| 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 _____ | 03/12/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WORLAND HEALTHCARE AND REHABILITATION CENTER | 1901 HOWELL 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 176 SS=D | 483.10(n) SELF ADMINISTRATION OF DRUGS<br><br>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, and medical record review, the facility failed to ensure the interdisciplinary team (IDT) evaluated 1 (#18) of 2 sample residents who wished to self-administer medications. The findings were:<br><br>Observation on 3/10/09 at 10:40 AM revealed resident #18 kept a tube of Aquaphor ointment on the bedside table. During the observation, the resident stated s/he applied the ointment and wanted to keep it for personal use. Review of the medical record revealed an assessment by the IDT for self-administration of medications was lacking. Interview with the Minimum Data Set coordinator, the person responsible for completing the assessment, on 3/11/09 at 10:15 AM confirmed the assessment had not been completed. The coordinator stated she was unaware the resident had the medication in his/her room for self-administration. | F 176 | Preparation and execution of this plan of correction does not constitute an admission or agreement by this provides of the truth of the facts alleged or conclusions set forth in statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposed and correlate with the most recently contemplated or accomplished corrective action and do not necessarily correspond chronologically to date the facility is of the opinion it was in compliance with requirements of participation or that corrective action was necessary.<br><br>F176<br>The facility will ensure that individual residents may self-administer drugs if the interdisciplinary team has determined that this practice is safe.<br><br>This requirement will be met as evidenced by: | |
| F 272 SS=E | 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive | F 272 | 1. Upon admission every new resident will be informed of the right to self administer medications.<br>2. When a resident expresses the desire to self administer any medications a Self-Administration Assessment and | 04/26/09<br><br>04/26/09 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lin Johnson Can — TITLE: Administrator — (X6) DATE: 04/17/09

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.

This POC accepted w all additions & corrections per phone conversation w/ Bayeon, DON & Betty Nelson RN, State Health Surveyor on 4/17/09 @ 1526.

| 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 _____ | 03/12/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WORLAND HEALTHCARE AND REHABILITATION CENTER | 1901 HOWELL 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 176 SS=D | 483.10(n) SELF ADMINISTRATION OF DRUGS<br><br>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, and medical record review, the facility failed to ensure the interdisciplinary team (IDT) evaluated 1 (#18) of 2 sample residents who wished to self-administer medications. The findings were:<br><br>Observation on 3/10/09 at 10:40 AM revealed resident #18 kept a tube of Aquaphor ointment on the bedside table. During the observation, the resident stated s/he applied the ointment and wanted to keep it for personal use. Review of the medical record revealed an assessment by the IDT for self-administration of medications was lacking. Interview with the Minimum Data Set coordinator, the person responsible for completing the assessment, on 3/11/09 at 10:15 AM confirmed the assessment had not been completed. The coordinator stated she was unaware the resident had the medication in his/her room for self-administration. | F 176 | Consent Form will be completed by a licensed professional.<br>3. The Interdisciplinary Team will make a decision (based on the assessment) whether or not a resident is capable/competent to self-administer medication.<br>4. Order will be obtained from primary physician to allow self-administration of medication and if appropriate to keep medication at beside.<br>5. If a resident is self-administering medication it will be added to the Medication Administration Record or the Treatment Administration Record as appropriate. Nurses to monitor daily.<br><br>Resident #2 had an assessment completed on 3/30/09 and is determined capable of self-administration of medication. An order was obtained to allow the self-administration of medications (Aquaphor & Eucerin Cream) and to keep at bedside.<br><br>ID of Residents: All residents have the ability to be affected. All rooms to be checked by nursing to ensure no medications/ointments/etc. in rooms. If found, will be assessed by IDT to be | 04/26/09<br><br>04/26/09<br><br>04/26/09 |
| F 272 SS=E | 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive | F 272 | Systems: Licensed Personnel to be in-serviced on 4/20/09: Will address the need to assess for medications, which resident wished to keep at | |

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

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

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 _____ | 03/12/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WORLAND HEALTHCARE AND REHABILITATION CENTER | 1901 HOWELL 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 176 SS=D | 483.10(n) SELF ADMINISTRATION OF DRUGS<br><br>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, and medical record review, the facility failed to ensure the interdisciplinary team (IDT) evaluated 1 (#18) of 2 sample residents who wished to self-administer medications. The findings were:<br><br>Observation on 3/10/09 at 10:40 AM revealed resident #18 kept a tube of Aquaphor ointment on the bedside table. During the observation, the resident stated s/he applied the ointment and wanted to keep it for personal use. Review of the medical record revealed an assessment by the IDT for self-administration of medications was lacking. Interview with the Minimum Data Set coordinator, the person responsible for completing the assessment, on 3/11/09 at 10:15 AM confirmed the assessment had not been completed. The coordinator stated she was unaware the resident had the medication in his/her room for self-administration. | F 176 | bedside and/or self-administration of medication as well as obtaining a physician order for those who have been assessed as safe to do so.<br><br>Monitoring: Director of Nursing, Assistant Director of Nursing and/or designee to monitor for medications in room at random checks no less than bi-monthly. Any issues will be addressed immediately.<br><br>Quality Assurance: Results of monitoring will be reported quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions. | |
| F 272 SS=E | 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive | F 272 | | |

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

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

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 _____ | 03/12/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WORLAND HEALTHCARE AND REHABILITATION CENTER | 1901 HOWELL 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 176 SS=D | 483.10(n) SELF ADMINISTRATION OF DRUGS<br><br>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, and medical record review, the facility failed to ensure the interdisciplinary team (IDT) evaluated 1 (#18) of 2 sample residents who wished to self-administer medications. The findings were:<br><br>Observation on 3/10/09 at 10:40 AM revealed resident #18 kept a tube of Aquaphor ointment on the bedside table. During the observation, the resident stated s/he applied the ointment and wanted to keep it for personal use. Review of the medical record revealed an assessment by the IDT for self-administration of medications was lacking. Interview with the Minimum Data Set coordinator, the person responsible for completing the assessment, on 3/11/09 at 10:15 AM confirmed the assessment had not been completed. The coordinator stated she was unaware the resident had the medication in his/her room for self-administration. | F 176 | | |
| F 272 SS=E | 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive | F 272 | F272<br>The facility will ensure comprehensive assessments are completed in all areas related to Minimum Data Set as appropriate.<br><br>This requirement will be met as evidenced by:<br><br>1. The Comprehensive Assessment for resident #2 for Minimum | 04/26/09 |

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

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

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 _____ | 03/12/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WORLAND HEALTHCARE AND REHABILITATION CENTER | 1901 HOWELL 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 272 | Continued From page 1<br>assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure comprehensive assessments were completed in a variety of areas related to the Minimum Data Set (MDS) assessments for 8 (#2, #8, #12, #18, #23, #29, #45, #60) of 15 sample residents. The findings were:<br><br>1. Review of the 10/1/08 significant change Minimum Data Set (MDS) assessment for resident #2 revealed there were multiple areas that triggered for a comprehensive assessment. | F 272 | Data Set dated 10/01/08 was completed on 03/30/09 to address the areas of mood, behavior, and psychotropic drug use.<br>2. The Comprehensive Assessment for resident #8 for Minimum Data Set dated 10/18/08 was completed on 03/30/09 to address the areas psychosocial well-being, mood, state, and behavioral symptoms.<br>3. The Comprehensive Assessment for resident #12 was completed on 04/01/09 to address causes and contributing factors of resident's incontinence.<br>4. The Comprehensive Assessment for resident #18 was completed on 03/11/09 to address causes and contributing factors for potential dehydration.<br>5. The Comprehensive Assessment for resident #23 was completed on 03/30/09 to address psychotropic drug use.<br>6. The Comprehensive Assessment for resident #29 was completed on 03/30/09 to address the used of psychotropic drugs.<br>7. The Comprehensive Assessment for resident #45 was completed to address the resident's vision and psychotropic drugs.<br>8. The Comprehensive Assessment for resident #60 was completed to address the area of delirium. | 04/26/09<br>04/26/09<br>04/26/09<br>04/26/09<br>04/26/09<br>04/26/09 |

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 _____ | 03/12/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WORLAND HEALTHCARE AND REHABILITATION CENTER | 1901 HOWELL 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 272 | Continued From page 2<br>Further review showed there were no comprehensive assessments to address the areas of mood, behavior, and psychotropic drug use. Interview with the MDS coordinator on 3/12/09 at 9:05 AM confirmed the assessments were not comprehensive.<br><br>2. Review of the 10/18/08 admission MDS assessment for resident #8 revealed the areas of psychosocial well-being, mood state, and behavioral symptoms were among those that triggered and required additional comprehensive assessments. Review of the medical record showed the areas were not comprehensively assessed. Interview with the MDS coordinator on 3/12/09 at 9:05 AM confirmed the assessments were not comprehensive.<br><br>3. According to the 1/24/09 quarterly MDS assessment, resident #12 was frequently incontinent of bowel and occasionally incontinent of bladder. Review of information provided by the facility showed the causes and contributing factors of the resident's incontinence were not addressed. After reviewing the information on 3/11/09 at 10:45 AM, the MDS coordinator confirmed the assessments were not comprehensive.<br><br>4. Review of the 1/14/09 admission MDS assessment showed resident #18 required a comprehensive assessment of his/her hydration status. Review of the Resident Assessment Protocol (RAP) summary showed that assessment was completed by dietary. However, the information provided by dietary showed the resident required between 1200 and 1985 milliliters of fluids per day with 360 to 540 ml being provided at every meal. A comprehensive | F 272 | ID of Residents: All residents have the ability to be affected. Charts will be checked weekly until all resident charts are reviewed initially. Corrections will be made as indicated<br><br>Systems: Members of the Interdisciplinary Team in-serviced on 04/03/09 about need to complete comprehensive assessments in all areas related to Minimum Data Set.<br><br>Monitoring: Completed Minimum Data Sets will be reviewed by Care Plan Team at weekly meeting to ensure comprehensive assessments completed as appropriate. Director of Nursing and/or designee to monitor at random no less than monthly. Any issues noted will be addressed immediately.<br><br>Quality Assurance: Results of monitoring will be reported quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions. | |

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 _____ | 03/12/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WORLAND HEALTHCARE AND REHABILITATION CENTER | 1901 HOWELL 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 272 | Continued From page 3<br>assessment identifying the causes and contributing factors for potential dehydration had not been provided. Interview with the MDS coordinator on 3/11/09 at 10:15 confirmed a comprehensive assessment was lacking.<br><br>5. Review of the 7/10/08 annual MDS assessment for resident #23 revealed further assessment was required for psychotropic drug use. Review of the attached RAP review report for psychotropic drug use revealed it was not a comprehensive assessment. During an interview on 3/12/09 at 9 AM, the MDS coordinator stated it was not a comprehensive assessment.<br><br>6. Review of the 3/18/08 annual MDS assessment for resident #29 revealed further assessment was required for psychotropic drugs. However, review of the attached RAP review report for psychotropic drug use showed a comprehensive assessment was not completed. During an interview on 3/12/09 at 9 AM, the MDS coordinator confirmed the assessment was not comprehensive.<br><br>7. Review of the 4/10/08 annual MDS assessment for resident #45 revealed further assessment was needed for vision and psychotropic drugs. Review of the attached RAP review report for psychotropic drug use showed it was not comprehensive. Review of section V, the section indicating the location of assessment information, showed the assessment for vision was located at "social services 4/5/08." However, review of the social services note dated 4/5/08 revealed vision was not addressed. During an interview on 3/12/09 at 9 AM, the MDS coordinator stated the psychotropic drug use RAP was not a comprehensive assessment. In | F 272 | | |

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 _____ | 03/12/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WORLAND HEALTHCARE AND REHABILITATION CENTER | 1901 HOWELL 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 272 | Continued From page 4<br>addition, she confirmed an assessment for vision was lacking.<br><br>8. Review of the 12/24/08 admission MDS assessment for resident #60 revealed a comprehensive assessment was needed related to the triggered area of delirium. Further review of the record showed the comprehensive assessment was lacking. Interview with the MDS coordinator on 3/12/09 at 9:05 AM confirmed the area of delirium was not addressed. | F 272 | | |
| F 278 SS=B | 483.20(g) - (j) RESIDENT ASSESSMENT<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a | F 278 | F278<br>The assessment will accurately reflect eh resident's status.<br><br>This requirement will be met as evidenced by:<br><br>1. The Minimum Data Set for resident #12 dated 01/24/09 was modified for accuracy on 03/18/09 to reflect no change in condition, rather than the inaccurate improvement. The Minimum Data Set dated 07/31/08 was modified for accuracy on 03/27/09 related to bladder incontinence. The Minimum Data Set dated 01/24/09 was updated for accuracy on 03/19/09 related to inaccurate date signed for sections G, H, I, J, M, N, O, P, Q, R, & W in Section AA9.<br>2. The Annual Minimum Data Set dated 03/18/08 had a modification done on 03/27/09 to reflect accuracy for condition of skin. | 04/26/09<br><br>04/26/09 |

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 _____ | 03/12/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WORLAND HEALTHCARE AND REHABILITATION CENTER | 1901 HOWELL 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 278 | Continued From page 5<br>material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to assure the accuracy of the Minimum Data Set (MDS) assessments for 3 (#12, #29, #51) of 15 sample residents. The findings were:<br><br>1. Medical record review showed the facility coded resident #12 as requiring limited assistance with bed mobility on the 10/25/08 quarterly MDS assessment and extensive assistance on the 1/24/09 MDS assessment (a decline from 2 to 3). However, review of Section Q2, overall change in condition, showed that the resident's condition had improved on 1/24/09. Interview with the MDS coordinator on 3/11/09 at 10:45 AM revealed this was an inaccurate coding for the 1/24/09 assessment. In addition, after reviewing the nurse aide flow sheets, the MDS coordinator stated the resident was coded incorrectly for bladder incontinence on the 7/31/08 annual MDS assessment. Furthermore, during the same interview, the MDS coordinator verified that areas G, H, I, J, M, N, O, P, Q, R, and W in Section AA9 were signed and dated as finalized on 1/27/09; this was three days after the registered nurse (RN) coordinator affirmed on 1/24/09 that the assessment was complete.<br><br>2. Review of the 3/18/08 annual MDS assessment for resident #29 revealed the resident did not have any pressure ulcers. Furthermore, the resident was coded as not having a history of healed ulcers (section M). However, review of the attached Resident | F 278 | 3. The Annual Minimum Data Set dated 02/05/09 was updated by Registered Nurse Coordinator signing and dating section VB1 and 2 and Section VB3 and 4 to reflect that the RAP assessment was complete.<br><br>ID of Residents: All residents have the ability to be affected. Charts will be checked weekly until all resident charts are reviewed initially.<br><br>Systems: Members of Interdisciplinary Team in-serviced on 04/03/09 about need to insure Minimum Data Set coding, signatures, and dates are compete and accurate.<br><br>Monitoring Completed Minimum Data Sets will be reviewed by Care Plan Team at weekly meeting for prior week to ensure comprehensive assessments completed as appropriate. Director of Nursing and/or designee to monitor at random no less than monthly. Any issues noted will be addressed immediately.<br><br>Quality Assurance: Results of monitoring will be reported quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions. | 04/26/09 |

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 _____ | 03/12/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WORLAND HEALTHCARE AND REHABILITATION CENTER | 1901 HOWELL 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 278 | Continued From page 6<br>Assessment Protocol (RAP) review report for pressure ulcers revealed the resident "has had an open area on coccyx." During an interview on 3/12/09 at 9 AM, the MDS coordinator stated the MDS was not accurate for skin condition.<br><br>3. Review of the 2/5/09 annual MDS assessment for resident #51 revealed the RN coordinator did not sign or date that the RAP assessment process was complete (section VB1 and 2). In addition, there lacked a signature and date for the completion of the care planning process (section VB3 and 4). During an interview on 3/12/09 at 9 AM, the MDS coordinator stated the facility had a process in place to assure all assessments were signed, but that this one "slipped through." | F 278 | | |
| F 371 SS=F | 483.35(i) SANITARY CONDITIONS<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and review of in-service education reports, the facility failed to maintain an effective concentration of sanitizing solution for wiping surfaces. In addition, staff failed to ensure acceptable thawing practices were followed. The census at the time of survey was 58. The findings were: | F 371 | F371<br>The facility will procure food from sources approved or considered satisfactory by Federal, State, or Local authorities and store, prepare, distribute and serve food under sanitary conditions.<br><br>This requirement will be met as evidenced by:<br><br>1. A log was posted 04/17/09 with the accepted level of concentration of 50-100 parts per million ~~in kitchen~~ to ensure sanitizer water is tested for concentration of chlorine each time water is changed throughout the day. All dietary staff reminded that can only thaw food in cooler or under running cool water. | 04/26/09 |

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 _____ | 03/12/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WORLAND HEALTHCARE AND REHABILITATION CENTER | 1901 HOWELL 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 371 | Continued From page 7<br>1. Observation on 3/10/09 at 3:35 PM revealed a sanitizing sink was being used to hold sanitizing solution and wiping towels. Interview with cook #1 at that time confirmed the sanitizer in the solution was chlorine. The cook then stated she had not tested it, and there was no log kept for testing the solution. When tested at 3:45 PM the test strip showed the concentration was 10 parts per million (ppm) of chlorine. Further interview with cook #1 revealed she was unsure what the concentration should be. She stated when preparing the solution she just added a capful or two of bleach. Interview with the dietary manager on 3/10/09 at 3:45 PM revealed, and review of the printed instructions on the bottle of chlorine bleach confirmed, the chlorine sanitizing solution was to be 50 to 100 ppm. Review of in-service education reports showed the registered dietitian covered this topic on 12/18/08, and cook #1 was in attendance.<br><br>2. Observation in the kitchen on 3/10/09 from 3:35 PM to 5:15 PM revealed a tub containing a frozen pre-cooked turkey and a frozen pre-cooked ham sitting on a cart next to the preparation table. Interview with cook #1 at 3:55 PM revealed the ham and turkey were thawing. She stated her plan was to leave them out until the end of her shift. She was worried they would not thaw in time for a meal the next day if kept in the refrigerator. Interview with the dietary manager on 3/10/09 at 5:20 PM confirmed she was aware that food should not be thawed at room temperature. | F 371 | ID of Residents: All residents have the ability to be affected.<br><br>Systems: All dietary staff to be in-serviced by Dietary Manager and Dietician on Safe thawing practices to be followed by Safe Serve Food In-service by Sysco Representative and Dietician scheduled for 04/28/09. Dietary staff in-serviced 03/11/09 on correct concentration of sanitizer water.<br><br>Monitoring: Dietary Manager and Dietician to monitor no less weekly. Any issues to be corrected immediately.<br><br>Quality Assurance: Results of monitoring will be reported quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions. | |
| F 425<br>SS=D | 483.60(a),(b) PHARMACY SERVICES<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in | F 425 | F425<br>The facility will ensure medications are available when required for administration as ordered. | |

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 _____ | 03/12/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WORLAND HEALTHCARE AND REHABILITATION CENTER | 1901 HOWELL 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 425 | Continued From page 8<br>§483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>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.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of medical records, and staff interview, the facility failed to ensure medications were available when required for administration for 1 (#37) of 8 residents observed during medication passes. The findings were:<br><br>Observation showed registered nurse (RN) #4 prepared and administered medications to resident #37 on 3/10/09 at 7:17 AM. Reconciliation of the medication pass with the physician's orders showed the RN should have also administered acidophilus. Review of the medication administration record showed the medication was scheduled for administration at 8 AM and 5 PM. Interview with RN #4 at 7:43 AM that morning revealed acidophilus was a stock medication, and the facility was out of it. The RN further stated the director of nursing was ordering | F 425 | The requirement will be met as evidenced by:<br><br>Medication Acidolphilus was obtained from local pharmacy and available for the 5pm does. Medical Doctor notified of missed 8am dose.<br><br>ID of Residents: All residents have the ability to be affected.<br><br>Systems:<br>Medication to be ordered from Corporate Supplier weekly or when on hand supply is noted to be down to two bottles. If facility is unable to obtain from Corporate Supplier then will obtain from pharmacy. Licensed professionals to be in-serviced on 04/20/09 on need to notify Director of Nursing if new order obtained and medication not readily available in house so may be obtained from local pharmacy.<br><br>Monitoring: Director of Nursing, Assistant Director of Nursing and/or designee will randomly review new orders no less than weekly to ensure medication readily available. All issues will be corrected immediately.<br><br>Quality Assurance: Results of monitoring will be reported quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions. | 04/26/09 |