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 _____	C 03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORLAND HEALTHCARE AND REHABILITATION CENTER	1901 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 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 3/10/20 to 3/11/20. The survey was prompted by complaint intake WY00003033.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy review, the facility failed to ensure residents were free from physical abuse for 1 of 8 sample residents (#2). This failure resulted in harm to resident #2, who fell and sustained broken ribs after being hit on the back of the head by another resident. The findings were: Review of the 10/28/19 admission minimum data set (MDS) assessment showed resident #2 was admitted to the facility with diagnoses that included Alzheimer's disease, age-related osteoporosis, restlessness and agitation,	F 600	F600 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	8/11/20

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

Electronically Signed | 08/01/2020

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F 600	Continued From page 1 dementia with behavioral disturbance, and depressive episodes. The resident had a brief interview for mental status (BIMS) score of 99, indicating the resident was cognitively unable to complete the interview. Interview with CNA #1 on 3/11/20 at 12:58 PM revealed resident #2 liked to "get in everybody's business" which caused problems with other residents, and the staff tried to keep them separated. Interview with CNA #2 on 3/11/20 at 1:10 PM revealed resident #2 had a "couple of residents that [s/he] constantly picked at" and was hard to redirect. Interview with RN #1 on 3/11/20 at 1:33 PM revealed resident #6 had "a habit of being volatile." Further, RN #1 stated resident #2 upset people with "the nagging and bossing." Interview with RN #2 on 3/11/20 at 1:45 PM revealed resident #6 and resident #2 had a "love/hate relationship" were at one time "an item." Further, RN #2 revealed resident #2 became more "bossy" following the discontinuation of an anti-psychotic medication, and resident #6 did not like to be "bossed." Interview with the nursing home administrator on 3/11/20 at 2:11 PM revealed resident #6 did have increased behavioral outbursts, and his/her temper was more easily "set off." The administrator stated resident #2 did seek out specific individuals to "pick at." The following concerns were identified: 1. Review of the progress note dated 2/23/20 and timed 6:57 AM showed resident #6 hit resident #2 on the back of the head with a closed fist. Resident #2 lost his/her balance and tried to catch him/herself on a chair. The note further showed the resident "Must have hit [his/her] right back by lower ribs against armrest of wooden chair."	F 600	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. Correction: Resident #6 no longer resides at facility. Resident #2's behavioral care plan was evaluated by the IDT on 3/11/2020 and it was updated to include interventions to address her behaviors that may affect others. Her medication regimen was reviewed and updated by her primary Physician. Identification: Residents who reside on the Special Care Unit may be subject to this alleged deficient practice. Systemic Changes: The NHA/Designee provided re-education to the Interdisciplinary Care Team 3/11/2020 on the Abuse Prohibition and Prevention Program, with a focus on specifically ensuring Residents are Free from abuse along with handling dementia residents and associated behaviors. On or before the alleged date of compliance, facility staff will be re-educated by the DON/Designee on (1) Abuse Prohibition and Prevention Program, specifically ensuring Residents are free from abuse. (2) Changes to Resident #2's care and how to respond and redirect if she is exhibiting actions that can be annoying to others. An attendance sheet will be utilized at the	

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F 600	Continued From page 2 2. Review of a progress note dated 2/23/20 and timed 10;12 AM showed the resident was sent to the emergency room (ER) via facility van in "fair condition." The ER notified the facility the resident was being admitted to the hospital with 3 broken ribs. 3. Review of progress notes for resident #6 showed documentation of aggressive behavior on 1/30/20, 2/2/20, 2/9/20, and 2/13/20. a. Review of the care plan titled "I get confused due to a diagnosis of dementia" showed it was initiated 8/17/18 and last revised on 9/23/19. There was no evidence of updates related to identified behaviors. b. Review of the care plan titled "the resident has impaired cognitive function related to dementia" showed it was initiated on 11/27/18, and last revised on 7/2/19. There was no evidence of updates related to identified behaviors. c. Review of the care plan titled "admitted on an antipsychotic medication for behavior management related to my dementia and poor coping mechanisms" showed it was initiated 6/24/18 and late revised 7/2/19. There was no evidence of updates related to identified behaviors. 4. Review of progress notes for resident #2 showed documentation of behavior that caused agitation in other residents on 1/23/20, 1/28/20, 2/6/20, 2/7/20, 2/9/20 and 2/11/20. a. Review of the care plan titled "The resident has impaired cognitive function/dementia or impaired thought process related to dementia" showed it was initiated on 10/29/10. There was no evidence of updates related to identified behaviors. b. Review of the care plan titled "I have the potential for alteration in my mood and	F 600	re-education and staff currently employed will be re-educated. Going forward, the education will be provided upon hire, annually, and as needed thereafter. Facility staff will follow facility policy and procedure as prescribed in facility Abuse Prohibition and Prevention Program. Resident #2 will continue to be monitored by whom and how often) along with behavioral notes and care plan revisions to facilitate her care. The IDT will review her response to the changes in her plan of care monthly and as needed to identify her response to the changes. Currently no negative outcomes have been identified. Monitoring: The DON/Designee will monitor the effectiveness of the systematic changes through review of the 24-hour report during the morning stand up meeting 4 days/week for 4 weeks, then weekly for 1 month and then as needed. The NHA/Designee will monitor compliance monthly for 3 months and as needed at the facility QAPI meetings.	

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F 600	Continued From page 3	F 600		

behavior. At times I exit seek, I tell people that I am only here for a little while and that I need to go home to take care of things. I need the keys to my care so I can leave. Resident becomes upset when she feels like she is not allowed to leave or held prisoner. My court appointed guardian has place me here permanently due to my unsafe behaviors at home" showed it was initiated on 11/18/19. There was no evidence of updates related to identified behaviors.

5. Review of the facility policy titled "Abuse, Neglect, and Exploitation Prohibition and Prevention Program", approved on 3/21/17 showed " ...A. Every resident has the right to be free from verbal, sexual, physical, and mental abuse; corporal punishment; neglect; exploitation; involuntary seclusion; and any physical or chemical restraint not required to treat the resident's medial symptoms or conditions. B. Each community takes reasonable, appropriate steps to ensure that each resident is free from abuse, neglect, and exploitation by anyone, including (but not limited to) staff, other residents, family members, friends, or other individuals."