PRINTED: 07/13/2017
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 _____	06/29/2017

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 from 6/26/17 to 6/29/17. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide MDS- Minimum Data Set mg- milligrams 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)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) 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; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and	F 167	F167 The facility will have reports with respect to any surveys, certification, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request. Correction Action: On June 29, 2017 facility Administrator placed a note at the front of current year survey binder stating "Three years of survey are available upon request." On July 18, 2017 the Residents were made aware of the ability to review the prior 3 years during their monthly Resident Council Meeting. Identification: Residents residing in the facility may be	8/4/17

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

Heidi Glanz Administrator 8/8/17

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

POC Accepted 8/9/17 11:48 Mark Cuny
spoke with Heidi Glanz, Admin.

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F 167	Continued From page 1 (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a notice of the availability of survey reports for the preceding 3 years was posted as required. The census was 67. The findings were: Observation on 6/29/17 at 7:15 AM showed a binder placed in the lobby contained the most recent health and life safety survey results. Further observation showed no notice posted informing the public that the previous 3 years' survey results were available upon request. Interview with the administrator on 6/29/17 at 7:30 AM confirmed the notice was not posted. She further revealed she was unaware of the requirement.	F 167	subject to this deficiency. Systemic changes: The facility will ensure that measures 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 and have not been altered by the facility unless authorized by the State agency, and are available to residents along with 3 preceding years available upon request. The Nursing Home Administrator will ensure the binder always has the most recent survey results and that the 3 preceding years are readily available. Monitoring: The Nursing Home Administrator or designee will monitor monthly to ensure the survey book is available to all residents and visitors and the most recent survey results are in the binder and that three preceding years are available upon request. Issues identified will be corrected at that time. On a quarterly basis the Nursing Home Administrator or designee 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 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) 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 ensure a safe and sanitary environment for 3 of 4 resident hallways (Hallways 1, 3, and 4). The findings were:	F 253		

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F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) 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 ensure a safe and sanitary environment for 3 of 4 resident hallways (Hallways 1, 3, and 4). The findings were:	F 253	F253 The facility will maintain a sanitary, orderly, and comfortable interior. Corrective Action: 1. Resident Room 116 – the hole in the bathroom door will be patched and painted by Facility Maintenance. The gouge in the wood frame will be sanded and re-finished.	8/4/17

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F 253	Continued From page 2 1. Observation on 6/28/17 beginning at 10:45 AM revealed the following concerns: a. In resident room 116, the inside of the bathroom door had a 3/4 inch by 2 inch hole located 3 1/2 inches from the bottom. There was also a gouge in the wood at 26 inches from the bottom, creating a rough surface which could not be effectively cleaned. b. In resident room 112, the entry door had an area on the upper left corner of the kickplate which was peeling away from the wood. Additionally, the wall behind the head of the bed had multiple scrapes and gouges, exposing rough drywall and creating a surface which could not be effectively cleaned. Further, the left closet door had a hole that measured 3 1/2 inches by 1 1/2 inches. c. In resident room 103, the floor had sixteen 12 inch by 12 inch floor tiles with various sized cracks and chips, which were darkened with an accumulation of dirt and debris. Further, the bottom of the wooden trim around the closet had worn down to rough wood, creating a surface which could not be effectively cleaned. d. In resident room 303, there were nineteen 12 inch by 12 inch floor tiles which were cracked and darkened with dirt. Additionally, the kickplate on the entry door was peeling up along the bottom left corner. Further, the finishing of the wooden trim around the closet had worn down, exposing rough wood which could not effectively be cleaned. e. In resident room 302, the threshold to the bathroom was missing, and the floor surface was uneven and darkened with an accumulation of dirt and debris. f. In resident room 401, the seam along the wall and baseboard to the left of the entryway had	F 253	2. Resident Room 112 – entry door kick plate will be repaired. The wall behind the head of bed was repaired on 7/6/17 by facility Maintenance. The closet door will be repaired with a new stainless steel kick plate. 3. Resident Room 103 – a bid is being obtained for the entire room to be re-tiled by outside contractor. The wooden trim around the closet will be sanded down and re-finished by Maintenance Director. 4. Resident Room 303 – a bid is being obtained for the said 19 tiles to be replaced by outside contractor. The kick plate will be repaired. The wooden trim around the closet will be sanded down and re-finished by Maintenance Director. 5. Resident Room 302 – Facility Maintenance will install a transition in said area. 6. Resident Room 401 – Facility Maintenance will repair exposed hole. 7. Resident Room 404 – Facility Maintenance will replace the 8 cracked/chipped tiles. 8. Resident Room 409 – a bid is being obtained from outside contractor to replace the bathroom floor and said cracked/chipped tiles. Facility Maintenance will repair kick plate on bathroom door. 9. Shower Room Hall 3 and 4 – a bid is being obtained for outside	8/4/17 8/4/17 8/4/17 8/4/17 8/4/17 8/4/17 8/4/17

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F 253	Continued From page 3 separated, exposing a hole 4 inches long and 2 1/2 inches deep. g. In resident room 404, there were eight 12 inch by 12 inch floor tiles in the entryway which were cracked and darkened with dirt. h. In resident room 409, there were various 12 inch by 12 inch floor tiles with multiple cracks that were darkened with dirt. Additionally, the linoleum floor in the bathroom had a 3 inch long tear to the right of the door which was peeling up, creating a surface which could not effectively be cleaned. Further, the kickplate on the bathroom door was peeling up along the bottom left corner. i. The shower room in hall 4 had 3 damaged and chipped tiles along the top of the half-wall in the shower stall, creating a surface which could not be effectively cleaned. Additionally, the wall to the right of the sink cabinet had 2 missing tiles. j. The entry door to the therapy gym had an area on the upper right corner of the kickplate which had cracked and started to peel away from the wood. Additionally, the bottom right section of the door, below the kickplate, was worn and exposed rough wood. 2. Interview with the maintenance director on 6/29/17 at 8 AM confirmed the identified areas were in need of repair. He further revealed he relied on nursing staff to inform him when areas in resident rooms needed maintenance.	F 253	contractor to replace said broken/chipped tiles. 10. Therapy Room Entry Door – Facility Maintenance will install a new stainless steel kick plate. Identification: On or before the date of compliance room to room visual rounds will be done. Any findings will be repaired. Residents residing in the facility may be subject to this deficiency. Systematic Changes: The Maintenance Supervisor will conduct weekly visual rounds to ensure that the facility maintains a sanitary, orderly, and comfortable interior. Beginning 7/17/17 and up to the allegation date of compliance the Administrator/designee will in-service facility staff on communication of maintenance and 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:	8/4/17
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) 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"	F 274	The Maintenance Supervisor will monitor each resident room monthly specific to cracked/chipped floor tiles, damaged or loose kick plates, and damage to walls. Findings resulting in repair will be addressed immediately. On a quarterly basis the Maintenance Supervisor and/or designee will identify any patterns and if	

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F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) 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"	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 4 means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a significant change MDS assessment for 2 of 7 sample residents (#10, #35) who required that assessment. The findings were: 1. Review of the 7/19/16 annual MDS assessment revealed resident #35 was frequently incontinent of bladder and bowel and did not have weight loss. Review of the subsequent quarterly MDS assessment dated 10/21/16 showed the resident had declined to always incontinent of bladder and bowel, and experienced weight loss. During an interview on 6/29/17 at 7:25 AM the MDS coordinator stated the 10/21/16 MDS assessment should have been a significant change assessment because of the resident's increased incontinence, and weight loss. 2. Review of the 12/29/16 significant change MDS assessment showed resident #10 required limited assistance for bed mobility, transfers, dressing, and toilet use. Additionally, the resident was coded as requiring supervision for locomotion on and off the unit, and was continent of bowel. Review of the 4/4/17 quarterly MDS assessment showed the resident was newly coded as requiring extensive assistance for bed mobility, transfers, dressing, toilet use, and	F 274	Corrective Action: 1. On July 7, 2017 a significant change in status assessment was completed on resident #35. 2. On July 6, 2017 a significant change in status assessment was completed on resident #10. 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. Further, the IDT team will monitor residents weekly during the facilities "Fall, Behavioral, Skin, and Weight Management Meeting" that are triggering in more than one area to see if the condition warrants a significant change. The Interdisciplinary Team has been in-serviced with regards to this process. The Director of Nursing/Designee will oversee process. Monitoring: The Minimum Data Set Nurse/Designee	8/4/17 8/4/17

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F 274	Continued From page 5 locomotion on and off the unit. Additionally, the resident was newly coded as being frequently incontinent of bowel. Interview with the MDS coordinator on 6/29/17 at 7:25 AM confirmed the resident's decline in multiple ADL areas and continence status indicated a significant change MDS assessment should have been completed.	F 274	will review resident records according to weekly Care Plan schedule to determine if there is a decline or improvement consistently 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.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is	F 278		

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F 278	Continued From page 6 subject to a civil money penalty or not more than $6,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the accuracy of the MDS assessment for 2 of 15 sample residents (#30, #61). The findings were: 1. Review of the significant change MDS assessment with an assessment reference date (ARD) of 5/18/2017 showed resident #61 had been marked as not having any falls since his/her prior assessment. However, a nurse's note dated 5/11/17 and timed 11 PM stated "Resident found sitting on floor between toilet and wall...resident assisted off floor and into bed." A nurses note dated 5/12/17 and timed 8:45 AM stated the resident's family member had been "notified of fall." Interview with the MDS coordinator on 6/29/17 at 7:25 AM confirmed that the significant change MDS assessment dated 5/18/17 for resident #61 should have included documentation of the fall occurring on 5/11/17. She stated information about falls was generally obtained from looking at the nurse's notes. 2. Review of the significant change MDS assessment with an assessment reference date (ARD) of 6/4/17 showed resident #30 did not have any behavioral symptoms (physical, verbal, or other). However, review of social services and nursing notes showed the resident threw his/her breakfast and was hitting and kicking staff on 5/30/17, was hitting staff on 5/31/17, and was swearing at staff on 6/4/17. During an interview	F 278	System Changes: The Interdisciplinary Team will review the accuracy of the assessment each quarter following Resident Care Plan Schedule. Additionally the IDT team will track behaviors and falls and report during the facilities weekly "Fall, Behavioral, Skin, and Weight Management Meeting." This form will be completed and a copy given to each IDT member to ensure accuracy of MDS. The Interdisciplinary Team has been in-serviced with regards to this process. The Director of Nursing/Designee will oversee process. Monitoring: The Minimum Data Set Nurse/Designee will review resident records according to weekly Care Plan schedule to determine if the assessment completed reflects the resident's current status for the said period. 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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PRINTED: 07/13/2017
FORM APPROVED
OMB NO. 0938-0391

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	535048	A. BUILDING _____ B. WING _____	06/29/2017

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 278	Continued From page 7 on 6/29/17 at 7:25 AM the MDS coordinator stated the section on behaviors was not coded correctly. She stated the MDS assessment should have indicated behaviors occurred 1 to 3 days during the observation period.	F 278		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, review of logs, and staff interview, the facility failed to ensure staff monitored the dish machine to ensure sanitization for 1 of 1 dish machines. In addition, the facility	F 371	F371 The facility will ensure proper food procure, store/prepare/service is sanitary. Corrective Action: 1. On 6/26/17 dietary staff #1 was in-serviced on proper procedures to follow when dish machine is not testing at proper concentration. 8/4/17 2. On 6/28/17 dietary staff #2 was in-serviced on the required holding temperature of food on steam table and also calibrating of thermometers. 8/4/17 3. On 6/29/17 the ceiling vents and sprinkler heads were cleaned by the CDM. 8/4/17 Identification: Residents residing at Worland Healthcare are at risk. Systematic changes: Starting on 06/26/17 and up to the allegation date of compliance the Certified Dietary Manager/ Designee will in-service dietary staff on monitoring and recording of dish machine sanitizer to ensure sanitizer concentration, ensure thermometers are calibrated and	

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	535048	A. BUILDING _____ B. WING _____	08/29/2017

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F 371	Continued From page 8 failed to ensure thermometers were calibrated and that staff were knowledgeable of holding temperatures for food in the steam table for 1 of 2 observations at the steam table. Furthermore, the facility failed to ensure ceiling vents and sprinkler heads were maintained in a clean manner in 1 of 1 main kitchens. The findings were: 1. Observation during the initial tour of the kitchen on 8/26/17 at 3:37 PM revealed dietary staff #1 was washing dishes in the dish room. Review of the posted log for the dish machine showed it was a chemical sanitizing machine and staff recorded the concentration of hypochlorite three times per day (each meal). Further review of the log showed no documentation for the breakfast or lunch meal that day (8/26/17). Upon request, dietary staff #1 tested the concentration of the dish machine solution using test strips. The results were less than 50 parts per million (ppm). The staff person stated the concentration was not at least 50 ppm, but then continued to remove dishes from the dish machine, and put dirty dishes in the machine to wash (did not take corrective action). The surveyor then brought the dish machine issue to the attention of the certified dietary manager (CDM), who verified the concentration was less than 50 ppm. The CDM then primed the machine, had the staff person change the bucket of solution, and then re-tested the solution which showed it was now at least 50 ppm. At that time, the CDM verified there lacked documentation on the log for the breakfast and lunch meals for that day. On 8/29/17 at 9:47 AM the CDM stated staff were instructed to prime the machine and check the sanitizer bucket if they were getting less than 50 ppm when testing the concentration. She stated if that didn't work, staff should inform her or the maintenance supervisor.	F 371	knowledge of holding temperatures, and regular cleaning of vents and sprinkler heads. An attendance sheet will be reconciled with an active staff roster and those staff unable to attend will be provided 1:1 education. Monitoring: The Certified Dietary Manager or Designee will complete random sanitizer concentration checks and review of recorded log 3 times a week for one month, then weekly and as needed to identify concerns regarding dish machine sanitizer concentration. The Certified Dietary Manager or Designee will conduct random thermometer calibration tests weekly and review recorded log, then bi-weekly for a month, then monthly and as needed to identify concerns regarding calibration. The cleaning of vents and sprinkler heads will be added to a bi-weekly cleaning schedule and Certified Dietary Manager will perform random monthly checks to ensure cleanliness. 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 9 Review of the Food Code 2013, U.S. Public Health Service, FDA, 4-701.11 Hot Water and Chemical, "After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED in...(C) Chemical manual or mechanical operations, including the application of SANITIZING chemicals by immersion, manual swabbing, brushing, or pressure spraying methods, using a solution as specified under 4-501.114. Contact times shall be consistent with those on EPA-registered label use instructions by providing: (1) Except as specified under Subparagraph (C)(2) of this section, a contact time of at least 10 seconds for a chlorine solution specified under 4-501.114 (A), (2) A contact time of at least 7 seconds for a chlorine solution of 50 mg/L that has a pH of 10 or less and a temperature of at least 38 degrees C (100 degrees F) or a pH of 8 or less and a temperature of at least 24 degrees C (75 degrees F)..." 2. Observation of the meal in the assisted dining room on 6/27/17 at 11:57 AM revealed dietary staff #2 took temperatures of the food on the steam table. The staff person recorded the temperature of the pureed chicken as 130 degrees and the pureed dumplings as 125 degrees on the food temperature log. The staff person prepared to serve the food. The surveyor asked her what the requirement was for holding temperature of food on the steam table and she stated "I don't have with me," and told the surveyor that information would be in the kitchen. The surveyor suggested the staff person call the CDM for instructions. At 12:17 PM the CDM used a different thermometer to take the temperature of the food, which was 148 degrees and 154 degrees for the two food items. The CDM stated	F 371		

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F 371	Continued From page 10 that maybe the first thermometer used needed to be calibrated. At 12:25 PM the CDM stated "I had to calibrate the other thermometer." During an interview on 6/29/17 at 9:47 AM the CDM stated dietary staff #2 was new and "panicked." She stated they calibrate thermometers once per week, but did not have any documentation related to that. Review of the Food Code 2013, U.S. Public Health Service, FDA, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding, showed "(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under 3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) at 57 degrees C (Celsius) (135 degrees F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11 (B) or reheated as specified in 3-403.11 (E) may be held at a temperature of 54 degrees C (130 degrees F) or above, or (2) at 5 degrees C (41 degrees F)." Further review of the Food Code 2013, 4-502.11 Good Repair and Calibration, revealed "FOOD TEMPERATURE MEASURING DEVICES shall be calibrated in accordance with manufacturer's specifications as necessary to ensure their accuracy." 3. Observation in the main kitchen on 6/27/17 at 11:02 AM revealed 2 of 2 ceiling vents and 5 of 6 sprinkler heads were visibly dusty/dirty. One of the ceiling vents was located above a tray of uncovered rolls. During an interview on 6/29/17 at 9:47 AM the CDM stated she was short-staffed in the kitchen and it had been about 3 weeks since the vents were cleaned.	F 371		

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F 371	Continued From page 11 Review of the Food Code 2013, U.S. Public Health Service, FDA, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, showed "NONFOOD-CONTACT SURFACES OF EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris."	F 371		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by; Based on observation and staff interview, the facility failed to remove 6 expired medications from 1 of 5 medication storage areas (300/400 unit medication room). The findings were: Observation on 6/28/2017 at 3:50 PM of the medication room for the 300/400 units showed there were 6 bottles of unopened aspirin 325 mg, each with an expiration date of 5/2017. Interview on 6/28/2017 at 4:00 PM with RN #1 confirmed the aspirin was expired and available	F 425	F425 The facility will provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each residents. The facility will remove expired medications from medication storage areas. Corrective Action: 1. On 6/29/17 the Assistant Director Of Nursing Removed and Destroyed the 6 bottles of unopened aspirin 325mg from the 300/400 unit Medication Room. Identification: On or before the date of compliance all storage areas that house medication will be gone through and expired medications will be removed and destroyed. Residents who reside at Worland Healthcare and Rehabilitation are at risk.	8/4/17

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F 425	Continued From page 12 for administration to residents.	F 425	Systematic Changes: Beginning July 17, 2017 and up to the allegation date of compliance the Director of Nursing and/or Designee will in-service Charge Nurses currently employed on the importance of checking dates and removing expired mediations from resident use. The Charge Night Nurse will do a monthly audit of all medications that will expire within the next month; the audit will be turned into Director of Nursing. An attendance sheet will be reconciled with an active staff roster and those licensed staff unable to attend will be provided 1:1 education. Monitoring: The Director of Nursing and/or Designee will do monthly rounds of medication rooms to ensure compliance. Issues identified will be tracked and corrected at that time, trends will be presented in Quality Assurance Performance Improvement by the Director of Nursing/Designee to ensure plan has been implemented, sustained, and evaluated for its effectiveness.	
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to:	F 441		

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F 425	Continued From page 12 for administration to residents.	F 425		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to:	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. Corrective Action: 1. On June 28, 2017 the Infection Control Nurse in-serviced CNA #1 on proper Catheter Bag handling and proper hand hygiene per Facility Policy. 2. One June 28, 2017 the Infection Control Nurse in-serviced CNA #2 on proper Catheter Care and proper hand hygiene per Facility Policy. 3. On June 28, 2017 the Infection Control Nurse began in-servicing all employees on proper hand hygiene during the passing of ice and handling residents' water mugs. Identification: Residents who reside at Worland Healthcare and Rehabilitation are at risk. Systemic Changes: Beginning June 28, 2017 and continuing up until the allegation date of compliance the Infection Control Nurse and/or	8/4/17 8/4/17 8/4/17

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F 441	Continued From page 13 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and policy and procedure review, it was determined the facility failed to follow proper infection control when handling elimination drainage bags for 1 of 3 sample residents (#61) with a drainage bag, and for 1 of 1 (#61) observation of peri-care with gloves. Additionally, the facility failed to follow proper infection control protocol for prevention of cross contamination for 1 random observation of	F 441	Designee will in service Licensed staff currently employed at facility on facility's Infection Control practices as they pertain to ensuring proper Catheter Bag handling, Catheter Care, and proper hang hygiene when doing catheter care, and proper hand hygiene when passing ice and handling resident's water mugs. An attendance sheet will be reconciled with an active staff roster and those licensed staff unable to attend will be provided 1:1 education. Monitoring: The Infection Control Nurse/Designee will complete visual rounds during ice pass time 3 times weekly for one month, then weekly for one month, then monthly and as needed thereafter to ensure staff is providing sanitary hand hygiene. The Infection Control Nurse/Designee will complete visual rounds during catheter care 3 times weekly for one month, then weekly for one month, then monthly and as needed thereafter to ensure staff is providing sanitary catheter bag handling, catheter care, and proper hand hygiene in between care. Issues identified will be tracked and corrected at that time, trends as well as infection control reports will be presented in Quality Assurance Performance Improvement by the Infection Control Nurse/Designee to ensure plan has been implemented, sustained, and evaluated for its effectiveness.	

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F 441	Continued From page 14 providing ice to residents. The findings were: 1. Observation on 6/27/17 at 9:30 AM showed resident #61 received assistance from CNA #1 to transfer from a wheelchair to a recliner. During the transfer, the CNA removed the resident's catheter drainage bag and tubing from the wheelchair using her bare hands and placed the bag on the floor. After transferring the resident, the CNA then pulled the catheter bag across the floor, and placed it into a plastic tub on the floor. Without washing her hands the CNA then touched the resident's water mug, soda bottle, remote control and wheelchair handles. 2. Observation on 6/27/17 at 11:18 AM showed resident #61 received pericare from CNA #2 in the resident's bathroom. While wearing gloves, the CNA cleaned feces off of the resident using disposable wipes. While wearing the same gloves, the CNA then used other disposable wipes to provide catheter care, touching the catheter tubing with the potentially contaminated gloves. 3. Observation on 6/27/17 between 10:30 AM and 10:40 AM showed CNA #1 was putting ice in residents' room water cups. The following concerns were identified: a. At room 405 the CNA took both residents' cups out of the room at the same time, handled both mugs with both hands including removing lids without sanitizing in between, filled them with ice, and replaced the mugs back in the room. There was no hand sanitizing before entering the next room. b. At room 404 the CNA took both residents' cups out of the room at the same time, handled both mugs with both hands including removing	F 441		

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F 441	Continued From page 15 lids without sanitizing in between, filled them with ice, and replaced the mugs back in the room. c. At room 305 the CNA took both residents' cups out of the room at the same time, handled both mugs with both hands including removing lids without sanitizing in between, filled them with ice, and replaced the mugs back in the room. There was no hand sanitizing before entering the next room. d. At room 306 the CNA took both residents' cups out of the room at the same time, handled both mugs with both hands including removing lids without sanitizing in between, filled them with ice, and replaced the mugs back in the room. There was no hand sanitizing before entering the next room. e. At room 303 the CNA took a resident's cup out of the room , handled the mug with both hands including removing the lid, filled them with ice, and replaced the mug back in the room. There was no hand sanitizing before entering the next room. f. At room 304 the CNA took a resident's cup out of the room , handled the mug with both hands including removing the lid, filled them with ice, and replaced the mug back in the room. There was no hand sanitizing before entering the next room. 4. During an interview on 6/27/17 at 4:30 PM the infection control preventionist stated catheter drainage bags should not touch the floor. In addition, she stated staff should perform hand hygiene after handling the catheter bag. She further stated staff should remove gloves and perform hand hygiene when changing tasks, such as after cleaning a resident who was incontinent of bowel and before performing catheter care.	F 441		

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

PRINTED: 07/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	06/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORLAND HEALTHCARE AND REHABILITATION CENTER	1801 HOWELL AVENUE WORLAND, WY 82401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 16 On 6/27/17 at 5:06 PM the infection control preventionist stated staff should perform hand hygiene between handling residents' water mugs when passing ice. 5. Review on 6/28/17 of the facility policy titled "Hand Washing" revealed the instructions "Hand washing is one of the most crucial measures in reducing transmission of pathogens in healthcare settings. The use of gloves does not eliminate the need to wash hands. Hand washing is performed...before and after each resident contact...after contact with soiled or contaminated articles, such as articles that are contaminated with blood or body fluids...after contact with an object (e.g. door knobs) or source where there is a concentration of microorganisms such as mucous membranes, non-intact skin, body fluids, or wounds...handling food." 6. Review on 6/28/17 of the facility policy titled "Urinary Catheter & Drainage Bag Care" revealed the instructions "Wash hands before and after providing urinary catheter care...Do not allow the catheter bag, holder, tubing, or spigot to touch the floor."	F 441		