POC review d
and approved with Terroll Walter RN
5/2/05 9:45 am
Anita Cox-Mills RN

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

PRINTED: 04/28/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535045	A. BUILDING _____ B. WING _____	C 04/14/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORLAND HEALTHCARE AND REHABIL	1951 HOWELL WORLAND, WY 82401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=J	483.25(h)(1) QUALITY OF CARE The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, facility documentation review, preliminary coroner's report review and observation, the facility failed to ensure a Tri-Cell inflatable air mattress used in conjunction with half side rails did not pose a safety risk for one (#1) of one resident who utilized this brand of mattress. The practice resulted in the death of resident #1 and resulted in an immediate jeopardy situation. Facility actions abated the immediate jeopardy which was removed on-site. The findings were: Closed record review revealed the 9/16/04 annual Minimum Data Set (MDS) assessment and the 3/17/05 quarterly assessment showed resident #1 had a diagnosis of Alzheimer's disease. In addition, both assessments showed the resident was unable to communicate, weighed 208 lbs, and was totally dependant on staff for bed mobility. Review of nursing notes revealed that on 1/7/05 the use of an inflatable air-flow mattress was initiated for this resident. In addition, interview with the facility administrator on 4/13/05 at 3:00 PM revealed that bilateral half side rails were used in conjunction with the air-flow mattress to assist nursing staff in turning the resident. The following concerns were noted pertaining to the use of the air-flow mattress and the half rails: a. According to nursing notes dated 1/23/05 at 5:30 PM, the resident was found on the floor	F 323	Preparation and execution of this plan of correction does not constitute an admission or agreement by this provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision 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 actions were necessary. F 323 The facility will ensure that the resident's environment remains as free of accident hazards as is possible. This requirement will be met as evidenced by:	

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

Terroll Walter — Administrator — 4-29-05

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: BD3I11 Facility ID: WY4009 If continuation sheet Page 1 of 4

reviewed & approved 5/2/05 9:45 Anita Mich RN

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

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	535043	A. BUILDING _____ B. WING _____	C 04/14/2005

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

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F 323	Continued From page 1 beside his/her bed. Interview with the facility administrator and the director of nursing on 4/13/05 at 3:00 PM revealed the resident had been pushed onto the floor by the air-flow movement of the mattress. Further interview at that time revealed the administrative team had suspected the cause to be the result of nursing staff over inflating the mattress. However, review of facility documentation and interview with the MDS coordinator and director of staff development on 4/14/05 at 10:00 AM, revealed there had been no investigation into other possible causes for the incident, nor were staff trained in regard to the incident. b. According to nurse communication to the physician dated 3/14/05, the resident was found to have rolled into the half side rail. The air-flow mattress was ballooned up on the right side of the resident, with little air underneath him/her. As a result, the resident sustained an indentation from the rail on his right arm above his elbow towards the back. Furthermore, as a result of the bed linen being bunched underneath him/her, the resident sustained indentation marks on his right hip. Interview with the director of nursing on 4/14/05 at 10:00 AM revealed the resident's bed was situated sideways against the bedroom wall. As a result, the wall had prevented the resident from again being pushed to the floor by the air-flow mattress. Further interview with the director of nursing at that time revealed the administrative team suspected the cause to be related to nursing staff not positioning the resident in the center of the mattress. However, subsequent review of facility documentation and further interview on 4/14/05 at 10:00 with the MDS coordinator and director of staff development revealed there had been no investigation into other possible causes for the	F 323	A. Each resident shall be assessed for removal of all side rails. A team comprised of the Physical Therapist, MDS Coordinator, Staff Development Coordinator, and Director of Nursing will assess each resident for removal of side rails and alternative measures:	04/09/05
			B. All air mattresses will be removed from facility. Air mattresses/bed rails have been used as recommended by manufacture of mattresses per manufacture manual for use. Alternative mattresses will be provided.	done 4/14/05 04/09/05 Accumax Quantum pressure relief systems
			C. All reports of incidents will be reviewed and appropriate interventions implemented by the interdisciplinary team.	04/12/05
			D. Interdisciplinary Team will review interventions/recommendations and changes initiated as necessary. Staff Development Coordinator will inform/instruct staff of any changes or implementations.	04/12/05

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	530040	A. BUILDING _____ B. WING _____	C 04/14/2005

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

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F 323	Continued From page 2 incident, nor were staff trained in regard to the incident. c. Nursing notes dated 4/8/05 at 5:00 AM showed a registered nurse (RN) entered the resident's room and found the resident's body off the side of the bed with the head face down and trapped between the half side rail and the air-flow mattress. Although the RN attempted to lift the resident's head away from the rail, she was unable to do so. The nursing notes further documented the resident was cool, ashen in color and did not have a pulse. In addition, the resident sustained petechiae areas especially on the forehead and an ecchymotic area measuring approximately one-fourth inch wide and about four inches in length was found on the resident's right cheek. Another less prominent area which measured one-eighth inch in width and three inches in length was also noted on the resident's right cheek. Review of the coroner's preliminary report obtained on 4/13/05, showed the cause of death was a result of mechanical asphyxiation. d. Observation and interview with the administrator and the director of nursing on 4/14/05 at 09:30 AM revealed a 6 inch gap between the half rails and the sides of the air-flow mattress. Re-enactment at that time by the facility administrator showed that with the movement of the mattress along with the addition of body weight, the dimensions would have increased the risk for entrapment. Interview with the director of nursing at that time revealed that when she re-enacted lying in the middle of the air-mattress, the air movement had almost pushed her to the floor. However, she was able to stop herself from falling with her feet. e. Interview with the director of staff development on 4/14/05 at 10:15 AM, revealed staff were not trained regarding the use of the	F 323	E. Documentation and care plans will be reviewed with each incident for completeness and accuracy. F. Staff will be in-serviced on the removal of side rails. G. Staff will be in-serviced on proper method of incident reporting. I.D. of Residents: All residents have the ability to be affected. Systems: Side rails have all been removed with alternative safety measures in place. Staff Development Coordinator will in-service new staff as necessary. Interventions will be made as necessary. Care plans updated and licensed and non-licensed staff will review updated care plan. Monitoring: Administrator, Director of Nursing, and or designee will monitor for compliance with monthly checks. Re-evaluations of residents and in-servicing will occur as necessary.	04/12/05 04/11/05 04/12/05 04/19/05 04/11/05 04/12/05 04/19/05

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	535048	A. BUILDING _____ B. WING _____	C 04/14/2005

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

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F 323	Continued From page 3 mattress when it was initiated in January 2005. In addition, on 4/14/05 at 10:00 AM the MDS coordinator stated the interdisciplinary team had not evaluated the half rails for intermittent use by staff when the resident was turned, or the safe use of the mattress for this resident. f. On 4/13/05 at 2:30 PM the facility administrator was informed of the immediate jeopardy. On that same date at 4:30 PM the immediate jeopardy was removed on-site. All residents utilizing side rails were assessed and all side rails for those residents were removed from the facility. All types of air mattresses were removed from the facility with alternative measures implemented.	F 323	Quality of Assurance. Results of monitoring will be reported by the Administrator and/or Staff Development Coordinator quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	