PRINTED: 12/15/2005
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, 7 out of 7 times the facility failed to notify a physician of blood sugar readings below 100, for sample resident #54. The findings were:	F 157	Preparation and execution of this plan of correction does not constitute an admission or agreement by this provide 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 purposes and correlate with the most recently contemplated or accomplished corrective action and do not necessarily correspond chronologically to the date the facility is of the opinion it was in compliance with requirements of participation or that corrective action was necessary. F157 The facility will inform the resident; consult with the resident's physician; and if known the legal representative or an interested family member of any changes which may or may not require physician intervention. This requirement will be met as evidenced by: 1. Clarification obtained from	1/15/06

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

Terrell Walter Administrator by Yvonne Bergeron Director of Nursing 12/27/05

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation. POC accepted with changes made 1/4/05 1520 by Yvonne Bergeron, RN, DON

Karen Wonacie RN, Health Surveyor

PRINTED: 12/15/2005
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 157	Continued From page 1 Review of the November 2005 physician's orders for resident #54 revealed an order dated 9/30/05 to notify the physician if the resident's blood sugar readings were less than 100. Review of the resident's documented blood sugar levels revealed that 7 of the 8 times readings were taken during November 2005, this resident had blood sugars readings of less than 100 seven of the eight times it was taken during the month of November 2005. Review of the entire medical record revealed the physician was not notified of any of these readings. Interview with the director of nurses on 12/1/05 at 2:30 PM confirmed the physician was not notified of the blood sugar levels below 100. She further stated the facility had no policy that addressed physician notification.	F 157	physician on 12/19/05 as to parameters for blood sugar readings on non-hyperglycemic resident #54 and when to notify when out of that parameter. 2. Will obtain specific parameters and when to notify physician on an individual basis for residents without a diagnosis of hyperglycemia, but who get blood sugar testing i.e. new tube feeds. (Our current order is parameters for hyperglycemic residents only.) ID of Residents: All residents have the ability to be affected. System: Clarification sent to physician on 12/19/2005. Charge Nurses in serviced on 12/18/2002, 12/19/2005 and 1/10/2006 to seek individual orders for non-hyperglycemic residents who have blood sugar testing ordered. Re-in servicing will occur as necessary. Monitoring: Director of Nursing and/or designee will monitor for compliance.	1/15/06
F 248 SS=D	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to offer scheduled, individualized, and meaningful activities for 2 (#49, #57) of 15 sample residents. The findings were: 1. Observation on 11/29/05 from 9:30 AM until 11:50 AM revealed resident #49 remained in bed.	F 248		

PRINTED: 12/15/2006
FORM APPROVED.
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 157	Continued From page 1 Review of the November 2005 physician's orders for resident #64 revealed an order dated 9/30/05 to notify the physician if the resident's blood sugar readings were less than 100. Review of the resident's documented blood sugar levels revealed that 7 of the 8 times readings were taken during November 2005, this resident had blood sugars readings of less than 100 seven of the eight times it was taken during the month of November 2005. Review of the entire medical record revealed the physician was not notified of any of these readings. Interview with the director of nurses on 12/1/05 at 2:30 PM confirmed the physician was not notified of the blood sugar levels below 100. She further stated the facility had no policy that addressed physician notification.	F 157	Quality of Assurance: Results of monitoring will be reported by Director of Nursing quarterly or more frequently as needed at the Quality of Assurance Meeting for review and suggestion.	
F 248 SS=D	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to offer scheduled, individualized, and meaningful activities for 2 (#49, #57) of 15 sample residents. The findings were: 1. Observation on 11/29/05 from 9:30 AM until 11:50 AM revealed resident #49 remained in bed.	F 248	F248 The facility will provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This requirement will be met as evidenced by: 1. Resident #49 a. Will be encouraged to attend activities with active participation and if does not attend or actively participate	1/15/06

2a

PRINTED: 12/15/2005
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 248	Continued From page 2 The following concerns were identified: a. Review of the November 2005, activity calendar highlighting activities the resident attended revealed the resident did not attend any activities that month. b. Interview with the director of activities on 12/1/05 at 12 noon confirmed no activities were attended by the resident in November and stated it was because the resident was placed on the one-to-one activity program. However, the activity director was unable to find evidence that one-to-one activities were provided for the resident. c. Review of the one to one participation schedule revealed the resident's name was not on the list of those who were to receive one-to-one activities. 2. Observation on 11/29/05 from 9:30 AM until 9:45 AM revealed resident #57 was in bed. Observation on 11/29/05 at 9:45 AM revealed the resident was dressed by staff and transferred into a wheelchair. The resident was then placed in the hallway across from the nursing station and remained there until 11 AM when he/she was wheeled into the dining room by staff. The following concerns were identified: a. Review of the September 2005, activity calendar that highlighted the resident's activities revealed he/she had attended activities only 6 of the 30 days. b. Review of the November 2005, activity calendar that highlighted activities the resident attended revealed he/she had attended activities only 6 of the 30 days. c. There were no activity goals identified for November 2005.	F 248	will receive a 1 on 1 program at least two times weekly. b. Documentation will be kept current for activities attended with participation and/or 1 on 1 program. c. Care plan will be updated to reflect needs. 2. Resident #57 a. Will be encouraged to attend activities with active participation and if does not attend or actively participate will receive a 1 on 1 program at least two times weekly. b. Documentation will be kept current for activities attended with participation and/or 1 on 1 program. c. Activity goals will be identified, documented and care plan updated. ID of Residents: All residents have the ability to be affected. Systems: Activity staff will be in serviced on the need to provide documentation of participation in activities, on group activities attended and/or 1 on 1 program.	1/15/06

SH 2/1/06 Wording changes made to summary Statement at Informal Dispute Resolution held January 27, 2006.

PRINTED: 12/15/2005
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 248	Continued From page 3 Interview with the activity director on 12/1/05 at 12 noon confirmed the calendars that documented the resident's attendance by highlighting the activities were accurate.	F 248	Monitoring: Activity Director and/or designee will monitor for compliance. Re-in-servicing will occur as necessary	
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.	F 272	Quality of Assurance: Result of monitoring will be reported by Activity Director quarterly and/or more frequently as needed at the Quality Assurance meeting for review and suggestions.	

PRINTED: 12/15/2005
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 248	Continued From page 3 Interview with the activity director on 12/1/05 at 12 noon confirmed the calendars that documented the resident's attendance by highlighting the activities were accurate.	F 248		
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.	F 272	F272 The facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. This requirement will be met as evidenced by: 1. Resident #23 a. Nutritional assessment completed on 12/16/05 and care plan updated to reflect any/all changes. b. Activity assessment completed on 12/26/05 and any/all changes documented in plan of care. c. Restorative Nurse will initiate a bowel and bladder assessment. Upon completion of these assessments the Restorative Nurse will review for pattern and document in the plan of care. 2. Resident #3 a. Restorative Nurse will initiate a bowel and bladder assessment.	1/15/06 1/15/06

4a

PRINTED: 12/15/2005
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of facility policies and procedures, the facility failed to ensure comprehensive assessments of identified problem areas for 9 (#3, #13, #23, #49, #54, #57, #67, #68, #70) of 15 sample residents. The findings were: 1. Review of section V of the 9/21/05 significant change Minimum Data Set (MDS) assessment for resident #23 revealed the triggered areas requiring a comprehensive assessment included: urinary incontinence, activities, and nutritional status. Review of the medical record revealed no evidence comprehensive assessments were completed for these three areas. Interview with the director of nursing (DON) on 12/1/05 at 1:40 PM confirmed there were no comprehensive assessments done for these areas. 2. Review of section V of the 10/20/05 annual MDS assessment for resident #3 revealed urinary incontinence and use of indwelling catheter was triggered, and required a comprehensive assessment. Review of the medical record revealed no evidence that a comprehensive assessment was done. Interview with the DON on 12/1/05 at 1:40 PM confirmed there was an incomplete Resident Assessment Protocol (RAP) module on urinary incontinence and use of indwelling catheter dated 10/15/05; stated that she did not know why the assessment was not completed. 3. Review of section V for the 9/18/05 admission MDS assessment for resident #70 revealed the area of activities was triggered and required a	F 272	Upon completion of these assessments the Restorative Nurse will review for pattern and document in the plan of care. b. MDS Coordinator in serviced on 12/19/2005 on necessity to ensure that any RAP that triggers e comprehensively assessed and documented as such. 3. Resident #70 (resident no longer in facility.) a. Admission Activity Assessments will be completed within 7 days of admission. 4. Resident#49 a. Restorative Nurse will initiate a bladder assessment. Upon completion of this assessment the Restorative Nurse will review for pattern and document in the plan of care. b. Restorative serviced on 12/26/05 the need for comprehensive bladder assessments to include such information as 1. Type of incontinence (i.e. urge, stress, mixed, overflow or functional) 2. History of incontinence including onset, duration,	1/15/06 1/15/06

PRINTED: 12/16/2005
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 5 comprehensive assessment. Review of the closed medical record revealed no evidence an assessment was done. Interview with the DON on 12/1/05 at 4:46 PM revealed that she would look for the assessment on activities, however no additional information was found. 4. Review of the 7/3/05 significant change and the 10/2/05 quarterly MDS assessments for resident #49 revealed he/she was incontinent (all or almost all of the time) of bowel and bladder. Review of the 10/31/05 bladder assessment performed by the facility revealed the assessment was not comprehensive and lacked the following information. a. Type of incontinence (e.g., urge, stress, mixed, overflow, or functional); b. History of incontinence, including onset, duration, characteristics, precipitants, associated symptoms, and previous treatment and/or management, including the response to the interventions; c. Patterns of fluid intake, such as amounts, time of day, alterations and potential complications, such as decreased or increased urine output; e. Use of urinary tract stimulants or irritants (e.g., frequent caffeine intake); and f. Environmental factors and assistive devices that may restrict or facilitate a resident's ability to access the toilet (e.g., grab bars, raised or low toilet seats, inadequate lighting, distance to toilet or bedside commodes, use of bed rails or restraints, or fear of falling). In addition, review of the entire medical record revealed there was no bowel assessment completed. Interview with the DON on 12/1/05 at 2:30 PM revealed there was no other bladder assessment and no bowel assessment performed	F 272	characteristics, precipitants, associated symptoms, and previous treatment and/or management including response to interventions. 3.Pattern of fluid intake, such as amounts, alternatives, and potential complications such as increase or decrease in urinary output. 4.Use of urinary tract stimulants or irritants (i.e. caffeine intake.) 5.Environmental factors with assistive devices that may restrict or facilitate a resident's ability to access the toilet (i.e., grab bars, raised or low toilet seats, inadequate lighting, distance to toilet or bedside commode, use of restraints or fear of falling) c.Restorative Nurse will initiate a bowel assessment. Upon completion of this assessment the Restorative Nurse will review for pattern and document in the plan of care. 5. Resident #49 a.A comprehensive pain assessment completed on 12/20/05 and will include the	1/15/06

PRINTED: 12/15/2005
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 6 for this resident. 5. Review of the diagnosis detail report from October 2005 for resident #49 revealed he/she had an active diagnosis of limb pain. Review of the 10/10/05 pain assessment revealed it was not comprehensive and lacked the following information as outlined on the facility's pain assessment form. a. Current pain management measures in use (both pharmacological and non-pharmacological); b. Accompanying symptoms (e.g., nausea/vomiting, itching, sedation, constipation, urinary retention); c. Non-verbal signs that would indicate pain (e.g., grimacing, reduced attention span, avoidance of social contact, avoidance of conversation, refusing to eat, moaning, striking out, or rubbing/splinting of body parts); and d. Nursing interventions/evaluation. 6. Review of the initial 10/11/05 MDS assessment for resident #54 revealed he/she was incontinent of bowel and bladder. Review of the entire medical record revealed there was no bowel of bladder assessment completed. Interview with the DON on 12/1/05 at 2:45 PM confirmed there was no bowel or bladder assessment completed. 7. Review of the October 2005 physician's orders and diagnosis detail report for resident #57 revealed he/she was admitted to the hospital with a hip fracture on 10/13/05. Review of the admission record revealed the resident was readmitted to the facility on 10/21/05. Review of the 10/21/05 quarterly MDS assessment revealed the resident had moderate pain in his/her hip every day. Review of the 10/21/05 nursing	F 272	following information as outlined on the facility's pain assessment form. Assessment will be reviewed and results documented in the plan of care 12/20/05. b. A comprehensive pain assessment form will be completed on admission and with each MDS review to include, quarterly, annually and change of condition reviews. Plan of care updated to reflect any changes. c. Comprehensive pain assessment to include: 1. Current pain management measures in use (both pharmacological and non-pharmacological) 2. Accompanying symptoms (i.e. nausea, vomiting, itching, sedation, constipation, urinary retention) 3. Non-verbal signs that would indicate pain (i.e. grimacing, reduced attention span, avoidance of social contact, avoidance of conversation, refusing to eat, moaning, striking out, or rubbing/splinting of body part.)	

PRINTED: 12/15/2005
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 7 assessment completed at the time of readmission revealed there was no pain assessment completed. Interview with the DON on 12/1/05 at 2:45 PM confirmed no pain assessment was completed. In addition, review of the 10/21/05 nursing assessment revealed the resident was readmitted on 10/21/05 with a Foley catheter. Review further revealed the catheter was ordered to be removed on 10/31/05. Observations on 11/29/05 through 12/1/05 revealed the resident did not have a catheter. Interview with certified nurse aide (CNA) #1 revealed the resident had no catheter. Review of the entire medical record revealed there was no bladder assessment completed since removal of the catheter. Interview with the DON on 12/1/05 at 2:30 PM confirmed there was no bladder assessment since the removal of the catheter and that there should have been one completed. 8. According to the 10/23/05 significant change MDS assessment, resident #13 required comprehensive assessments for use of hypnotic medications, bowel and bladder incontinence, and activities. Review of the assessment information listed in Section V of that MDS revealed comprehensive assessments were not completed. During an interview on 11/30/05 at 10:50 AM, the MDS coordinator verified an assessment for hypnotic medications was not completed. On 12/1/05 at 1:45 PM, the DON confirmed the facility lacked comprehensive assessments of the resident's bowel and bladder status. Interview with the activity director on 12/1/05 at 2:45 PM confirmed lack of a comprehensive assessment for activities. 9. Review of the 8/4/05 significant change MDS	F 272	4.Nursing interventions/evaluations. 6. Resident #54 a.Restorative Nurse will initiate a bowel and bladder assessment. Upon completion of these assessments the Restorative Nurse will review for pattern and will document in the plan of care. 7. Resident #57 a.Pain assessment to be completed on admission, annually, quarterly and with change of condition. Plan of care will be updated to reflect assessment findings. b.Restorative Nurse will initiate a bowel and bladder assessment. Upon completion of this assessment the Restorative Nurse will review for pattern and document in the plan of care. c.If a resident is admitted with a Foley catheter, the physician must state a medical need and medically justify the catheter placement (i.e. urinary retention, pressure ulcer(s), terminal disease or severe impairment)	1/15/06 1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 8 psychoactive medications. The location of the assessment information for those triggered areas was the Resident Assessment Protocols dated 7/30/05. Review of that information revealed the facility failed to complete comprehensive assessments. In addition, a comprehensive bowel assessment was lacking. 10. According to the 8/18/05 annual MDS assessment, resident #68 was totally incontinent of bowel, received psychoactive medications, and experienced mild daily pain. Review of the assessment information itemized in Section V of the 8/18/05 MDS revealed the facility failed to complete a comprehensive assessment for psychoactive medications. In addition, a bowel assessment was lacking, and the 11/11/05 pain assessment documented the resident had mild pain; however, the assessment did not identify the location of the pain.	F 272	d. Seven (7) to ten (10) days after a Foley catheter is removed the Restorative Nurse will initiate a bladder assessment. Upon completion of this assessment the Restorative Nurse will review for pattern and document in the plan of care. 8. Resident #13 – expired a. When a significant change MDS is initiated: 1. A bowel and bladder assessment will be initiated. Upon completion these assessments the Restorative Nurse will review for pattern and document in the plan of care. 2. Activity assessment will be completed with the plan of care updated to reflect any changes. 3. If medication classified as a hypnotic is in use an assessment will be completed with the plan of care updated to reflect findings.	1/15/06
F 275 SS=D	483.20(b)(2)(iii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure a reassessment was completed for one (#57) of seven sample residents who had an annual reassessment due. The findings were: According to the Centers For Medicare and	F 275	9. Resident # 67 a. Restorative Nurse will initiate a bowel and bladder assessment. Upon completion of these assessment the Restorative nurse will review for pattern	1/15/06

Wording changes made to summary Statement at Informal Dispute Resolution held January 27, 2006.

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 8 psychoactive medications. The location of the assessment information for those triggered areas was the Resident Assessment Protocols dated 7/30/05. Review of that information revealed the facility failed to complete comprehensive assessments. In addition, a comprehensive bowel assessment was lacking. 10. According to the 8/18/05 annual MDS assessment, resident #68 was totally incontinent of bowel, received psychoactive medications, and experienced mild daily pain. Review of the assessment information itemized in Section V of the 8/18/05 MDS revealed the facility failed to complete a comprehensive assessment for psychoactive medications. In addition, a bowel assessment was lacking, and the 11/11/05 pain assessment documented the resident had mild pain; however, the assessment did not identify the location of the pain.	F 272	and document in plan of care. b. Any RAP (Resident Assessment Protocol) that triggers on the MDS (Minimum Data Set) for significant change will require a comprehensive assessment with documentation of where information is located. 10. Resident #68 a. Restorative Nurse will initiate a bowel assessment. Upon completion of this assessment the Restorative Nurse will review for pattern and document in the plan of care. b. Pain assessment completed on 12/26/05 and the plan of care updated to reflect findings. Documentation of complaint of pain to include (but not limited to) location of pain. c. Resident identified "at risk" for pressure area(s), plan o care to be updated to reflect measures to protect/prevent pressure sores. d. Any area on skin not identified as, but has potential to become pressure sore, will be assessed thoroughly with pressure sore precautions in place with plan of care updated to reflect these changes.	1/15/06
F 275 SS=D	483.20(b)(2)(iii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure a reassessment was completed for one (#57) of seven sample residents who had an annual reassessment due. The findings were: According to the Centers For Medicare and	F 275		

CIA

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 8 psychoactive medications. The location of the assessment information for those triggered areas was the Resident Assessment Protocols dated 7/30/05. Review of that information revealed the facility failed to complete comprehensive assessments. In addition, a comprehensive bowel assessment was lacking. 10. According to the 8/18/05 annual MDS assessment, resident #68 was totally incontinent of bowel, received psychoactive medications, and experienced mild daily pain. Review of the assessment information itemized in Section V of the 8/18/05 MDS revealed the facility failed to complete a comprehensive assessment for psychoactive medications. In addition, a bowel assessment was lacking, and the 11/11/05 pain assessment documented the resident had mild pain; however, the assessment did not identify the location of the pain.	F 272	11. Any/all assessments to be initiated by ARD (Assessment Reference Date) ID of residents – All residents has the ability to be affected. System – Nursing staff to be I serviced. Comprehensive assessments to include (but not limited to) Pain, Bowel and Bladder, Activity, Nutritional, Skin and use of hypnotics (if applicable) will be completed on admission, annually, quarterly and with change of condition. Personalized interventions will be implemented based on findings. Plan of care will be updated and nursing staff will review updated plan of care. There must be (documented) medical	1/15/06
F 275 SS=D	483.20(b)(2)(iii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure a reassessment was completed for one (#57) of seven sample residents who had an annual reassessment due. The findings were: According to the Centers For Medicare and	F 275	justification to support use of Foley catheter. Assessments will be initiated on Assessment Reference Date (ARD). Monitoring – Director of Nursing and/or designee will monitor for compliance, with a minimum of monthly checks. Re-in servicing will occur as necessary. Quality of Assurance – Results of monitoring will be reported by Director of Nursing and/or designee quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestion.	

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 8 psychoactive medications. The location of the assessment information for those triggered areas was the Resident Assessment Protocols dated 7/30/05. Review of that information revealed the facility failed to complete comprehensive assessments. In addition, a comprehensive bowel assessment was lacking. 10. According to the 8/18/05 annual MDS assessment, resident #68 was totally incontinent of bowel, received psychoactive medications, and experienced mild daily pain. Review of the assessment information itemized in Section V of the 8/18/05 MDS revealed the facility failed to complete a comprehensive assessment for psychoactive medications. In addition, a bowel assessment was lacking, and the 11/11/05 pain assessment documented the resident had mild pain; however, the assessment did not identify the location of the pain.	F 272	F275 The facility will conduct a comprehensive assessment of a resident not less than once every twelve (12) months. This requirement will be met as evidenced by: 1. Resident #57 a. Annual Minimum Data Set assessment initiated on 12-01-2005. b. All disciplines will be inserviced on need to check computer generated Minimum Data Set review calendar and ensure proper Minimum Data Set Review completed (annually versus quarterly) ID of residents – All residents have the ability to be affected. Systems – All disciplines will be inserviced. Computer generated Minimum Data Set review list will state what quarterly assessment (i.e. Q1, Q2, Q3 or Annual (Q4)) is due. Monitoring – Director of Nursing	1/15/06
F 275 SS=D	483.20(b)(2)(iii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure a reassessment was completed for one (#57) of seven sample residents who had an annual reassessment due. The findings were: According to the Centers For Medicare and	F 275		

9C

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 275	Continued From page 9 Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual, version 2.0, revised August 2005, page 2-3, the annual comprehensive reassessment must be completed within 366 days of the most recent comprehensive assessment. Review of the initial 10/31/04 Minimum Data Set (MDS) assessment for resident #57 revealed his/her annual reassessment was due on 10/31/05. Review of the medical record revealed a quarterly MDS assessment was completed on 10/29/05 but no annual assessment was done. Interview with the MDS Coordinator on 12/1/05 at 9:30 AM confirmed there was no annual reassessment completed.	F 275	and/or designee will monitor for compliance. Re-in servicing will occur as necessary. Quality of Assurance – Results of monitoring will be reported by Director of Nursing or designee quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	
F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F279 The facility will use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility will develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan will describe the services that are to be furnished to attain or maintain the resident's highest physical, mental, and psychosocial well-being. This requirement will be met as evidenced by: 1. Resident #49 a. Plan of care updated on 12/01/2005 to address nutrition	1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 279	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure a care plan was developed that addressed identified problems for 5 (#4, #23, #49, #54, #68) of 15 sample residents. The findings were: 1. Review of the Resident Assessment Protocol (RAP) summary dated 7/3/05 for resident #49 revealed nutrition was identified as an area that should be addressed in the care plan because of weight loss. Review of the 10/05 care plan, however, revealed nutrition was not addressed. Interview with the Minimum Data Set (MDS) Coordinator on 12/1/05 at 1:50 PM confirmed there was no current care plan that addressed nutrition. 2. Review of the initial 10/11/05 MDS assessment for resident #54 revealed activities was identified as an area that should be addressed in the care plan. Review of the October 2005 care plan revealed activities was not addressed. Interview with the director of nursing (DON) on 12/1/05 at 2:45 PM confirmed there was no activities care plan. 3. Review of the medical record for resident #23 revealed a diagnosis of Down's Syndrome. Review of the 9/21/05 significant change MDS assessment showed that communication triggered, and was checked as addressed in the care plan. A comprehensive assessment dated 9/20/05 was Done describing the resident as "essentially non-verbal". However, communication was not addressed in the 8/29/05 resident care	F 279	and weight loss issues. 2. Resident #54 a. Plan of care will be updated to address activities for resident. 3. Resident #23 a. Plan of care will be updated to address communication needs/difficulties for resident. 4. Resident #4 a. Plan of care updated to address activity for resident. ID of residents – All residents have the ability to be affected. Systems – Disciplines will be inserviced on need to update plan of care with each annual, quarterly or change of condition Minimum Data Set review. Director of Nursing and/or designee will randomly review at a minimum of monthly Minimum Data Set reviews to ensure that any area that triggers is addressed and/or updated in plan of care by appropriate discipline. Monitoring – Director of Nursing and/or designee will monitor for compliance. Re-in servicing will occur as necessary. Quality of Assurance – Result of monitoring will be reported by Director of Nursing and/or designee quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	1/15/06 1/15/06 1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 279	Continued From page 11 plan. Interview with the DON on 12/1/05 at 1:45 PM confirmed that the care plan did not address communication. 4. Review of the 1/2/05 annual MDS assessment for resident #4 revealed activities was a triggered area, and was checked as addressed in the care plan. An assessment was Done; however, activities were not addressed in the 10/6/05 resident care plan. Interview with the DON on 12/1/05 at 1:45 PM confirmed the care plan did not address activities.	F 279		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of policies and procedures, the facility failed to assure staff maintained professional standards of practice related to medication administration for 2 of 13 sample residents (#13, #68) and one non-sample resident (#19). In addition, resident #13 was admitted without an order for an existing indwelling urinary catheter. The findings were: 1. Observation on 11/29/05 at 11:40 AM showed resident #13 had an indwelling urinary catheter and an open pressure sore on the coccyx. The pressure sore was approximately 1.5 centimeters in diameter with scar tissue around the edges and granulation tissue in the base. Certified nurse aide #2 applied Desitin ointment to the open area.	F 281	F281 The services provided or arranged by the facility will meet the professional standards of quality. This requirement will be met as evidenced by: 1. Resident #13 – expired 2. Nurses inserviced on 12/13/05 and 01/06/06 serviced on: a. Need to review admission orders carefully. b. If resident is admitted with a Foley catheter—need order for use of Foley catheter and need to have a diagnosis or medical justification for use on admission orders. 3. Resident # 19 a. Licensed Staff inserviced on	1/15/06 1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 281	Continued From page 12 According to the admission orders, the resident was re-admitted on 11/23/05. Review of the admission orders and those received since that date revealed neither the indwelling catheter, nor Desitin ointment to the pressure sore, was ordered. Furthermore, review of the facility's 1/1/01 policy and procedure, "Pressure Ulcer Prevention Guidelines," number CI-Nur-1401, revealed Desitin was not an approved intervention. Interview with the director of nursing (DON) on 11/30/05 at 10:30 AM verified lack of an order for the catheter. Further interview with the DON on 12/1/05 at 1:38 PM confirmed Desitin was neither ordered by the physician nor included in the facility's policies and procedures. According to the July 2005 Wyoming Nurse Practice Act, nurses shall provide care according to the directions of a licensed physician. 2. Observation on 11/29/03 at 10:30 AM showed licensed practical nurse (LPN) #1 administered Cogentin per percutaneous enteral gastrostomy (PEG or feeding) tube for resident #19. The LPN flushed the tube with water, administered the medication per gravity flow, and flushed the tube with water after medication administration was complete. However, she failed to check for placement of the tube prior to flushing it. When questioned immediately after the procedure, the LPN verified she did not check for placement of the PEG tube prior to medication administration. When asked how long the resident had the PEG tube in place, the LPN stated, "Not too long." Review of the facility's undated policy, "Enteral Tube Medication Administration Procedures," #5460 revealed verification of tube placement should be done prior to medication administration. According to the 2004 3rd edition of "Nursing Interventions & Clinical Skills" by	F 281	12/13/05 and 01/06/06 on protocol for medication administration via enteral tube. b. Placement of tube to be checked prior to administration of medication, flushing and/or feeding. 4. Resident #68 a. Order for use of oxygen obtained on 12/01/05 and in medical chart. b. Licensed staff inserviced on 12/13/05 and 01/06/06 need to obtain an order for continual and/or PRN use of oxygen. c. Licensed staff inserviced on 12/13/05 and 01/06 06 needs to notify physician if oxygen usage is necessary and resident does not have an order for. ID of Residents – All residents have the ability to be affected. Systems – Nursing Staff will be in serviced. Licensed Staff will review physician's protocols. A physician order will be obtained for use of Foley catheter with a diagnosis or medical justification for use. When oxygen is used for respiratory distress (as per physician protocols) the physician will be notified and an order obtained to continue use if necessary. Physician protocols will be reviewed before use of any perineal ointment and if not	1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 281	Continued From page 13 Elkin, Perry, and Potter, placement of the tube should be checked prior to administering medication through any kind of feeding tube. 3. Observation on 11/29/05 at 9:37 AM and 1:15 PM and on 11/30/05 at 8:25 AM showed resident #68 utilized oxygen at 3 liters per minute (LPM). Review of the physician's orders dated 11/15/05 showed oxygen was not ordered. Review of standing orders dated 1/10/05 showed oxygen could be utilized at 2 to 3 LPM for respiratory distress, but the physician was to be notified immediately. During an interview on 12/1/05 at 10:30 AM, LPN #1 verified lack of an order for oxygen. In addition, the LPN confirmed the physician was not notified when oxygen was first utilized. According to the July 2005 Wyoming Nurse Practice Act, nurses shall provide care according to the directions of a licensed physician.	F 281	listed on protocol an order will be obtained for use (i.e. Desitin) Monitoring – Director of Nursing and/or designee will monitor for compliance. Director of Nursing and/or designee will review admission orders with admitting nurse to ensure compliance. Re-in servicing will occur as necessary. Quality of Assurance – Report of monitoring will be reported by Director of Nursing and/or designee quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure the care plan was followed for 2 (#10, #49) of 15 sample residents. The findings were: 1. Review of the October 2005 care plan for	F 282	F282 The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. This requirement will be met as evidenced by: 1. Resident #49 a. Landing strip mat in place on floor beside bed 12/02/05. b. Nursing staff in serviced on 12/12/05, 12/13/05, 01/05/06 and 01/06/05 need to review plan of care for any ancillary equipment necessary, and provide as listed.	1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 282	Continued From page 14 resident #49 revealed he/she was identified as at risk for falls. Review further revealed the resident was to have a landing strip (mat) on the floor beside the bed when the resident was lying down because of the risk of injury from a fall. Observation from 9:30 AM on 11/29/05 to 12:30 PM revealed there was no landing strip on the floor by the bed. Observation again on 12/1/05 at 11:05 AM revealed there was still no landing strip on the floor by the bed. Interview with the director of nursing (DON) and registered nurse #1 on 12/1/05 at 11:20 AM confirmed there was no landing strip on the floor for this resident and that there should be one to prevent injury from a fall. 2. Review of the care plan dated 8/18/05 revealed resident #10 was to have, "Assist of one with meals at an assisted table. One item at a time and one piece of silverware at a time." However, observation on 11/29/05 at 11:55 PM revealed the resident was sitting at an assisted table with three uncovered bowls of food and four beverages in front of him/her. Interview with the DON on 12/1/05 at 1:45 PM confirmed the care plan should have been followed.	F 282	c.Nursing staff will be in serviced on 12/12/05, 12/13/05, 01/05/06, and 01/06/06 on ancillary equipment that should be utilized if resident is listed as a "fall risk" (i.e. landing strip on floor) to assist in preventing injury from fall. 2. Resident #10 a.Nursing staff in-serviced on 12/13/05, 12/13/05, 01/05/06 and 01/06/06 on need to review plan of care and follow as listed: 1.Resident to receive one utensil for use at a time and one bowl of food at a time. 2.Nursing staff in serviced when resident is finished with the one bowl of food to remove that bowl from area before giving next item,	1/15/06
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff	F 312		1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 282	Continued From page 14 resident #49 revealed he/she was identified as at risk for falls. Review further revealed the resident was to have a landing strip (mat) on the floor beside the bed when the resident was lying down because of the risk of injury from a fall. Observation from 9:30 AM on 11/29/05 to 12:30 PM revealed there was no landing strip on the floor by the bed. Observation again on 12/1/05 at 11:05 AM revealed there was still no landing strip on the floor by the bed. Interview with the director of nursing (DON) and registered nurse #1 on 12/1/05 at 11:20 AM confirmed there was no landing strip on the floor for this resident and that there should be one to prevent injury from a fall. 2. Review of the care plan dated 8/18/05 revealed resident #10 was to have, "Assist of one with meals at an assisted table. One item at a time and one piece of silverware at a time." However, observation on 11/29/05 at 11:55 PM revealed the resident was sitting at an assisted table with three uncovered bowls of food and four beverages in front of him/her. Interview with the DON on 12/1/05 at 1:45 PM confirmed the care plan should have been followed.	F 282	ID of residents – All resident have the ability to be affected. Systems – Nursing staff will be inserviced. Nursing staff will review plan of care. Re-in servicing will occur as necessary. Monitoring – Director of Nursing and/or designee will monitor for compliance. Quality of Assurance – Results of monitoring will be reported by the Director of Nursing and/or designee quarterly or more frequently as needed at the Quality Assurance mee4ting for review and suggestions. F312 A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This requirement will be met as	
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff	F 312	evidenced by: 1.Nursing staff in serviced on 12/13/05, 12/13/05, 01/05/06, and 01/06/06 on proper procedure to use when providing perineal care. a.Policy/Procedure #CL-NU-1716 reviewed with nursing on providing proper perineal care. b.Staff Development Coordinator will inservice and/or monitor	1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 312	Continued From page 15 interviews, medical record review, and review of policies and procedures, the facility failed to assure staff provided appropriate personal care for dependent residents. During six observations of perineal care provided for incontinent residents, three perineal care procedures for three residents (sample residents #49 and #68 and non-sample resident #51) were completed incorrectly. In addition, staff failed to provide appropriate oral care for sample resident #68. The findings were: 1. Interview with, and observation of, resident #68 on 11/29/05 at 1:10 PM showed a moderate amount of brownish substance caked on the resident's tongue. The resident stated staff only provided oral care every three to four days, and it was not done that morning. The resident further stated s/he preferred daily oral care and did not like having the substance caked on his/her tongue. Observation with licensed practical nurse (LPN) #2 on 12/1/05 at 8:03 AM showed the resident's tongue was still caked with a brown substance. When asked if that was acceptable oral care, the LPN stated she "would expect more." According to the current care plan, the resident required "assist of one for oral hygiene as needed." Review of the facility's 1/1/01 policy and procedure, "Morning Care," number CI-Nur-1702, revealed the purpose was "To facilitate resident's overall comfort, cleanliness, grooming and well being." It included oral care. Observation on 11/29/05 at 1:50 PM showed certified nurse aide (CNA) #3 transferred resident #68 from the wheelchair to the bed. During the observation, the CNA confirmed the resident's incontinence brief and clothing were saturated with urine, and the Dycem mat (a plastic pad to		Nursing assistants when providing perineal care for proper techniques. c. Charge Nurse will provide supervision on Nursing Assistants to ensure proper techniques utilized when providing perineal care. d. One on one instruction will be provided as necessary to ensure proper technique is utilized when providing perineal care. 2. Nursing staff will be in serviced on proper procedure for providing oral care.. a. Policy/Procedure #CL-NU-1702 reviewed with nursing staff. b. Staff Development Coordinator to inservice and/or monitor nursing assistant when providing oral care. c. Charge nurse will provide supervision to ensure that oral care is provided. d. One on one instruction will be provided to ensure proper technique is utilized and to ensure tat oral care is provided. e. Oral care to be provided every shift for residents that receive no nutrition or fluids by mouth (i.e. utilize an Enteral feeding tube for nutritional support.)	1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 312	Continued From page 16 prevent sliding) and wheelchair seat were wet. In addition, there was a strong smell of urine present. When providing perineal care, the CNA failed to cleanse the resident's genitalia and groin areas and the anterior and posterior thighs, all of which had been in contact with urine. After completion of perineal care, the CNA left the resident lying on the same protective pad which was in contact with the resident's saturated brief, clothing, and skin. 2. Review of the 11/1/05 significant change MDS assessment for non-sample resident #51 revealed he/she was incontinent of urine and bowel (all or almost all of the time) and required extensive staff assistance with personal hygiene. Observation on 11/29/05 at 11:25 AM revealed the resident was incontinent of urine. Observation further revealed CNA #1 provided perineal care for the resident. Observation of the perineal care for this resident revealed the CNA used 'back to front' motion with a wash cloth, three times, to cleanse the perineum. Interview with the CNA at that time confirmed she should have used 'front to back' strokes to cleanse the resident. 3. Review of the 7/3/05 significant change Minimum Data Set (MDS) assessment for resident #49 revealed he/she was incontinent of urine (all or almost all of the time) and required extensive staff assistance with personal hygiene. Observation on 11/29/05 at 11:50 AM revealed the resident was incontinent of urine and feces. Observation further revealed certified nurse aide (CNA) #1 provided perineal care for the resident. Observation of the perineal care revealed the CNA used 'back to front' motion with a wash cloth, two times, to cleanse the perineum. Review the facility's policy on perineal care dated 1/1/01	F 312	ID of residents – All residents have the ability to be affected. Systems – Nursing staff in serviced on proper technique for providing perineal care. Nursing staff in serviced on importance of providing oral care and when to do so. Monitoring – Director of Nursing and/or designee will monitor for compliance and re-inservice as necessary. Quality of Assurance – Results of monitoring will be reported quarterly or more frequently as needed by the Director of Nursing and/or designee for review and suggestions.	

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 312	Continued From page 17 revealed instructions to "Clean, rinse and dry [the] perineal area, ...wiping front to back."	F 312	F314 Based on the comprehensive assessment of a resident, the facility will ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and a resident having a pressure sore receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This requirement will be met as evidenced by: 1. Resident #68 (Resident listed as at risk for pressure sores). a. Nursing staff will be in serviced on Policy/Procedure #CL-NUR-1401 Pressure Ulcer Guidelines and CL-NUR 1403 Pressure Ulcer Prevention Guidelines. b. Residents will be assessed annually, quarterly and with a change of condition for risk. c. Plan of care will reflect resident at risk with proper prevention techniques and/or equipment to be utilized and updated as necessary. d. Dietician to review residents at risk for developing pressure areas to see if additional	1/15/06
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interviews, and review of policies and procedures, the facility failed to provide one of two sample residents (#68) with interventions to facilitate alleviation of pressure to a bony prominence. The findings were: According to the 8/18/05 annual Minimum Data Set (MDS) assessment, resident #68 had no cognitive impairments and required total assistance with bed mobility and transfers. Further review showed the resident was at risk for pressure sores due to decreased mobility secondary to a cerebral vascular accident with left sided hemiplegia. Observation on 11/29/05 at 1:15 PM showed resident #68 had an area of skin on the right heel which was intact, discolored, and identified by the resident as painful. The area was approximately 2.54 centimeters in diameter and brownish in color. After the observation the	F 314		

Wording changes made to summary Statement at Informal Dispute Resolution held January 27, 2006.

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 314	Continued From page 18 resident was left lying in bed with the heels flat on the mattress. Interview with licensed practical nurse (LPN) #1 on 11/29/05 at 2:45 PM revealed the resident previously had a large blister on that spot that healed without opening. Observation with a second surveyor and the DON present on 11/30/05 at 3:45 PM again showed the discolored lesion as described above. At the conclusion of the observation, the resident was again left with the heels flat on the mattress. Observation on 11/30/05 at 8:25 AM and again on 12/1/05 at 8:03 AM showed the resident was seated in a reclining geriatric chair with his/her heels flat against the footrest. Review of the 8/18/05 care plan showed staff were to monitor skin "after any incontinence and on bath days...encourage resident to reposition as needed." The care plan also instructed staff to get the resident up before breakfast, lunch, and supper and to put the resident down after breakfast, lunch, and supper. The following concerns were identified: a. On four separate occasions, staff positioned the resident, who was at risk for pressure ulcer development, with the heels flat against the mattress or footrest of a geriatric chair. b. Care plan interventions to prevent pressure were not identified or initiated. c. Review of the facility's 1/1/01 policy and procedure, "Pressure Ulcer Prevention Guidelines," number CI-Nur-1401 showed the purpose was to assure "residents at risk for the development of pressure ulcers...receive interventions to reduce the risk of pressure ulcers." Included in the interventions were use of "devices that totally relieve pressure on the heels..." for residents who were completely immobile, "seating and positioning devices for chair-bound residents for..pressure relief," and	F 314	nutritional support is necessary (i.e. protein, calories, Vitamin C, iron, zinc). Dietician reviewed resident #68 with recommendations sent to MD on 11/30/05. e. Nursing staff inserviced on 12/12/05, 12/13/05, 01/05/06, and 01/06/06 on proper techniques to be utilized to protect any bony prominence at risk for developing a pressure area/sore. f. Pain assessments to be completed on admission, quarterly, annually and with change of condition. Plan of care will reflect findings. g. Each resident will be evaluated/assessed for pain each shift with proper interventions initiated to address complaint of pain and/or level of pain. Plan of care will be updated as necessary. ID of Residents – All residents have the ability to be affected. Systems – Nursing staff will be inserviced. At risk assessment will be completed on admission, annually, quarterly and with change of condition. Personalized interventions will be initiated based on the findings. Nursing	

Wording changes made to summary Statement at Informal Dispute Resolution held January 27, 2006.

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 314	Continued From page 19 "provide nutritional support...(protein, calories, vitamin C, iron, and zinc)..."	F 314	staff will review updated plan of care. Pain assessment form to be completed on admission, annually, quarterly and with change of condition. Personalized	
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and medical record review, the facility failed to manage urinary incontinence for one (#68) of nine sample residents in a manner which promoted dryness and maintained the resident's dignity. The findings were: According to the 8/18/05 annual MDS assessment, resident #68 had no cognitive impairments, was completely incontinent of urine, required total staff assistance with toileting, and was transferred per mechanical lift. Review of the 8/18/05 care plan showed staff were to check and change the resident before and after meals, at bedtime, at routine checks during the night, and as requested. Interview with certified nurse aide (CNA) #2 on 11/29/05 at 1:10 PM revealed the resident did not use the toilet but was on a check and change	F 315	interventions will be initiated based on findings. Nursing staff will review updated plan of care. Monitoring – Director of Nursing and/or designee will monitor for compliance. Re-in servicing will occur as necessary. Quality of Assurance – Results of monitoring will be reported by Director of Nursing and/or designee quarterly or more necessary if needed to the Quality Assurance Meeting for review and suggestions. F315 Based on resident's comprehensive assessment, the facility will ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless resident's clinical condition demonstrates that catheterization was necessary; and a resident who is continent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This requirement will be met as evidenced by:	

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 315	Continued From page 20 program. The CNA stated the usual procedure was to change the resident's incontinence brief between 9 and 10 AM when s/he was assisted up and then to check and change it, if needed, around 2 PM when the resident was put back to bed. During an interview on 11/29/05 at 1:15 PM, the resident stated the aforementioned procedure was the "usual routine," but that s/he would like to use the toilet as s/he recognized the need to urinate. In addition, the resident stated s/he had to use "Attends" (incontinence briefs) as s/he was unable to walk to the bathroom and had to be transferred per mechanical lift. Furthermore, when asked about the incontinence briefs, the resident stated "It's nasty" to be wet. Observation on 11/29/05 revealed the resident's brief was not checked or changed from 9:37 AM until 1:50 PM. At 1:50 PM CNA #3 transferred the resident from the wheelchair to the bed. During the observation, the CNA confirmed the resident's incontinence brief and clothing were saturated with urine and the Dycem mat (a plastic pad to prevent sliding) and wheelchair seat were wet. In addition, there was a strong smell of urine present.	F 315	1. Resident #68 a. Restorative Nurse will initiate a bowel and bladder assessment. Upon completion of this assessment the Restorative Nurse will review for pattern and document in the plan of care. b. When indicated by assessment a toileting program will be devised by the restorative Nurse based on findings to include transferring ability, cognitive impairment, and ability to recognize need to toilet. Plan of care will reflect any changes. c. Resident #68 will be checked and changed before and after meals, at bedtime and at routine checks during the night and as requested until bowel and bladder assessment is completed.	1/15/06
F 318 SS=E	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by:	F 318	ID of residents – All residents have the ability to be affected. Systems – Nursing staff will be in serviced. Bowel and bladder assessment will be initiated on admission, annually, quarterly and with change of condition. Personalized interventions will be implemented based on comprehensive findings. Nursing staff will review the updated plan of care.	

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 315	Continued From page 20 program. The CNA stated the usual procedure was to change the resident's incontinence brief between 9 and 10 AM when s/he was assisted up and then to check and change it, if needed, around 2 PM when the resident was put back to bed. During an interview on 11/29/05 at 1:15 PM, the resident stated the aforementioned procedure was the "usual routine," but that s/he would like to use the toilet as s/he recognized the need to urinate. In addition, the resident stated s/he had to use "Attends" (incontinence briefs) as s/he was unable to walk to the bathroom and had to be transferred per mechanical lift. Furthermore, when asked about the incontinence briefs, the resident stated "It's nasty" to be wet. Observation on 11/29/05 revealed the resident's brief was not checked or changed from 9:37 AM until 1:50 PM. At 1:50 PM CNA #3 transferred the resident from the wheelchair to the bed. During the observation, the CNA confirmed the resident's incontinence brief and clothing were saturated with urine and the Dycem mat (a plastic pad to prevent sliding) and wheelchair seat were wet. In addition, there was a strong smell of urine present.	F 315	Monitoring – Director of Nursing and/or designee will monitor for compliance. Re-in servicing will occur as necessary. Quality of Assurance – Results of monitoring will be reported by Director of Nursing and/or designee quarterly or more frequently as needed to the Quality Assurance Meeting for review and suggestions.	
F 318 SS=E	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by:	F 318	F 318 Based on the comprehensive assessment of a resident the facility will ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This requirement will be met as evidenced by: 1. The Restorative Nurse will develop and initiate an individualized Range of Motion	1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 318	Continued From page 21 Based on medical record review, observation, and staff interview, the facility failed to ensure 5 (#10, #49, #57, #67, #68) of 6 sample residents receiving range of motion services were provided with services as ordered. The findings were: 1. Medical record review for resident #10 revealed a physician order dated 10/27/05 for active assistive range of motion to all extremities to maintain and or increase functional mobility in range of motion three times per week. Observation on 11/29/05 at 10:20 AM revealed a group exercise activity in the secure unit called "dining dynamics" which included upper extremity stretching with jingle bells and music. Resident #10 was seated in the group, but did not participate in the exercise other than tapping his/her feet to the music, and was not assisted with the activity. Review of the November 2005 restorative calender for resident #10 revealed the aforementioned observed activity was part of the restorative program. However, the calendar did not indicate any resident participation or any duration of time spent doing this or any other activity for the entire month. 2. Review of the hospital discharge summary for resident #49 revealed he/she was hospitalized with a fractured hip from 4/29/05 to 5/4/05. Review of the nursing restorative program records revealed the resident was scheduled for restorative exercises three times per week to maintain and or increase strength and endurance in all extremities. Review of the 9/05 restorative records revealed the resident did not receive services three times per week during three of the four weeks. Further review of this document revealed a restorative note dated 9/30/05 that	F 318	Program for resident #10 and plan of care will be updated. Will receive restoratives at a minimum of three times per week. 2. The Restorative Nurse will develop and initiate an individualized Range of Motion Program for Resident #49 and plan of care will be updated. Will receive restoratives at a minimum of three times per week. 3. The Restorative Nurse will develop and initiate an individualized Range of Motion Program for Resident #57 and plan of care will be updated. Will receive restorative services at a minimum of three times per week. 4. The Restorative Nurse will develop and initiate an individualized Range of Motion Program for Resident #67 and plan of care will be updated. Will receive restorative services at a minimum of three times per week. 5. The Restorative Nurse will develop and initiate an individualized Range of Motion	1/15/06 1/15/06 1/15/06 1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 318	Continued From page 22 stated "Restorative has been pulled to work [the] halls as [a] CNA all month." Review of the documented program for October and November 2005 was a calendar with highlighted activities which included exercise groups, dining dynamics, and AAROM/PROM. Review of the calendars revealed there were no stated goals for the program, no duration of the program, no level of participation by the resident, and no documentation of the resident's response or progress. Observation on 11/29/05 at 11:10 AM showed the resident was present for group exercises but had his/her chin lying on his/her chest with his/her eyes closed. Observation revealed the resident did not participate in the group exercises. In addition, observation revealed no encouragement or assistance was offered by staff to participate in the program. Review of the restorative documentation for October and November 2005 failed to show any evidence the program was completed as prescribed. 3. Review of the hospital history and physical for resident #57 revealed he/she was hospitalized from 10/13/05 to 10/21/05 because of a hip fracture. Review of the 10/29/05 quarterly MDS assessment revealed the resident had a decline in range of motion with partial loss in one leg. Review of the 11/2/05 physical therapy evaluation and plan of care, as well as the 11/2/05 physical therapy progress notes, revealed the resident was to receive restorative nursing services to maintain AAROM in the right extremity until the resident could begin weight bearing on that extremity. Review of the entire medical record revealed the resident did not receive any restorative services. Interview with the DON on 12/1/05 at 8:30 AM revealed she was unaware	F 318	Program for Resident #68 and plan of care will be updated. Will receive restorative services at a minimum of three times per week. 6. When resident is discharged from skilled therapy, the Director of Nursing will receive a copy of the discharge order and inform the Restorative Nurse. The Restorative Nurse will assess and if necessary develop a Restorative program and the plan of care will be updated. 7. The Restorative Nurse will assess residents for need of restorative program on admission (if admitted with skilled therapy services will assess once discharged from therapy caseload), annually, quarterly and with change of condition. Plan of care will be updated. 8. Restorative services to be provided a minimum of three times a week and documentation to reflect such. 9. Documentation of program to include goals for program, duration of program, participation by resident and resident's response to program.	1/15/06 1/15/06 1/15/06 1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 318	Continued From page 23 the resident required restorative services. 4. Review of the 8/4/05 significant change Minimum Data Set (MDS) assessment showed resident #67 had limited range of motion (ROM) on both sides with partial loss of voluntary movement in the arm and "other." According to the 7/28/05 physical therapy documentation, the resident was discharged to the restorative program for manual stretching of the foot and ankle three to five times a week. Review of the restorative program for September 2005 showed the resident received 15 minutes of passive ROM (PROM) to the ankle and 15 minutes of active assistive ROM (AAROM) three times a week. However, the documented program for October and November 2005 was a calendar with highlighted activities which included exercise groups, AAROM, PROM, and dining dynamics. Goals for the program, duration of the program, participation by the resident, and the resident's response were not included. Observation on 11/29/05 at 11:20 AM showed the resident participated for a short time in the group exercise program, then s/he ignored it and read the paper. No encouragement or assistance was offered by staff. Review of the restorative documentation for October and November 2005 failed to show any evidence the restorative program for this resident was completed as prescribed. 5. According to the 8/18/05 annual MDS assessment, resident #68 had limited ROM with partial loss of voluntary movement on one side for the arm, hand, leg, and foot. Review of the September 2005 documented restorative program showed the resident received PROM for 15 minutes to all extremities on the left side, 15	F 318	ID of Residents – All residents have the ability to be affected. Systems – Restorative Nurse will in service restorative nursing assistants. Restorative Nurse will assess residents on admission, annually, quarterly and with change of condition. Personalized interventions will be implemented based on findings. Plan of care will be updated accordingly and nursing staff to review updated plan of care. Monitoring – Director of Nursing and/or designee will monitor for compliance. Restorative Nurse will monitor restorative nursing assistants for compliance. Re-in servicing will occur as necessary. Quality of Assurance – The results of the monitoring will be reported by the Director of Nursing and/or designee quarterly or more frequently as necessary at the Quality Assurance Meeting for review and suggestions.	

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 318	Continued From page 24 minutes of active ROM (AROM) to extremities on the right side, and paraffin baths for 20 minutes to both hands. The program was completed three times a week. However, the documented program for October and November 2005 was a calendar with highlighted activities which included paraffin baths, exercise groups, AAROM, PROM, and dining dynamics. Goals for the program, duration of the program, participation by the resident, and the resident's response were not included. Observation on 11/29/05 at 11:25 AM showed the resident shook a bell with the right hand during the group exercises. However, no one provided PROM to the left side, encouraged the resident to complete AROM to all extremities on the right side, or checked to see if greater ROM could have been obtained. Review of the restorative documentation for October and November 2005 failed to show any evidence the program was completed as prescribed. 6. Interview with the DON on 12/1/05 at 8:30 AM confirmed staffing had been a problem during the months of September and October and that restorative staff had been required to work the halls as CNAs.	F 318		
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	F329 Each resident's drug regimen will be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring, or without adequate indications for it's use; or in presence of adverse consequences which indicate	

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 329	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of facility policy, the facility failed to assure the drug regimen was free of unnecessary drugs for two (#12 #13) of two sample residents who received hypnotic medications. The findings were: 1. Review of the medical record, and the October and November 2005 medication administration records (MARs) revealed resident #12 had an order for, and was receiving Ambien 10 milligrams for insomnia every evening starting on 9/16/05. Review of the psychoactive drug reduction follow up review dated 11/16/05 revealed Restoril was changed to Ambien (both hypnotic medications) on 9/16/05. However, this form indicated no other alternatives to hypnotic use were recommended or attempted. In addition, although the change in hypnotic use was two months prior to the review date, the resident was not considered for a dose reduction and the reason documented was "recent med [medication] change." Interview with registered nurse #4 on 12/1/05 at 4:38 PM confirmed there was no behavior tracking done for the Ambien in October or November 2005. Additional interview with the director of nursing on 12/01/05 at 1:40 PM revealed she was unaware of any additional documentation regarding dose reduction for the Ambien. Review of the 10/30/01 facility policy titled: Psychotropic medications, indications for use and reduction revealed, hypnotics should be evaluated after 10 days of continued use. Additionally, review of the August 2001 clinical	F 329	the dose should be reduced or discontinued; or any combinations of the reasons above. This requirement will be met as evidenced by: 1. Psychoactive Drug Monthly Flow Record initiated on 12/01/05 for Resident #12 for use of Ambien. 1/15/06 2. Addressed with physicians 12/29/2005 the need for hypnotic as short-term use only (no greater that ten consecutive nights) with need for evaluation after that time for continued use. 1/15/06 3. Policy/Procedure #5515 residents will be assessed and a gradual dose reduction attempted at least 3 times in a 6-month period before a clinical contraindication is documented. 4. Resident #13 expired. 1/15/06 5. Residents to be assessed after 7 consecutive days of hypnotic use. Assessment to include causes of insomnia such as depression, pain, noise, light, caffeine, incontinence or indwelling catheter. 6. If a hypnotic is designated as medically necessary, the physician will document that 1/15/06	

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 329	Continued From page 26 policy (# 5515) from Emissary Pharmacy being utilized by the facility for psychoactive drug monitoring showed, "Residents who receive antidepressant, hypnotic, antianxiety, or antipsychotic medications are monitored to evaluate the effectiveness of the medication." Additionally, for hypnotics, "a gradual dose reduction is attempted at least three times within six months before a clinical contraindication is documented." 2. Review of a physician's order dated 8/25/05 revealed resident #13 was prescribed Ambien (a sleep aid) every evening as needed. Review of the October 2005 medication administration record (MAR) showed, that with the exception of 10/11/05, the resident received Ambien nightly from October 1st through October 25, 2005. On 10/17/05, the physician ordered Lunesta (sleep aid) nightly to be started after the Ambien was completed. Review of the October and November MARs showed the resident received Lunesta nightly from 10/26/05 through 11/6/05; the resident was then hospitalized. Lunesta was reordered nightly on 11/26/05 after the resident was re-admitted, and according to the November 2005 MAR, it was administered as ordered. According to the 2005 edition of the "PDR Nurse's Drug Handbook," Ambien is for short term use, identified as 7 to 10 days. Review of the manufacturer's insert showed use of Lunesta is recommended for 7 to 10 days, with a maximum of two weeks. Review of the medical record failed to show the resident was assessed for causes of insomnia such as depression, pain, noise, light, caffeine, incontinence, or an indwelling catheter. Interview with the Minimum Data Set (MDS) assessment coordinator on 11/30/05 at 10:50 AM confirmed	F 329	the benefits for excessive duration of use exceed the risks of taking the hypnotic. 7. If there is a need for continued use of hypnotic. The physician will reassess on a regular basis and document in medical record. 8. Hypnotics will be monitored to evaluate for effectiveness. 9. Nursing staff to inform the Director of Nursing of any/all new orders received for use of hypnotics. ID of residents – All residents have the ability to be affected. Systems – Nursing staff will be in serviced. Plan of care will be updated. Nursing staff will review updated plan of care. Monitoring – Director of Nursing and or designee will monitor for compliance. Rein servicing will occur as necessary. Quality of Assurance – Results of monitoring will be reported by Director of Nursing and/or designee at the Quality Assurance Meeting quarterly or more frequently as needed for review and suggestions.	1/15/06 1/15/06 1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 329	Continued From page 27 the facility lacked an assessment to determine the cause of the resident's insomnia. In addition, she confirmed there was no evidence the physician had documented that the benefits for the excessive duration of use exceeded the risks of taking the hypnotics. Furthermore, review of the medical record and interview with licensed practical nurse #1 on 12/1/05 at 4:45 PM, confirmed the facility was not monitoring the resident for behaviors and side effects from the use of the hypnotics. According to the facility's August 2001 policy and procedure, "Psychoactive Drug Monitoring" number 5515, "Residents who receive...hypnotic...medications are monitored to evaluate the effectiveness of the medication." Further review showed "Residents receive a psychoactive medication only if designated medically necessary by the prescriber. The medical necessity is documented in the resident's medical record...The continued need for the psychoactive medication is reassessed regularly by the prescriber" and "indicated in the medical record...The clinical record contains evidence to support justification for use of a drug not meeting the dosage criteria but considered clinically appropriate by the physician."	F 329		
F 331 SS=D	483.25(l)(2)(ii) ANTIPSYCHOTIC DRUGS Based on a comprehensive assessment of a resident, the facility must ensure that residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 331	F331 Based on a comprehensive assessment of a resident, the facility will ensure that residents who use anti-psychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This requirement will be met as evidenced by: 1. Resident #10 was assessed on 12/13/2005 and a dose reduction request was sent to	1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 331	Continued From page 28 by: Based on review of the medical record, review of facility policy, and staff interview, the facility failed to ensure that 1 (#10) of 1 sample residents using antipsychotic medication received gradual dose reductions. The findings were: 1. Review of the medical record, and the October and November 2005 medication administration records (MAR) revealed, resident #10 received Seroquel (an antipsychotic)100 milligrams three times daily per physician's order dated 4/16/04. According to the psychoactive drug assessment/reduction plan dated 4/27/05, Seroquel was listed under medications. However, the form was not filled out entirely, and there was no mention of any attempt to decrease the dose of Seroquel even though the resident had received the same dose for 19 months. Review of the psychoactive drug reduction follow up dated 8/31/05 revealed the medication being reviewed was not indicated. Additionally, "No changes" was written in the section for changes and/or responses to interventions. Further, the section for reduction and/or elimination was marked "no" and the comment was,"optimal at this time, changes in unit dynamics." No physician statement verifying that this was an optimal dose was included in the medical record. Interview with the director of nursing on 12/01/05 at 1:40 PM revealed she was unaware of any additional documentation regarding dose reduction for the Seroquel. According to the August 2001 clinical policy (# 5515) from Emissary Pharmacy being utilized by the facility for psychoactive drug monitoring, "Residents receive gradual dose reductions of the	F 331	the physician. 2. Residents receiving antipsychotic medication will be reviewed and assessed for dosage reduction on a quarterly basis and as necessary. 3. The psychoactive drug assessment/reduction plan form will provide documentation to support reason for and/or for not reducing a psychoactive medication. 4. Physicians to provide statement verifying at optimal dose if no change is to be made and to be included in medical records. ID of Residents – All residents have the ability to be affected. Systems – Nursing staff will be inserviced. Plan of care will be updated and nursing staff will review updated plan of care. Monitoring – Director of Nursing and/or designee will monitor for compliance and rein servicing will occur as necessary. Quality of Assurance – Results of monitoring will be reported quarterly or more frequently as necessary at Quality Assurance Meeting for review and suggestions.	1/15/06 1/15/06 1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 331	Continued From page 29 antipsychotics drug, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs."	F 331	F3[illegible] The facility will have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments, and individual plans of care.	
F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide sufficient staff to provide timely care and services for five (#10, #49, #57, #67, #68) of six residents who required restorative services. The findings were:	F 353	This requirement will be met as evidenced by: 1. Restorative Nurse will develop and individualized Range of Motion Program for resident #49 and plan of care will be updated. Will receive restorative services at a minimum of three times per week. 1/15/06 2. Restorative nurse will develop an individualized Range of Motion Program for resident#10 and plan of care will be updated. Will receive restorative services at a minimum of three times per week. 1/15/06 3. Restorative nurse will develop an individualized Range of Motion Program for resident #57 and plan of care will be updated. Will receive restorative services at a minimum of three times per week. 1/15/06	

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 353	Continued From page 30 1. Review of the hospital discharge summary for resident #49 revealed he/she was hospitalized with a fractured hip from 4/29/05 to 5/4/05. Review of the nursing restorative program records revealed the resident was scheduled for restorative exercises three times per week to maintain and or increase strength and endurance in all extremities. Review of the 9/05 restorative records revealed the resident did not receive services three times per week during three of the four weeks. Further review of this document revealed a restorative note dated 9/30/05 that stated, "Restorative has been pulled to work [the] halls as [a] CNA all month." Review of the documented program for October and November 2005 was a calendar with highlighted activities which included exercise groups, dining dynamics, and AAROM/PROM. Review of the calendars revealed there were no stated goals for the program, no duration of the program, no level of participation by the resident, and no documentation of the resident's response or progress. Observation on 11/29/05 at 11:10 AM showed the resident was present for group exercises but had his/her chin lying on his/her chest with his/her eyes closed. Observation revealed the resident did not participate in the group exercises. In addition, observation revealed no encouragement or assistance was offered by staff to participate in the program. Review of the restorative documentation for October and November 2005 failed to show any evidence the program was completed as prescribed. 2. Review of the hospital history and physical for resident #57 revealed he/she was hospitalized from 10/13/05 to 10/21/05 because of a hip	F 353	4. Restorative nurse will develop an individualized Range of Motion Program for resident #67 and plan of care will be updated. Will receive restorative services at a minimum of three times per week.	1/15/06
			5. Restorative nurse will develop an individualized Range of Motion Program for resident #68 and plan of care will be updated. Will receive restorative services at a minimum of three times per week.	1/15/06
			6. Restorative services will be provided at a minimum of three times a week for residents with an individualized restorative program.	1/15/06
			7. Restorative Nurse will provide supervision for restorative nursing assistants to ensure compliance.	1/15/06
			ID of Residents – All residents have the ability to be affected. Systems – Restorative Nurse will inservice restorative nursing assistants. Documentation will reflect stated goal, duration of program, resident's response and/or progress. Restorative nursing assistants will review updated plan of care.	

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 353	Continued From page 31 fracture. Review of the 10/29/05 quarterly MDS assessment revealed the resident had a decline in range of motion with partial loss in one leg. Review of the 11/2/05 physical therapy evaluation and plan of care as well as the 11/2/05 physical therapy progress notes revealed the resident should receive restorative nursing services to maintain AAROM in the right extremity until the resident can begin weight bearing on that extremity. Review of the entire medical record revealed the resident did not receive any restorative services. Interview with the DON on 12/1/05 at 8:30 AM revealed she was unaware the resident required restorative services. 3. Medical record review for resident #10 revealed a physician order dated 10/27/05 for active assistive range of motion to all extremities to maintain and or increase functional mobility in range of motion three times per week. Observation on 11/29/05 at 10:20 AM revealed a group exercise activity in the secure unit called "dining dynamics" which included upper extremity stretching with "jingle bells" and music. Resident #10 was seated in the group, but did not participate in the exercise other than tapping his/her feet to the music, and was not assisted with the activity. Review of the November 2005 restorative calender for resident #10 revealed the aforementioned observed activity was part of the restorative program. However, the calendar did not indicate any resident participation or any duration of time spent doing this or any activity for the entire month. 4. Review of the 8/4/05 significant change Minimum Data Set (MDS) assessment showed resident #67 had limited range of motion (ROM)	F 353	Monitoring – Director of nursing and/or designee will monitor for compliance. Restorative Nurse will supervise Restorative nursing assistants with a minimum of monthly checks. Reinservicing will occur as necessary. Quality of Assurance – Results of monitoring will be reported quarterly or more frequently as necessary at Quality Assurance Meeting for review and suggestions.	

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 353	Continued From page 32 on both sides with partial loss of voluntary movement in the arm and "other." According to the 7/28/05 physical therapy documentation, the resident was discharged to the restorative program for manual stretching of the foot and ankle three to five times a week. Review of the restorative program for September 2005 showed the resident received 15 minutes of passive ROM (PROM) to the ankle and 15 minutes of active assistive ROM (AAROM) three times a week. However, the documented program for October and November 2005 was a calendar with highlighted activities which included exercise groups, AAROM, PROM, and dining dynamics. Goals for the program, duration of the program, participation by the resident, and the resident's response were not included. Observation on 11/29/05 at 11:20 AM showed the resident participated for a short time in the group exercise program, then s/he ignored it and read the paper. No encouragement or assistance was offered by staff. Review of the restorative documentation for October and November 2005 failed to show any evidence the program was completed as prescribed. 5. According to the 8/18/05 annual MDS assessment, resident #68 had limited ROM with partial loss of voluntary movement on one side for the arm, hand, leg, and foot. Review of the September 2005 documented restorative program showed the resident received PROM for 15 minutes to all extremities on the left side, 15 minutes of active ROM (AROM) to extremities on the right side, and paraffin baths for 20 minutes to both hands. The program was completed three times a week. However, the documented program for October and November 2005 was a calendar with highlighted activities which included paraffin	F 353		

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 353	Continued From page 33 baths, exercise groups, AAROM, PROM, and dining dynamics. Goals for the program, duration of the program, participation by the resident, and the resident's response were not included. Observation on 11/29/05 at 11:25 AM showed the resident shook a bell with the right hand during the group exercises. However, no one provided PROM to the left side, encouraged the resident to complete AROM to all extremities on the right side, or checked to see if greater ROM could have been obtained. Review of the restorative documentation for October and November 2005 failed to show any evidence the program was completed as prescribed. 6. Interview with the director of nursing (DON) on 12/1/05 at 8:30 AM confirmed staffing had been a problem during the months of September and October and that restorative staff had been required to work the halls as CNAs.	F 353		
F 426 SS=E	483.60(a) PHARMACY SERVICES - 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to assure expired medications at two of two nursing stations were removed from cabinets and made unavailable for resident use. The expired medications included both stock	F 426	F426 The facility will provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of each resident. This requirement will be met as evidenced by: 1. Nursing staff will review medication bottles in medication rooms at nurse's station on a monthly basis. 2. Pharmacist will continue to review as per his normal schedule. 3. Expired drugs will be pulled	1/15/06 1/15/06 1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 426	Continued From page 34 medications and those labeled for individual resident use. The findings were: 1. On 12/1/05 at 11:05 AM, the following expired medications were found in the medication room cabinets at the nurses' station for halls 1 and 2: a. 3 stock bottles of Theratabs, 100 tablets each, one opened, expired 7/04. b. 4 stock bottles of Aspirin, one opened, expired 8/05. c. 2 stock bottles of Aspirin, expired 10/05. d. 12 ounce stock bottle of Geri Max, opened, expired 10/05. e. 1000 milliliters of Acetic Acid 0.25 % irrigation solution for resident #2, expired 11/15/05. f. A stock bottle of Oyster Shell Calcium with Vitamin D, 100 tablets, expired 11/05. Interview with licensed practical nurse (LPN) #1 revealed the pharmacist checked monthly for outdated medications. The LPN also confirmed the itemized medications were expired. 2. On 12/1/05 at 11:30 AM, observation of the medication room cabinets at the nurses' station for halls 3 and 4 revealed a box containing 51 out of 60 doses of ipratropium bromide inhalation solution expired on 7/05. The box was unlabeled, but interview with registered nurse (RN) #2 revealed the medication was for a specific resident. However, the RN was unable to remember the resident's name. 3. On 12/1/05 at 11:35 AM, the director of nursing (DON) confirmed the pharmacist was to check monthly for expired medications. However, the DON stated that nursing was also to check for outdated medications.	F 426	from cabinets and given to Director of Nursing for destruction. ID of Residents – All residents have the ability to be affected. Systems – Nursing staff will be inserviced. Monthly checks will be completed by nursing staff in addition to those by the pharmacist. Monitoring – Director of Nursing and/or designee will monitor for compliance and reinservicing will occur as necessary. Quality of Assurance – Results of monitoring will be reported quarterly or more frequently as necessary at Quality Assurance Meeting for review and suggestions.	

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 429	Continued From page 35	F 429	F429	
F 429 SS=D	483.60(c)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities to the attending physician and the director of nursing. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the pharmacist identified excessive hypnotic use as an irregularity and reported it as required for 1 of (#13) two residents receiving hypnotics. The findings were: Review of the admission face sheet showed resident #13 was admitted to the facility on 8/25/05. Review of the admission orders showed they included Ambien (a sleep aid) every evening as needed. Review of the October 2005 medication administration record (MAR) showed, that with the exception of 10/11/05, the resident received Ambien nightly from October 1st through October 25, 2005. On 10/17/05, the physician ordered Lunesta (sleep aid) nightly to be started after the Ambien was completed. Review of the October and November MARs showed the resident received Lunesta nightly from 10/26/05 through 11/6/05; the resident was then hospitalized. Lunesta was reordered nightly on 11/26/05 after the resident was re-admitted, and according to the November 2005 MAR, it was administered as ordered. According to the 2005 edition of the "PDR Nurse's Drug Handbook," Ambien is for short term use. Short term use is identified as 7 to 10 days. Review of the manufacturer's insert showed use of Lunesta is recommended for 7 to 10 days, with a maximum	F 429	The pharmacist will report any irregularities to the attending physician and the director of nursing. This requirement will be met as evidenced by: 1. The pharmacist will communicate any/all medication irregularities to the physician and Director of Nursing utilizing the Physician Action Report. The original will be sent to the physician for signature and a copy placed in the resident's medical record until original returned with physician signature. 2. Addressed with physicians 12/29/2005 recommended use of hypnotics for short-term use only and the appropriate documentation and assessments needed to justify extended use. ID of Residents – All residents have the ability to be affected. Systems – Licensed staff will be inserviced. Plan of care will be updated and nursing staff to review updated plan of care. Assessments to include causes of insomnia such as depression, noise, light, pain, caffeine, incontinence and use of indwelling catheter. Physician must document that the benefits for excessive duration of use	1/15/06 1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 429	Continued From page 36 of two weeks. Review of the monthly drug regimen review completed by the pharmacist from August 2005 through November 2005 showed the pharmacist was aware of the ordered hypnotics. However, there was no evidence he identified the nightly use as an irregularity and reported it to the physician and director of nursing (DON). Interview with the DON on 12/1/05 at 2:12 PM confirmed she was unaware of the irregularity.	F 429	exceed the risks of taking the hypnotic. Monitoring – Director of Nursing and/or designee will monitor for compliance and reinservicing will occur as necessary. Quality of Assurance – Results of monitoring will be reported quarterly or more frequently as necessary at Quality Assurance Meeting for review and suggestions.	
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to assure staff decontaminated their hands when indicated. During two random observations involving residents #13 and #51, staff failed to cleanse their hands after providing care which contaminated them. The findings were: 1. Review of the 11/1/05 significant change MDS assessment for non-sample resident #51 revealed he she was incontinent of urine and bowel (all or almost all of the time) and required extensive staff assistance with personal hygiene. Observation on 11/29/05 at 11:25 AM revealed the resident was incontinent of urine. Observation revealed CNA #1 provided perineal care for the	F 444	F444 The facility will require staff to wash their hands after each direct contact for which hand washing is indicated by accepted professional practice. This requirement will be met as evidenced by: 1. Staff inserviced on hand washing and provided with Policy/Procedure CL-NUR-1722. 1/15/06 2. Nursing staff inserviced on need to remove gloves after providing perineal care and prior to continuing care of the resident. 1/15/06 3. All staff inserviced on need to wash hands or use alcohol based product after removing gloves and if moving from a contaminated body site during resident care or after contact 1/15/06	

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 444	Continued From page 37 resident. Observation further revealed the CNA did not remove her gloves after providing perineal care and prior to continuing care of the resident Interview with the CNA at that time revealed she knew she should have removed her gloves after providing perineal care. Review of the facility's policy on handwashing dated 1/1/01 revealed "After...or assisting others with toileting, or after personal grooming." 2. On 11/29/05 at 12:20 PM observation showed the occupational therapist (OT) repositioned resident #13 by placing her left hand on the resident's thigh and her right hand on the bottom of the resident's shoe. Without decontaminating her hands, the therapist then unwrapped the silverware and, using her contaminated right hand, handed it to the resident. Later during the meal, the therapist picked up the resident's cup with both hands and used her contaminated right hand to turn the straw towards the resident; the resident drank from the straw. 3. According to the guidelines published by the Centers for Disease Control (CDC) in October 2002, hands should be decontaminated (washed with soap and water or rub with an alcohol based product) "after removing gloves...if moving from a contaminated-body site to a clean-body site during patient [resident] care...after contact with inanimate objects in the immediate vicinity of the patient [resident]."	F 444	with inanimate objects in the immediate vicinity of the resident. ID of Residents – All residents have the ability to be affected. Systems – Staff Development Coordinator to provide inservicing to all staff on proper technique for handwashing. Alcohol based products made readily available to staff. Monitoring – Director of Nursing and/or designee will monitor for compliance and reinservicing will occur as necessary. Quality of Assurance – Results of monitoring will be reported quarterly or more frequently as necessary at Quality Assurance Meeting for review and suggestions.	
F 465 SS=B	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	F465 The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. This requirement will be met as evidenced by:	

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 465	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview the facility failed to ensure the kitchen hand washing sink used by staff was clean and sanitary. The findings were: Observation on 11/29/05 at 4:55 PM, and again on 11/30/05 at 10:50 AM revealed a blackish grey, rippled, slimy looking build-up in the uncovered drain of the kitchen hand washing sink. The drain was about two inches in diameter, and the build up extended from the opening of the drain to as far as could be seen down the drain (approximately 3 inches). Interview with the dietary manager on 11/30/05 at 11 AM confirmed that the build up was "slimy looking" and "gross," and it should be cleaned out.	F 465	1. Hand sink drains in dietary area will be cleaned with disinfectant and a brush nightly until approximately 1/20/2006. By 1/20/2006 EcoLab is scheduled to deliver and set up a Quat Cleaner that will be used on a daily basis. ID – All hand sinks in dietary area have the ability to be affected. System – Dietary Staff will be inserviced on proper technique to clean hand sink drain in dietary area with disinfectant and brush. After the Quat Clean is installed dietary staff will be inserviced on new method installed by EcoLab. This task will be added to the list of daily duties assigned the afternoon cook. Monitoring – Dietary Manager and/or designee will monitor for compliance. Reinservicing will occur if necessary. Quality of Assurance – Results of monitoring will be reported by Dietary Manager and/or designee quarterly or more frequently as needed at Quality Assurance Meeting for review and suggestions.	1/15/06
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to assure certified nurse aides (CNAs) provided oxygen in accordance with a directive from the Wyoming State Board of Nursing (SBON) for two	F 492		

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 465	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview the facility failed to ensure the kitchen hand washing sink used by staff was clean and sanitary. The findings were: Observation on 11/29/05 at 4:55 PM, and again on 11/30/05 at 10:50 AM revealed a blackish grey, rippled, slimy looking build-up in the uncovered drain of the kitchen hand washing sink. The drain was about two inches in diameter, and the build up extended from the opening of the drain to as far as could be seen down the drain (approximately 3 inches). Interview with the dietary manager on 11/30/05 at 11 AM confirmed that the build up was "slimy looking" and "gross," and it should be cleaned out.	F 465		
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to assure certified nurse aides (CNAs) provided oxygen in accordance with a directive from the Wyoming State Board of Nursing (SBON) for two	F 492	F492 The facility will operate services in compliance with all applicable Federal, State and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This requirement will be met as evidenced by: 1. Nursing staff inserviced 12/12/05. 12/13/05. 01/05/06, and 01/06/06 on Directive from Wyoming State Board of	1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 492	Continued From page 39 of two (#13, #68) sample residents who utilized oxygen. In addition, the nasal cannula for resident #68 was not cleansed or replaced after contact with the floor. The findings were: Observation on 11/29/05 at 9:35 AM showed resident #13 used oxygen at 6 liters per minute (LPM) per concentrator. Observation on 11/29/05 at 11:40 AM showed a CNA removed the resident's oxygen and transferred him/her from the bed to a wheelchair. After the transfer, the CNA changed the oxygen tubing from the concentrator to the portable tank and set the oxygen flow rate at 6 LPM. The flow rate was not posted on either the concentrator, the tank, or over the bed. The CNA confirmed the lack of a posted flow rate, but reported it was on the CNA charting sheet. The CNA stated he noted the rate on the concentrator and set the flow rate on the tank at the same LPM. In addition, the CNA stated CNAs turned on about 95 percent of the oxygen used by the residents. Immediately after completion of care, the CNA and the surveyor checked the CNA charting sheet; the documented oxygen flow rate was 2 LPM. According to the facility's 5/7/02 policy and procedure, "Oxygen Concentrator," number CI-Nur-1064, "the maximum flow rate on a concentrator is 5 liters." If a rate greater than 5 is required, "an alternative system must be considered." Further review of the policy revealed a CNA "may assist as allowed by state-specific regulations." According to the 6/13/01 directive from the Wyoming State Board of Nursing, CNAs may turn on oxygen liter flow or adjust the flow rate only if the liter flow rate "is clearly marked by the nurse on the concentrator &/or oxygen tank or over the client's bed."	F 492	Nursing dated 6-13-2001. CNA's may turn on liter flow or adjust liter flow if liter flow rate is marked by the nurse on the concentrator and/or portable oxygen tank. 2. Residents on oxygen will have concentrators and/or portable oxygen tanks marked with the correct liter flow. 3. Charge Nurse will monitor liter flow for residents on oxygen. Liter flow to be monitored on both concentrator and/or portable oxygen tank. If liter flow is not correct, the CNA will be inserviced immediately. 4. Nursing staff inserviced 12/12/05, 12/13/05, 01/05/06, and 01/06/06 on the need to provide clean nasal cannula for residents. If cannula dropped on the floor it should be cleaned or replaced with a new cannula. 5. Resident #13 expired 6. Resident #68 Nasal cannula replaced and concentrator and portable oxygen tank marked with liter flow. ID of Residents – All residents have the ability to be affected. Systems – Nursing staff will be inserviced. Plan of care updated and	1/15/06 1/15/06 1/15/06 1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 492	Continued From page 40 2. Observation on 11/29/05 at 9:37 AM showed resident #68 used oxygen at 3 LPM per portable tank. Observation on 11/29/05 at 1:50 PM showed a CNA transferred the resident from a wheelchair to a bed. The CNA dropped the resident's nasal cannula on the floor, picked it up, placed it on the resident without cleansing it, and turned on the oxygen concentrator at 2.5 LPM. The liter flow rate was not posted on the oxygen concentrator or tank, nor over the resident's bed. According to the 6/13/01 directive from the Wyoming State Board of Nursing, CNAs may turn on oxygen liter flow or adjust the flow rate only if the liter flow rate "is clearly marked by the nurse on the concentrator &/or oxygen tank or over the client's bed." Review of the facility's aforementioned policy related to oxygen administration revealed it did not address cleanliness of the nasal cannula.	F 492	nursing staff will review updated plan of care. Policy/Procedure CL-NUR-1064 will be revised/amended to include oxygen liter flow greater than five liters and also address the need for cleanliness of nasal cannula. Monitoring – Director of Nursing and/or designee will monitor for compliance and reinservicing will occur as necessary. Quality of Assurance – Results of monitoring will be reported quarterly or more frequently as necessary at Quality Assurance Meeting for review and suggestions.	
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview, and medical record review, the facility failed to ensure laboratory tests were completed as ordered for 1 (#57) of 15 sample residents. The findings were: 1. Review of the 10/13/05 physician's orders revealed an order for a liver profile in one month for resident #57. Review of the entire medical	F 502	F502 The facility will provide or obtain laboratory services to meet the needs of it's residents. The facility is responsible for the quality and timeliness of the services. This requirement will be met as evidenced by: 1. Resident #57—Physician informed on 12/2/05 regarding lipid panel done versus liver panel(ordered). 2. Nurses in-serviced on 12/13/05	1/15/06 1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 492	Continued From page 40 2. Observation on 11/29/05 at 9:37 AM showed resident #68 used oxygen at 3 LPM per portable tank. Observation on 11/29/05 at 1:50 PM showed a CNA transferred the resident from a wheelchair to a bed. The CNA dropped the resident's nasal cannula on the floor, picked it up, placed it on the resident without cleansing it, and turned on the oxygen concentrator at 2.5 LPM. The liter flow rate was not posted on the oxygen concentrator or tank, nor over the resident's bed. According to the 6/13/01 directive from the Wyoming State Board of Nursing, CNAs may turn on oxygen liter flow or adjust the flow rate only if the liter flow rate "is clearly marked by the nurse on the concentrator &/or oxygen tank or over the client's bed." Review of the facility's aforementioned policy related to oxygen administration revealed it did not address cleanliness of the nasal cannula.	F 492	and 01/06/05 regarding initiation of use of lab log-gin sheet. 3. nurses in-serviced on 12/13/05 and 01/06/06 regarding need to double check labs with orders received. ID: All residents with lab orders have potential to be affected.	1/15/06
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview, and medical record review, the facility failed to ensure laboratory tests were completed as ordered for 1 (#57) of 15 sample residents. The findings were: 1. Review of the 10/13/05 physician's orders revealed an order for a liver profile in one month for resident #57. Review of the entire medical	F 502	System: Nursing staff will in-serviced. Night shift to review labs and note verification on log sheet. Lab orders to be placed on the TAR. Care plan updated as necessary and nursing staff to review updated care plans. Monitoring: Director and/or designee to monitor for compliance. Re-in-servicing to occur as necessary. Quality Assurance: Results of monitoring will be reported by Director of Nursing quarterly or more frequently as needed as the Quality of Assurance meeting for review and suggestions.	

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 502	Continued From page 41 record revealed there was no liver profile test completed in November 2005. Review of the outpatient request form dated 11/15/05 revealed the test ordered was for a complete blood count and lipid panel. Review of the order form further revealed a liver profile was not marked as ordered. Interview with the director of nursing on 12/1/05 at 2:30 PM confirmed the liver profile was not done.	F 502		
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of an internal log, the facility failed to assure staff maintained complete, accurate resident records and internal logs of facility programs. Medical records for 1 (#57) of 13 sample residents were not accurate and the medical record for sample resident #58 was incomplete. The facility's internal log for the infection control program was inaccurate and the documentation was corrected inappropriately.	F 514	F514 The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible; and systematically organized. This requirement will be met as evidenced by: 1. Activity will be inserviced on the need to chart in a timely and accurate manner. a. Activity staff will be inserviced on documentation and need to be in chart where readily available. b. All activity charting will be placed in specific resident's medical chart at the end of the month. c. Activity documentation will be completed on a daily basis for	1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 514	Continued From page 42 The findings were: 1. During the 11/29/05 through 12/1/05 recertification survey, copies of the 9/05 and 10/05 activity calendars highlighting the residents attendance at activities for resident #57 were made. The facility faxed copies of the same calendars on 12/5/05. Review of the two sets of calendars revealed the following concerns with accuracy: a. On 9/1/05 the activities highlighted on the original document included exercise and music. On the copy faxed four days later, the activities documented were exercise, music, and bingo. b. On 9/15/05 the activities highlighted on the original documented included music. On the copy faxed four days later, the activities documented were exercise, music, and bingo. c. On 10/19/05 the activities highlighted on the original documented included hand massage and TV land. On the copy faxed four days later, activities documented included hand massage, TV land, and exercise. 2. Review of nursing notes dated 7/12/05 at 10:30 AM showed a urine specimen was obtained for resident #58 and sent to the laboratory (lab) for urinalysis (UA). The documentation indicated the lab results were back and on the chart, the physician was notified, a culture was to be done by the lab, and the resident was started on an antibiotic. Review of additional documentation dated 7/20/05 showed another UA was obtained and sent to the lab. This documentation also indicated the report was back and on the chart, a copy was faxed to the physician, and the lab was called to do a culture. Review of the medical record, including lab reports and physician orders, showed the culture results for 7/12/05 and the UA	F 514	each activity attended and for each resident specific. d. Activity staff will be inserviced on correct method of altering previous documentation, a single line through the area to be corrected, date, time and signature of person changing the documentation. 2. Nursing staff in-serviced 12/12/05, 12/13/05, 01/05/06, and 01/06/06 on correct method of altering any previous documentation, a single line through the area to be corrected, date, time and signature of person changing documentation. ID of residents – All residents have the ability to be affected. Systems – All staff inserviced on the proper method of altering previous documentation. Plan of care to updated and staff to review updated plan of care. Monitoring – Director of Nursing and/or designee will monitor for compliance and reinservicing will occur as necessary. Quality of Assurance – Results of monitoring will be reported quarterly or more frequently as necessary at Quality Assurance Meeting for review and suggestions.	1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 514	Continued From page 43 and culture results for 7/20/05 were not included in the record. Interview on 12/1/05 at 9:30 AM with a registered nurse (RN) confirmed the discrepancy between the nursing notes and the lab results. The RN was unable to locate the lab results. On 12/1/05 at 9:35 AM, the RN obtained the infection control log and stated she was the infection control coordinator. Review of the log with the RN showed a UA was obtained on 7/12/05, the results were logged as a nosocomial (facility acquired) infection, a culture was done on 7/12/05, and a horizontal line was drawn through the space for "organism." When the RN brought a copy of the log to the surveyor at 9:45 AM, it had been altered. The culture date was scribbled out for resident #58 and for the resident's name on the line above it, 7/20/05 was written as the culture date for resident #58, the date for the culture for the other resident was not documented, a zero with a diagonal line through it was drawn over the horizontal line in the space for "organism," and "7-20" was written in the space for "date cleared." Interview with the RN at that time revealed she had altered the log. The RN also stated she did not know which documentation, the nursing notes or the log, was accurate. On 12/1/05 at 10:25 AM, the RN brought copies of the lab results for all the aforementioned dates and stated they were not in the record so she obtained them from the lab. According to "The Lippincott Manual of Nursing Practice," seventh edition, 2001, a common legal claim is for "Departure from Standards of Care...Altering a medical record without noting it as a correction with signature, date and time of change."	F 514		
F 520	483.75(o)(1) QUALITY ASSESSMENT AND	F 520		1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 520 SS=D	Continued From page 44 ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of facility reports, and quality assurance information, the facility failed to correct identified deficiencies in the areas of incontinence care, activities of daily living care, range of motion, assessment, care planning, and following the care plan. The findings were: Review of the facility OSCAR 3 report (a history of deficiencies cited on the previous 4 annual surveys) revealed the following concerns: a. Incontinence care was identified as deficient in the years 2001, 2002, 2003, and 2004. b. Deficient practice in the provision of activities of daily living was identified in 2002 and 2003. c. Deficient practice in the provision of range of motion exercises was identified in 2004. d. Assessments were identified as deficient in the years 2001, 2002, 2003, and 2004. e. Care planning was identified as deficient in the years 2001 and 2002. f. Following the care plan was identified as deficient in 2002 and 2004. During the annual survey for 2005, all these areas were again cited for deficient practice. Interview with the director of nursing and the administrator on 12/1/05 at 10:15 AM revealed these areas	F 520	F520 This requirement will be met as evidenced by: 1. Quality Assurance Committee will review past deficiencies as taken from OSCAR 3 report concerning a. Incontinence care b. Activities of Daily Living c. Range of Motion d. Assessments e. Care Planning f. Following the Plan of Care. 2. The Quality Assurance Committee will monitor problem areas to ensure compliance. 3. Any suggestions made by the Quality Assurance Committee will be followed up on by Director of Nursing and/or Assistant Director of Nursing. ID of Residents – All residents have the ability to be affected. Systems – Nursing staff will be inserviced. The Quality Assurance Committee will review the concerns with revisions made as necessary to ensure compliance. Monitoring – Director of Nursing and/or designee will monitor for compliance and reinservicing will	1/15/06 1/15/06 1/15/06

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 _____	12/01/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 520	Continued From page 45 were not identified as problems or monitored through the quality assurance program.	F 520	occur as necessary. Quality of Assurance – Results of monitoring will be reported quarterly or more frequently as necessary at Quality Assurance Meeting for review and suggestions. 1/3/05 @ 1155 Interview c Yvonne Bergeron, RN, DON revealed a more specific addendum will be faxed to prove how QA will comply with monitoring. 1/6/06 See Faxed addendum. DOC date changed to 1/25/06	