or obtain the services of a licensed pharmacist who	

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F 431 SS=D	Continued From page 23 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. 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 policy	F 431	establishes a system of records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biological 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 biological 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. Corrective Action: On 9/2/16 the expired Lorazepam in thee 100/200 medication room refrigerator were replaced.	10/28/16

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F 431	Continued From page 24 and procedure review, the facility failed to ensure medications available for resident use were not past the manufacturer's recommended expiration dates in 1 of 5 medication storage areas (100/200 medication room). The findings were: Observation on 8/31/16 at 6:50 PM of the 100/200 medication room refrigerator showed five Lorazepam (an anti-anxiety medication) single-use vials that were expired. Two vials had expiration dates of 11/2015, and three vials had expiration dates of 2/2016. Interview with RN #2 on 8/31/16 at 6:50 PM verified the medication was available for resident use. Review of the policy titled "5.3 Storage and expiration of medications, biologicals, syringes, and needles", effective date 12/01/07 and revised dates of 05/01/10 and 01/01/13, showed: "...4. Facility should ensure the medications and biologicals: ...4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines."	F 431	Identification: On September 14, 2016 the pharmacy consultant reviewed the expiration dates of the emergency medications storage areas for expired medications, four other medications were found to be expired and were immediately removed from resident use. Residents residing in the facility have the potential to be affected by this practice. Systematic changes: Beginning September 14, 2016 and going forward, the pharmacy consultant will conduct a monthly review and remove any expired medications in the pharmacy's emergency medication storage areas and report findings to the Director of Nursing and pharmacy for replacement of medications that have or will expire that month. Beginning September 19, 2016 and continuing up until the allegation of compliance the Staff Development Coordinator/Designee will in-service Registered Nurses and Licensed Practical	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	Nurses on the requirement that all medications must be appropriately stored dated and labeled appropriately. Specifically outdated and/or undated medications must be removed for destruction. An attendance sheet will be kept and then reconciled with the list of active licensed nursing staff and those unable to attend will receive 1:1training	

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F 431	Continued From page 24 and procedure review, the facility failed to ensure medications available for resident use were not past the manufacturer's recommended expiration dates in 1 of 5 medication storage areas (100/200 medication room). The findings were: Observation on 8/31/16 at 6:50 PM of the 100/200 medication room refrigerator showed five Lorazepam (an anti-anxiety medication) single-use vials that were expired. Two vials had expiration dates of 11/2015, and three vials had expiration dates of 2/2016. Interview with RN #2 on 8/31/16 at 6:50 PM verified the medication was available for resident use. Review of the policy titled "5.3 Storage and expiration of medications, biologicals, syringes, and needles", effective date 12/01/07 and revised dates of 05/01/10 and 01/01/13, showed: "...4. Facility should ensure the medications and biologicals: ...4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines."	F 431	Monitoring: Beginning September 14, 2016 and going forward, the pharmacy consultant will complete monthly reviews and remove any expired medications in the pharmacy's emergency medication storage areas and report findings to the Director of Nursing and pharmacy for replacement of medications that have or will expire that month. Director of Nursing or designee will do monthly medication room and cart reviews to monitor for ongoing compliance, then quarterly and prn thereafter. Issues identified will be corrected at that time. Issues will be tracked and trended. Director of Nursing or designee will report the results to Quality Assurance Performance Improvement Committee monthly for the next 3 months and then as needed to assure plan is implemented, sustained and evaluated for its effectiveness.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	F441 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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(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 441	Continued From page 25 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure infection control practices were followed while providing meal assistance during 1 of 2 meal observations. The practice affected 1 sample resident (#13). The findings were: 1. Observation on 8/29/16 at 5:45 PM showed resident #13 was seated in the dining room in his/her wheelchair. There was a small bowl of	F 441	Corrective Action: ~~All~~ The staff ~~that assisted the resident in WOC eating the spilled fruit was~~ re-educated on proper infection control procedures. by DON/PS Identification: Residents who reside at Worland are at risk Systemic Changes: Beginning September 19, 2016 and continuing up until the allegation of Compliance the Director of Nursing/ Designee will in service the Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants on the facility's Infection Control practices as they pertain to ensuring residents are assisted in maintaining sanitary dining experience such as replacing spilled or dropped food and or eating utensils. An attendance sheet will be reconciled with an active staff roster and those nursing staff unable to attend will be provided 1:1 education. Monitoring: The Director of Nursing/Designee will complete visual rounds during meal time 3 times weekly for 1 month, then weekly for 1 month, then monthly and as needed thereafter to ensure staff are providing sanitary interventions in the dining room. Issues identified will be tracked and corrected at that time, trends as well as infection control reports will be presented	10/26/16 clearing

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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 _____ PS 10/14/16	09/01/2016

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F 441	Continued From page 26 nectarine slices placed on a tray table in front of him/her. The resident attempted to feed him/herself the nectarine slices with a weighted fork and spilled the them onto his/her lap and the side of the wheelchair. RN #1 picked up the spilled nectarine slices from the resident's lap and wheelchair and placed them back in the bowl with the resident's fork. The nurse then fed the same nectarines to the resident with the same fork. 2. Interview with the administrator, DON, and ADON on 8/31/16 at 7:10 PM stated "staff members should never pick up food off a resident's lap and feed it to them." Further, the expectation was the staff member obtain new food and utensils for the resident.	F 441	in Quality Assurance Performance Improvement by the Director of Nursing/Designee to ensure plan has been implemented, sustained, and evaluated for it's effectiveness.	