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 _____	08/01/2019

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 7/29/19 through 8/1/19. The following common abbreviations are used throughout this document: CDM- Certified Dietary Manager CNA- Certified Nurse Aide DON- Director of Nursing Services LPN- Licensed Practical Nurse MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such	F 565		9/6/19

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

Electronically Signed | 08/23/2019

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F 565	Continued From page 1 groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, review of resident council meeting minutes, review of the facility grievance log, and review of policies, the facility failed to act upon group grievances for 3 of 3 months of meeting minutes reviewed (May, June, July). The following concerns were identified: 1. Group interview with 9 residents on 7/30/19 at 11 AM revealed 2 of the 7 residents knew how to file a grievance, and the group felt the facility did not always follow up with them after voicing concerns. The following concerns were identified: a. Review of the resident council meeting minutes for May 2019 showed the resident council voiced concerns related to slow meal service, talking amongst staff during meal service, missing resident clothing, bugs in the facility, and a television not getting turned off. Review of the resident council meeting minutes for May 2019, June 2019, and July 2019 showed	F 565	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. F565 The facility will provide a resident or family group, if one exists, with private space; and take reasonable steps, with the	

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F 565	Continued From page 2	F 565		

no evidence the concerns were acted on or resolution was provided to the residents.

b. Review of the resident council meeting minutes for June 2019 showed there were concerns related to hand towels and wash cloths being available on hall 3, meal time, staff standing around while talking about family issues, and a television not being turned off. Review of the resident council meeting minutes for June 2019, and July 2019 showed no evidence the concerns were acted on or resolution was provided to the residents.

c. Review of the resident council meeting minutes for July 2019 showed the resident council voiced concerns related to missing clothes and a damaged toilet. Further review showed no evidence the concerns were acted on or resolution was provided to the residents.

d. Review of the grievance log for May 2019, June 2019, and July 2019 showed no evidence of the concerns from resident council or resolution related to the concerns.

e. Interview with the social services director (SSD) on 8/1/19 at 8:49 AM revealed issues brought up in resident council were to be given to the SSD by the activities director and he would complete a grievance form for each concern.

f. Interview with the activities director on 8/1/19 at 8:49 AM revealed when a concern was brought up in resident council she wrote them on a form and gave them to the department head responsible for the area of the concern. Further interview revealed the department head was responsible to follow up and resolve the concerns after they received it and the facility did not have a way to track concerns, outcomes, or responses to resident council concerns.

g. Review of the policy titled "Complaints/Grievances" last revised on 3/22/17 approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. The facility will provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. The facility will consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. The facility will be able to demonstrative their response and rationale for such response.

Corrective Action:
No individual residents were identified in the Statement of Deficiency. The facility is therefore unable to initiate corrective action for the residents who verbalized concerns to the survey team.

Identification:
Considering residents residing at facility can reasonably expect to have their complaints heard, and to have resolution attempts described to them, residents who reside at Worland are potentially at risk.

Systemic Change:
Monthly at Resident Council, Director of Activities/designee will personally receive complaints and suggestions from individuals present. Individual concerns will be documented on a grievance form and followed up via the facility grievance

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F 565	Continued From page 3 showed "...3. The staff member who receives a complaint (whether in person or by telephone) that is not immediately resolved...completes the Complaint/Grievance Report Form (the "Form") with assistance and input from the complaining person. The form should be signed by the individual filing the Grievance. If a written Complaint or Grievance is received, it is attached to the Form...14. A grievance is considered resolved when the resident or grievant is satisfied with the actions taken on his/her behalf..."	F 565	process. In addition, NHA/designee will review old business to validate the residents are aware of corrective action taken and evaluate if the corrective action was effective. Should it be determined that the action initiated by the facility is not meeting the needs of the residents, a new plan will be developed with resident input as appropriate and the efficacy will be reviewed again at the next meeting. Monthly, the Director of Activities/designee will document minutes from the Resident Council meeting to include old business, resolution and/or necessary continued action of group complaints, new business, and the facility□s grievance protocol. Monthly, each department manager will review the Resident Council Minutes and communicate appropriate corrective action plans to NHA. Monthly, department managers will attend the Resident Council meeting when invited by the resident group. Should a department leader be unable to attend, an appropriate designee will be appointed for that meeting. The presence of a designee will be explained to the residents and documented in the minutes. Prior to the date of compliance, department managers will be re-inserviced by NHA regarding the facility□s protocol for responding to resident complaints voiced in Resident Council, via the grievance protocol, and informally. Prior to the date of compliance, employees will be re-inserviced by NHA/designee regarding the facility□s protocol for responding to resident complaints and for reporting complaints to	

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F 565	Continued From page 4	F 565	the leadership staff via the grievance forms and/or 24-hour report form. Attendance sheets will be kept and reconciled with staff roster for those who are to be attending and staff members who were not present for in-service will be provided 1:1 reeducation. Monitoring: Each business day for 3 months, NHA/designee will follow-up on outstanding grievances to validate corrective action is in progress and that resolution will be communicated to the complainant. NHA/designee will review grievance trends, including outstanding group issues which require more than one month to reach resolution, with the QAPI Committee for three months and until the committee deems it prudent to receive a report less often.	
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services	F 582		9/6/19

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F 582	Continued From page 5 specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 582	F582	

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F 582	Continued From page 6 interview, the facility failed to ensure the Notice to Medicare Provider Non-coverage (NOMNC) was issued to 1 of 3 sample residents (#264) reviewed. The findings were: Review of the medical record showed resident #264 had a planned discharged on 3/28/19 and there was no evidence the NOMNC was provided and signed. Review of the discharge evaluation from a care conference on 3/25/19 at 13:30 showed the discharge date was set to occur on 3/28/19 at 9:30 AM. Interview with MDS coordinator on 7/31/19 at 2:32 PM confirmed the NOMNC was not given. The MDS coordinator believed the notice was not required because the resident chose to discharge to the community.	F 582	The facility will inform each Medicare resident before, or at the time of admission, and periodically during the resident□s stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility□s per diem rate. Resident #264 discharged Identification: Residents who reside at Worland Healthcare and Rehabilitation are at risk. Systematic Changes: On August 21, 2019 the Administrator and MDS Coordinator were in-serviced by the Regional Account Manager and the Corporate Medicare Specialist on when a NOMNC is necessary. Beginning August 21, 2109 all discharges that are planned and part of the discharge process will receive a NOMNC 72 hours prior to discharge. Monitoring: The Administrator/Designee will monitor discharges as discharge orders are obtained to ensure that NOMNC□s are administered appropriately. Issues identified will be tracked and corrected at that time, trends will be presented in the monthly Quality Assurance Performance Improvement by the Administrator/Designee to ensure plan has been implemented, sustained, and evaluated for its effectiveness.	

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F 585	Continued From page 7	F 585		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business	F 585		9/6/19

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address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement

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F 585	Continued From page 9 as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, medical record review, review of the facility grievance log, and policy review, the facility failed to ensure a process for grievance resolution for 2 of 5 sample residents (#14, #23) with reported grievances. The following concerns were identified: 1. Group interview with 9 residents, which included resident #14, on 7/30/19 at 11 AM revealed 2 of the 7 residents knew how to file a grievance and the group felt the facility did not always follow up with them after voicing concerns. Resident #14 indicated s/he had filed a grievance related to his/her toilet that took "2 months" to fix and s/he had to talk to 3 different people before anything was completed. The following concerns were identified: a. Review of the grievance log showed no evidence of a grievance filed by resident #14. b. Interview with the administrator on 8/01/19	F 585	F585 The facility will make information on how to file a grievance ore compliant available to the resident. The facility will establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents□ rights. Corrective Action: Resident□s #14□s toilet was fixed on 7/26/19. Facility followed up with Resident #14 regarding her grievance on 8/1/19, she had no complaints. Resident #23 was interviewed regarding the concern related to her room on 8/1/19 and a grievance was documented. The resolution was that she loves her room and roommate, just wished for the blinds to be open and privacy curtain to be pulled back when able. Follow-up interview on 8/19/19 revealed that staff is	

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at 9:30 AM revealed she was aware of the resident's concern, and she stated the concern should have been filed as a grievance.

c. Interview with the social services director on 8/01/19 at 8:25 AM revealed he did not recall any complaints of the toilet being broken.

2. Interview with resident #23 on 7/30/19 at 9:50 AM revealed the resident felt his/her room was dark and it made him/her feel "closed in." Observation at that time showed the resident was sitting in a recliner with a closet on his/her right side and the bed on his/her left side. A curtain was pulled in the center of the room and the window blinds were closed. Interview with the resident on 7/31/19 at 4:08 PM revealed the resident had previously reported concerns about the room to a nurse and had spoken with the social services director about it "4 or 5 months ago." The following concerns were identified:

a. Review of the grievance log showed no evidence of a grievance filed by resident #23.

b. Interview with the social services director on 8/1/19 at 8:25 AM revealed he was not aware the resident had concerns with his/her room.

3. Interview with the social services director on 8/1/19 at 8:25 AM revealed grievance resolution should occur within 5 days. He then confirmed the forms were available, but not within reach of residents who were wheelchair-bound.

4. Review of the policy titled "Complaints/Grievances" last revised on 3/22/17 showed "...3. The staff member who receives a complaint (whether in person or by telephone) that is not immediately resolved...completes the Complaint/Grievance Report Form (the "Form") with assistance and input from the complaining

getting better at making sure that blinds and privacy curtain are pulled.

A Resident council meeting was held on 8/13/19. Social Services and Ombudsman were guests and spoke to the grievance process and played Resident Rights Bingo. The grievance process was reviewed in detail from what a grievance is, to the paperwork that is filed and where it can be found, and to the follow-up and resolution. Residents in attendance did not voice any concerns during that time.

Identification:
Residents who reside at facility are at potential risk.

Systemic changes:
If a resident, a resident□s representative, or another interested family member of a resident has a complaint, a staff member should encourage and assist the resident, or person acting on the resident's behalf, to file a written grievance with the facility using the Grievance/Complaint report. Grievances and complaints may be submitted orally or in writing. The resident or the person filing the grievance or complaint on behalf of the resident should be encouraged to sign the grievance/complaint. The written grievance will be forwarded to the facility's administrator/designee within 24 hours of receipt. Upon receipt of a written grievance and/or complaint the Administrator/designee will refer it to the appropriate department head for

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F 585	Continued From page 11 person. The form should be signed by the individual filing the Grievance. If a written Complaint or Grievance is received, it is attached to the Form...14. A grievance is considered resolved when the resident or grievant is satisfied with the actions taken on his/her behalf..."	F 585	investigation. The department head will submit a written report of such findings to the Administrator within 3-5 working days of receiving the grievance and/ or complaint. The department head will follow up with the Resident/family member on the grievance. The investigation and report should be completed using a grievance/ complaint record. The resident council and or family council are additional forums for voicing complaints/grievances. Complaints/ grievances received from these councils will be acted upon in accordance with this procedure. Staff will be in serviced on the above process and an attendance sheet will be kept and reconciled with a staff roster to ensure attendance. Those unable to attend will be provided 1:1 reeducation Monitoring: The administrator/designee will document grievances daily on the Grievance/ Complaint QAPI log. This report will be tracked/ trended monthly as part of the facility's QAPI program. The administrator/designees will keep the grievances in a separate binder/folder. Further monitoring of system compliance will occur through resident interviews, resident/family council, and ombudsman feedback. Results will be tracked/ trended and reviewed by the facility's QAPI committee monthly to ensure plan had been initiated, sustained, and evaluated for its effectiveness.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		9/6/19

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	535048	A. BUILDING _____ B. WING _____	08/01/2019

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F 641	Continued From page 12 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure MDS assessments were accurate for 2 of 17 sample residents (#48, #62). The findings were: 1. Review of the medical record for resident #48 showed a preadmission screening and resident review (PASARR) was completed on 12/12/17 which indicated a referral for a PASARR level II. Further review showed the the PASARR Level II was completed on 12/28/17. Review of the 12/13/18 annual MDS assessment showed the resident had diagnoses which included depression and schizophrenia. Further review showed section A1500 was coded as no, which indicated the resident had not been evaluated by level II PASARR and determined to have a serious mental illness and/or mental retardation or a related condition. Interview with the MDS coordinator on 7/31/19 at 11:23 AM revealed the facility had identified PASARR Level IIs that were completed had not been accurately coded for residents; however, there was not a performance improvement plan in place and she was updating them on comprehensive assessments as they were due. Further interview confirmed the resident's annual MDS assessment was not coded correctly. 2. Observation on 7/30/19 at 10:20 AM showed resident #62 had a bruise that was healing under his/her right eye. Review of the 7/10/19 at 2:40 PM interdisciplinary team note showed the	F 641	F641 The facility will ensure accuracy of assessments and the assessment will accurately reflect the resident□s status. Corrective Action: On August 20, 2109 a modification was completed on the 12/13/18 Annual MDS showing that resident #48 does have a Level II completed. On July 31, 2019 a modification was completed on the 7/15/19 MDS showing that resident #62 did have significant change due to a fall with a major injury. Identification: On or before the date of compliance, residents that have a PASARR Level II will be reviewed to ensure that A1500 is coded yes on MDS. Residents that have had a major injury in the last 3 months will be reviewed to ensure that a significant change MDS was completed. If a modification to the assessment is determined necessary the assessment will be completed. Residents who reside in the facility are found to be potentially affected. System Changes: The Interdisciplinary Team will review the accuracy of the assessment each quarter following Resident Care Plan Schedule.	

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F 641	Continued From page 13 resident had a fall on 7/7/19. The fall required the resident to be transferred to the emergency department, and the resident was then admitted to the hospital. Review of the radiology report dated 7/7/19 at 3:01 PM confirmed thoracic compression fractures of an uncertain age. The following concerns were identified: a. Review of the 7/15/19 significant change MDS assessment showed the resident had 1 fall with non-major injury. b. Interview with the MDS coordinator on 7/31/19 at 2:46 PM confirmed a fall with major injury should have been coded.	F 641	Additionally the IDT team will track PASARR Level II□s and falls with major injury 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.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		9/6/19

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F 755	Continued From page 14 §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and policy and procedure review the facility failed to ensure medications available for use were not expired in 1 of 3 medication storage units (hall 3-4 medication storage room). The findings were: 1. Observation on 7/31/19 at 3:23 PM showed the hall 3-4 medication storage room refrigerator had 3 promethazine hcl (anti-histamine, sedative, anti-nausea) 25 mg suppositories available for use that expired 6/2019. Continued review showed 10 hydrocortisone acetate (corticosteroid) 25 mg suppositories that had expired 6/2019. Interview at that time with RN #1	F 755	F755 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: On 7/31/19, 3 promethazine hcl 25mg suppositories and 10 hydrocortisone acetate 25mg suppositories were	

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F 755	Continued From page 15 confirmed the medications were available for resident use and were expired. 2. Interview on 7/31/19 at 3:32 PM with DON revealed it was the facility expectation for nurse staff to remove expired medications from use when the medication had expired. 3. Review of the policy and procedure "LTC [long term care] Facility's Pharmacy Services and Procedures Manual" last revised 7/23/19 showed "...17. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medication..."	F 755	removed from the 3-4 medication storage room refrigerator. 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. Systematic Changes: Beginning August 19, 2019 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.	

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F 803	Continued From page 16	F 803		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to follow the menu related to portion sizes for 1 of 1 meal service observation (noon meal on 7/31/19). The findings were: Observation of the noon meal service in the secure unit on 7/31/19 at 11:41 AM showed CNA #1 was serving the food. When resident #33 was	F 803	F803 Menus will meet the nutritional needs of residents. Correction: The correct portion sizes will be communicated to nursing staff serving in the Secure Unit to ensure correct portions	9/6/19

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F 803	Continued From page 17 served s/he received 1 baked chicken leg and the side dishes. The following concerns were identified: a. Interview with CNA #1 at that time revealed she was uncertain what the serving size was for the pieces of chicken. On 7/31/19 at 11:56 AM the staff called to the kitchen and it was verified the serving size for the chicken was 2 pieces if a leg/wing/thigh or 1 breast piece. b. Continued observation showed resident #33 was not offered the second piece of chicken. c. Interview with CNA #1 on 7/31/19 at 12:09 PM revealed she had wanted to serve the remainder of the residents first, and by then the resident had left the table. d. Review of the resident's menu card showed a regular diet with no portion size modifications. The card showed 3 oz of "Citrus Chicken Breast" was the planned item and portion size. e. Interview with the CDM on 7/31/19 at 2:05 PM stated they don't always use the product that is on the sheet, and more education related to portion size and communication for those serving in the unit was needed.	F 803	are given to the residents. Identification: Residents residing in the facility have the potential to be affected by the alleged deficiency. Systemic Changes: On, or prior to the allegation of compliance, the Dietitian/Designee will re-educate the dietary staff and nursing staff on following all menu extensions, specifically portion sizes. The menus will be reviewed prior to meal service by the cook on the direct tray line. The Food Service Director/Designee will review full menu extensions with staff prior to meal delivery and complete the CQI FSD monitor sheet three times a week. The Food Service Director/Designee will obtain approval for any menu changes and updates will be reviewed and signed by the Dietitian. The menus and alternates will be reviewed weekly by the Dietitian with the Food Service Director and as needed. Monitoring: The Food Service Director/designee will monitor meal service 3 times a week for one month, and then weekly for one month and as needed to ensure menus are followed. Issues identified will be corrected at that time. The systematic changes will be monitored by the NHA/Designee monthly for 3 months and as needed at the QAPI meeting to ensure compliance.	

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F 812	Continued From page 18	F 812		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of food temperature logs, and review of the U.S. Public Health Service Food Code, the facility failed to ensure pureed foods were held at an appropriate temperature for 9 of 31 days reviewed. In addition, the hood vents in the kitchen were in need of cleaning. The findings were: Review of the hall 4 daily food temperature sheets for July 2019 showed there were 9 days when pureed foods were recorded below the hot holding temperature of 135 degrees Fahrenheit (F). The following concerns were identified: a. On 7/5/19 the pureed lunch vegetables	F 812	F812 The facility will store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Corrective Action: The hood vents in the kitchen were replaced with new ones on 8/15/19. On 8/1/19 the FSD/Dietician re-educated the dietary staff on ensuring food is only served when it is within the proper temperature ranges. On or before the allegation of compliance the Dietician/Designee will reeducate the staff	9/6/19

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F 812	Continued From page 19 were recorded as 54 degrees F. b. On 7/12/19 the pureed breakfast meat was recorded as 126 degrees F, and the pureed breakfast eggs were recorded as 130 degrees F. c. On 7/13/19 the pureed breakfast meat was recorded as 128 degrees F and the pureed lunch vegetable as 61 degrees F. d. 7/14/19 showed the pureed egg was recorded as 131 degrees F and the pureed lunch vegetable as 123 degrees F. e. 7/15/19 showed the pureed lunch starch was recorded as 127 degrees F. f. On 7/19/19 the pureed lunch meat was recorded as 130 degrees F and the pureed vegetable as 125 degrees F. g. On 7/22/19 the pureed breakfast meat was recorded as 124 degrees F, the egg as 123 degrees F and the pureed lunch meat as 110 degrees F. h. 7/27/19 showed the pureed breakfast egg was recorded as 130 degrees F, and the pureed lunch meat as 119 degrees F and the pureed starch as 134 degrees F. i. On 7/28/19 the pureed breakfast meat was recorded as 130 degrees F. 2. Observation on 7/29/19 at 4:28 PM and on 7/31/19 at 11:06 AM showed the removable hood vents above the range were in need of cleaning. There was a dark-colored accumulation of grease and dust visible in the vents. 3. Interview with the CDM on 7/31/19 at 2:05 PM verified the vents were on the cleaning schedule for every 2 weeks and they may be in need of more frequent cleaning. Further, the manager stated the food temperatures sheets showed there was education required on the appropriate food holding temperatures.	F 812	on proper food temperatures Identification: Residents that reside at the facility are at risk Systemic changes: On or before the allegation of compliance the Food Service Manager/ Designee will in service dietary staff on food safety program specifically to food temperatures at time of service. Foods should not be served if they are outside the safe temperature ranges for potentially hazardous foods. Hot foods are to be kept at 135F or higher. An attendance sheet will be kept and reconciled with the active dietary staff roster and those unable to attend will be provided 1:1 reeducation. On or before the allegation of compliance the Dietician/Designee will reeducate the staff on ensuring hood vents are thoroughly cleaned per the cleaning schedule. An attendance sheet will be kept and reconciled with the active dietary staff and those unable to attend will be provided 1:1 re education. Monitoring: The FSD/ Designee conduct Kitchen sanitation rounds weekly for 3 months and then prn and will monitor meal service 3 times weekly and different meal times for 3 months and then prn to ensure food is being served at the proper temperatures Issues identified will be corrected at that time. These issues will also be tracked, trended and the dietary manager will present the results in a report by the	

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F 812	Continued From page 20 4. According to Food Code 2017, U.S. Public Health Service: 3-501.16 "(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 57oC (135oF) 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 54oC (130oF) or above; or (2) At 5ºC (41ºF) or less.	F 812	FSD/Designee to QAPI monthly for review and suggestions as needed.	