

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

PRINTED: 05/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 585048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	OMB NO. 0938-0387 (X3) DATE SURVEY COMPLETED 04/28/2011
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 HOWELL AVENUE WORLAND, WY 82401	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CAA- Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set ROM- Range of Motion Less commonly used abbreviations will be annotated in each deficiency.	F 000	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 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 date the facility is of the opinion it was in compliance with requirements of participation or that corrective action was necessary.	
F 272 SS=D	483.20(b)(1) 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 resident assessment instrument (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;	F 272	F 272 The facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Corrective Action: 1. The DON/Designee will complete an assessment on resident #38 Foley use prior to the allegation of compliance. The care plan will be reviewed and revised if indicated at that time 2. The DON/Designee will complete a pain assessment on Resident #6 prior to the allegation of compliance.	05/25/11 05/25/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 60 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.

Wyoming Dept of Health

MAY 20 2018

**Office of Healthcare
Licensing and Surveys**

Approved 6/16/11 @ 1:48pm
Adm. & NH notified

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NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1801 HOWELL AVENUE WORLAND, WY 82401			
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F 272	Continued From page 1 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: <u>Based</u> on medical record review and staff interview, the facility failed to ensure a comprehensive assessment was performed for 2 of 13 sample residents (#8, #38) who triggered for further assessment on the MDS assessment. The findings were: 1. Review of the 3/7/11 quarterly MDS assessment for resident #38 showed s/he had an indwelling urinary catheter in place. Review of the medical record showed no evidence a comprehensive assessment was performed to determine continued medical necessity for the indwelling catheter. The most recent assessment was performed on 9/3/10. According to the physician's progress notes written on 12/15/10, the resident was without a catheter at that time, however, there was no assessment performed when the indwelling catheter was re-inserted. Interview with the DON on 4/28/11 at 8:25 AM revealed she was unsure why a comprehensive	F 272	The care plan will be reviewed/revise if indicated at that time Identification of other Residents who may be at Risk: 1. On or prior to the allegation of compliance the DON/Designee will review records of Residents who have indwelling Foley Catheters to ensure an assessment was completed. If an issue is identified the DON/Designee will complete the assessment at that time, and review/revise the plan of care if indicated 2. Residents who have pain and/or potential for Pain are at Risk. On or prior to the allegation of compliance the DON/Designee will complete a pain assessment on Residents who reside at facility to ensure an updated assessment was completed and review/revise the plan of care if indicated. Systemic Changes 1. The facility will assess the resident's need for an indwelling catheter using the "Bladder Incontinence Assessment Form" per Policy CL-NUR-1151. The resident's will be assessed on admission, quarterly, and with significant changes in status. On or before the allegation of compliance the				

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F 272	Continued From page 2 assessment was not performed. 2. Review of the 12/24/10 admission and the quarterly 1/18/11 MDS assessments for resident #8 showed s/he had no pain. Review of the 3/21/11 quarterly MDS assessment for the resident showed s/he had mild pain occasionally. Review of the medical record showed no evidence a comprehensive pain assessment was completed for this resident who had newly developed pain. There was no evidence the causation and contributing factors were evaluated to determine the source of the pain. During an interview with the DON on 4/28/11 at 8:25 AM, she said a pain assessment should have been performed.	F 272	DON/Designee will in-service the Nursing staff on the assessment of Indwelling Urinary Catheter Policy Number CL-NUR-1164 and CL- NUR-1151. An attendance sheet will be utilized and reconciled with the active Nursing Staff roster and those staff unable to attend will be provided 1:1 education. 2. The facility will provide a consistent method for the review, planning and development and evaluation of a pain management plan of care, this includes completing a pain assessment when the resident's pain intensity has changed. New pain will be communicated by the licensed nurses on the 24 hour report. The 24 hour report in reviewed by Nursing Leadership each business day. On or before the allegation of compliance the DON/Designee will in-service the Nursing staff on the Pain Risk		
F 273 SS-D	403.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who	F 273	Review and Management Program Policy Number CL-NUR-1201. An attendance sheet will be utilized and reconciled with the active Nursing Staff roster and those staff unable to attend will be provided 1:1 education Monitoring to ensure ongoing Compliance 1. The Director of Nursing/Designee will review records of Residents who have an indwelling Foley catheter on		

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F 272	Continued From page 2 assessment was not performed.	F 272	admission, each quarter, and/or with significant change in status at time of care plan to ensure that an assessment of the resident's continued need for indwelling catheter has been completed, and the care plan is revised if indicated. Issues identified will be corrected at that time and the Director of Nursing/Designee will reports issues in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness.		
F 278 SS=0	483.20(g) - (J) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who	F 278	2. The Director of Nursing/Designee will review the 24 hour report each business day to identify those resident's who may have new pain, or worsening pain. The Director of Nursing designee will review resident's record on admission, each quarter, and/or with significant change in status at time of care plan to ensure that an assessment of the resident's pain has been completed, and the care plan is revised if indicated. Issues identified will be corrected at that time and the Director of Nursing/Designee will reports issues in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness.		

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F 272	Continued From page 2 assessment was not performed. 2. Review of the 12/24/10 admission and the quarterly 1/18/11 MDS assessments for resident #8 showed s/he had no pain. Review of the 3/21/11 quarterly MDS assessment for the resident showed s/he had mild pain occasionally. Review of the medical record showed no evidence a comprehensive pain assessment was completed for this resident who had newly developed pain. There was no evidence the causation and contributing factors were evaluated to determine the source of the pain. During an interview with the DON on 4/28/11 at 8:25 AM, she said a pain assessment should have been performed.	F 272			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who	F 278	F278 The assessment will accurately reflect the resident's status. A registered nurse will conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse will sign and certify that the assessment is completed. Each individual who completes a portion of the assessment will sign and certify the accuracy of that portion of the assessment. Corrective Action: 1. For Resident #14 - The MDS was modified to accurately reflect his falls in Section J1900 2. For Resident #54 - The MDS	05/25/11 05/25/11	

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F 278 SS-D	Continued From page 3 willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the accuracy of the MDS assessment for 3 of 13 sample residents (#14, #47, #54). The findings were: 1. Review of the 2/2/11 quarterly MDS assessment revealed resident #14 had fallen since the last assessment (section J1900). However, at section J1900, no falls were coded. During an interview on 4/28/11 at 8:28 AM, the MDS coordinator confirmed the MDS was inaccurate at section J1900. She stated section J1900 should have been coded for 3 falls without injury. According to the Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, September 2010, if a resident had two or more non-injurious falls since the prior assessment, the correct coding would be "2". 2. Review of the 11/7/10 and 3/2/11 comprehensive MDS assessments for resident #54 revealed there lacked signatures and dates at section V (V0200, B and C). During an interview on 4/28/11 at 8:10 AM, the MDS coordinator stated section V should be signed and dated, but she must have "missed that" on	F 278	Sec V was signed. 3. For Resident #47 - The MDS was modified to accurately reflect the correct referenced date from the Dietary Note. Identification of other Residents who may be at Risk 1. Resident's who reside at facility are at risk. On or before the allegation of compliance the MDS Coordinator/ Designee will review Resident's MDS's to ensure that Section J1900 accurately reflects Number of Falls and Injury level. Issues Identified will be corrected at that time. 2. Resident's who reside at facility are at risk. On or before the allegation of compliance the MDS Coordinator/ Designee will review Resident's MDS's to ensure that Section V is signed. Issues Identified will be corrected at that time. 3. Resident's who reside at the facility are at risk. On or before the allegation of compliance the MDS Coordinator/Designee will review Resident's MDS to ensure that the correct Dietary Note is referenced in Section V. Issues Identified will be corrected at that time.	05/25/11	

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F 278	Continued From page 4 those two assessments. According to the Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, September 2010, the RN coordinator signs and dates at section V0200 B1 and B2 which certifies that the CAAs have been completed. A staff member signs and dates section V0200 C1 and C2 after the care plan is complete. 3. Review of the 3/23/11 significant change MDS assessment for resident #47 showed s/he triggered for comprehensive assessment in regard to nutrition. Review of section V of this assessment showed the location and date of the comprehensive assessment information was in the 3/18/11 dietary notes. However, review of the medical records showed the date was 3/23/11 and the document was the care area assessment, not the 3/18/11 dietary notes. Interview with the MDS coordinator on 4/28/11 at 8:25 AM confirmed the date and location of the assessment, as noted in section V, was inaccurate.	F 278	Systemic Changes On or before the allegation of Compliance the DON/ Designee with in-service the MDS Staff and Interdisciplinary Team on the importance of accurately assessing the Resident's status to include Signing Section V and Coding Section J1900. An attendance Sheet will be utilized and reconciled to the list of IDT Members and staff who code MDS's and the staff who were unable to attend will be given 1:1 education. The MDS Coordinator and/ or Designee will bring the Resident's MDS to the Care plan meetings and prior to Filing MDS in the Resident's Record. The MDS Coordinator and/ or Designee will Review Sec V for a signature and Section JO1800 and J1900 for accurate reflection of falls.		
F 280 S8=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280	Monitoring to ensure ongoing Compliance The MDS Coordinator and/ or Designee will bring the Resident's MDS to the Care plan meetings and prior to Filing MDS in the Resident's Record the MDS Coordinator and/ or Designee will Review Sec V for a signature and Section JO1800 and J1900 for accurate reflection of falls. Issues identified will be corrected at that time and the n trended the		

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F 278	Continued From page 4 those two assessments. According to the Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, September 2010, the RN coordinator signs and dates at section V0200 B1 and B2 which certifies that the CAAs have been completed. A staff member signs and dates section V0200 C1 and C2 after the care plan is complete. 3. Review of the 3/23/11 significant change MDS assessment for resident #47 showed the triggered for comprehensive assessment in regard to nutrition. Review of section V of this assessment showed the location and date of the comprehensive assessment information was in the 3/18/11 dietary notes. However, review of the medical records showed the date was 3/23/11 and the document was the care area assessment, not the 3/18/11 dietary notes. Interview with the MDS coordinator on 4/20/11 at 8:25 AM confirmed the date and location of the assessment, as noted in section V, was inaccurate.	F 278	DON/Designee will reports trends in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness.		
F 280 SS-D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280	F 280 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan will be developed within 7 days after the completion of the comprehensive assessment. Corrective Action: Prior to surveyors exiting the facility		

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F 280 SSD	Continued From page 5 disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the care plan was developed and revised as needed to meet the needs of the resident for 1 of 13 sample residents (#39). The findings were: Review of the 4/5/11 MDS assessment revealed resident #39 was frequently incontinent of bladder. Observation on 4/26/11 at 10:25 AM revealed the resident was incontinent of bowel and bladder. Review of the current care plan, dated 4/12/11, revealed the approaches for incontinence care included both "check q (every) 2 hrs" and "toilet before and after meals..." Review of the CNA care plan flow sheet revealed only "do not toilet due to trunk control", but did not identify how often the resident should be checked for incontinence. During an interview on 4/28/11 at 9:50 AM, the DON and house supervisor both stated the care plan was "confusing" and the toileting plan for the resident was not clear. Refer to federal citation F308 for details regarding the facility's failure to include positioning of the arm in the wheelchair for resident #39.	F 280	the DON/Designee corrected the care plan for Resident #39 to ensure that her need for the arm trough was on the care plan, and that her toileting interventions were clarified Identification of other Residents who may be at Risk Resident's who reside at facility are at risk. On or before the allegation of compliance the Interdisciplinary Team will review Resident's care plans to ensure that assistive devices if in use are on the care plan, and that the toileting interventions are clear, individualized, and do not contradict themselves. Issues Identified will be corrected at that time. Systemic Changes Resident's Care plans will be reviewed quarterly, annually, and with significant changes in status, Revisions if indicated will be completed at that time. RN's and LPN will place Resident status changes on the 24 hour Report, and the Interdisciplinary Team will review the 24 hour report and the telephone orders from the prior day each business day and identified status changes will be care planned at that time. On or before the allegation of compliance the DON/Designee will In-service the interdisciplinary Team members and the licensed Nursing Staff on Care plan	05/25/11	
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281			

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F 280	Continued From page 5 disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the care plan was developed and revised as needed to meet the needs of the resident for 1 of 13 sample residents (#39). The findings were: Review of the 4/5/11 MDS assessment revealed resident #39 was frequently incontinent of bladder. Observation on 4/28/11 at 10:25 AM revealed the resident was incontinent of bowel and bladder. Review of the current care plan, dated 4/12/11, revealed the approaches for incontinence care included both "check q [every] 2 hrs" and "toilet before and after meals..." Review of the CNA care plan flow sheet revealed only "do not toilet due to trunk control", but did not identify how often the resident should be checked for incontinence. During an interview on 4/28/11 at 9:50 AM, the DON and house supervisor both stated the care plan was "confusing" and the toileting plan for the resident was not clear. Refer to federal citation F309 for details regarding the facility's failure to include positioning of the arm in the wheelchair for resident #39.	F 280	Revisions. An attendance sheet will be utilized and reconciled with the Interdisciplinary Team and the Licensed Nursing Staff and those staff unable to attend will be provided 1:1 education. Monitoring to ensure ongoing Compliance The Resident Care plans will be reviewed on admission, each quarter, and/or with significant change in status at time of care plan meeting to ensure any appropriate Care plan Revisions have been made. Issues identified will be corrected at that time and the DON/Designee will reports issues in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness.		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281	The services provided or arranged by the facility will meet professional standards of quality.		

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

PRINTED: 05/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/28/2011
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 HOWELL AVENUE WORLAND, WY 82401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281 SS=E	Continued From page 6 PROFESSIONAL STANDARDS 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, and medical record review, the facility failed to ensure physician's orders were followed for 2 of 13 sample residents (#6, #47). In addition, the facility failed to ensure the RD (registered dietitian) performed a comprehensive nutrition assessment for 6 of 7 sample residents (#14, #29, #37, #39, #47, #50) who required one. The findings were: 1. The following concerns with professional standards related to following physician's orders were identified: According to the Wyoming Nurse Practice Act, revised July 2010, Section 3, pages 3-8 of the Wyoming State Board of Nursing's Administrative Rules and Regulations, nursing staff must function under the direction of a licensed physician. Refer to Federal citation F309 for details regarding failure to follow physician's orders for the monitoring and administration of blood pressure medications to residents #6 and #47. 2. Refer to F325 regarding the RD's failure to complete comprehensive nutritional assessments for residents #14, #39, #47, #29, #37, #50.	F 281	Corrective Action: - For Resident's #6 and #47 - Blood Pressure medications are only being given if Blood Pressures are within the Parameters ordered by the Physician. - The Dietary Director has been re-educated on her scope of practice and the CAA's will be completed by the Dietician/Designee. Identification of other Residents who may be at Risk - Resident's who currently receive Blood Pressure Medication with Parameters are at risk. Facility can not go back and correct earlier professional Standards deficient practice related to Blood pressure parameters. The facility will ensure going forward the nurses follow physician's orders regarding blood pressure parameters.	05/25/11 05/25/11	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	Resident's residing at Facility who required a CAA for Nutrition are at Risk. Facility can not go back and correct earlier professional Standards deficient practice related to The Dietary Manager Signing the Nutritional CAA which is outside her scope of Practice. The facility will ensure going forward the Dietary Manager		

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NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 HOWELL AVENUE WORLAND, WY 82401		
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F 281 SS=E	Continued From page 6 PROFESSIONAL STANDARDS 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, and medical record review, the facility failed to ensure physician's orders were followed for 2 of 13 sample residents (#6, #47). In addition, the facility failed to ensure the RD (registered dietitian) performed a comprehensive nutrition assessment for 6 of 7 sample residents (#14, #29, #37, #39, #47, #50) who required one. The findings were: 1. The following concerns with professional standards related to following physician's orders were identified: According to the Wyoming Nurse Practice Act, revised July 2010, Section 3, pages 3-8 of the Wyoming State Board of Nursing's Administrative Rules and Regulations, nursing staff must function under the direction of a licensed physician. Refer to Federal citation F309 for details regarding failure to follow physician's orders for the monitoring and administration of blood pressure medications to residents #6 and #47.	F 281	does not sign CAAs. Systemic Changes 1. Licensed Nursing Staff will follow Physician orders specific to Blood Pressure Parameters. On or before the allegation of compliance the DON/Designee will In-service the licensed Nursing Staff on the importance of following the blood pressure parameters as ordered. Blood pressure Parameters will be located on the resident's MARS for those Resident's that require them per physician's orders. An attendance sheet will be utilized and reconciled the Licensed Nursing Staff Roster and those staff unable to attend will be provided 1:1 education. 2. The Nursing Home Administrator/ Designee will reeducate the Dietary Manager on her scope of Practice which does not allow her to sign the Nutritional CAAs		
F 282 SS=D	2. Refer to F325 regarding the RD's failure to complete comprehensive nutritional assessments for residents #14, #39, #47, #29, #37, #50. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	Monitoring to ensure ongoing Compliance 1. The DON/Designee will Review Medication Administration Records 3 times weekly and as necessary to identify issues with following the Blood Pressure Parameters. Issues identified will be reviewed with the nurse		

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NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 HOWELL AVENUE WORLAND, WY 82401		
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F 281 SS=0	Continued From page 6 PROFESSIONAL STANDARDS 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, and medical record review, the facility failed to ensure physician's orders were followed for 2 of 13 sample residents (#6, #47). In addition, the facility failed to ensure the RD (registered dietitian) performed a comprehensive nutrition assessment for 6 of 7 sample residents (#14, #29, #37, #39, #47, #50) who required one. The findings were: 1. The following concerns with professional standards related to following physician's orders were identified: According to the Wyoming Nurse Practice Act, revised July 2010, Section 3, pages 3-8 of the Wyoming State Board of Nursing's Administrative Rules and Regulations, nursing staff must function under the direction of a licensed physician. Refer to Federal citation F309 for details regarding failure to follow physician's orders for the monitoring and administration of blood pressure medications to residents #9 and #47.	F 281	responsible and Reeducation will occur. If the same nurse continues to have ongoing issues progressive discipline per company policy will begin. The DON/Designee will reports issues in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness. 2. The MDS Coordinator/ Designee will do random reviews of the Nutritional CAA's to ensure the Dietary Manager is not signing them. Issues identified will be corrected at that time and reviewed with the Dietary Manager and Reeducation will occur. The DON/Designee will reports issues in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness.		
F 282 SS=0	2. Refer to F325 regarding the RD's failure to complete comprehensive nutritional assessments for residents #14, #39, #47, #29, #37, #50. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	282 The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. Corrective Action:		

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F 282 SS=D	Continued From page 7 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 staff followed the care plan for 2 of 13 sample residents (#8, #47). The findings were: 1. Review of the current care plan for resident #8 showed s/he was to be toileted before and after meals. Observation on 4/26/11 from 7:30 AM until 11:30 AM showed the resident was not toileted after breakfast. Interview with CNA #1 on 4/26/11 at 11:30 AM confirmed the resident was not toileted after breakfast. 2. Review of the current care plan for resident #47 showed s/he should have the soft seat belt restraint unfastened/removed for all meals. Observation of the meals on 4/25/11 (dinner), 4/26/11 (breakfast), and 4/27/11 (lunch) showed the seat belt was not removed or unfastened during the entire meal. Interview with the DON and house supervisor on 4/29/11 at 8:25 AM revealed the staff should have unfastened the seat belt during all meals.	F 282	1. Resident #6 is now toileted before and after meals per her plan of care. The DON/ designee re-educated the staff on her plan of care. 2. Resident #47 Restraint is now released during Meals. The DON/ designee re-educated the staff on her plan of care Identification of other Residents who may be at Risk Resident's who reside at facility are at risk. On or before the allegation of compliance the DON/Designee will re-educate the Licensed Nursing Staff and the C.N.A.'s on the importance of following the Resident's plan of care to include releasing restraint and toileting per the resident individual care plan. Systemic Changes The Resident's individual Toileting Plan and Restraint care if indicated will be included on the C.N.A.'s plan of care. The C.N.A.'s plan of care is updated by the MDS Coordinator/ designee when indicated. On or before the allegation of compliance the DON/Designee will re-educate the Licensed Nursing Staff and the C.N.A.'s on the C.N.A.'s care plan and the importance of following the Resident's plan of care to include releasing restraints and toileting per the resident individual care plan. An	05/23/11 05/25/11
F 309 SS=E	483.26 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		

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F 282	Continued From page 7 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 staff followed the care plan for 2 of 13 sample residents (#8, #47). The findings were: 1. Review of the current care plan for resident #8 showed s/he was to be toileted before and after meals. Observation on 4/26/11 from 7:30 AM until 11:30 AM showed the resident was not toileted after breakfast. Interview with CNA #1 on 4/26/11 at 11:30 AM confirmed the resident was not toileted after breakfast. 2. Review of the current care plan for resident #47 showed s/he should have the soft seat belt restraint unfastened/removed for all meals. Observation of the meals on 4/26/11 (dinner), 4/26/11 (breakfast), and 4/27/11 (lunch) showed the seat belt was not removed or unfastened during the entire meal. Interview with the DON and house supervisor on 4/28/11 at 8:25 AM revealed the staff should have unfastened the seat belt during all meals.	F 282	attendance sheet will be utilized and reconciled with the C.N.A's and the Licensed Nursing Staff and those staff unable to attend will be provided 1:1 education. Monitoring to ensure ongoing Compliance The DON/Designee will do facility rounds 3 times weekly and as necessary observing care to ensure staff are following the resident's toileting plan of care. The Leadership Team will do Dining rooms observations at each meal 3 times weekly and as necessary to ensure staff releases Restraints at meal times. Issues identified will be corrected at that time and the DON/designee will review trends in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness.		
F 309 99-E	483.26 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309	F 309 Each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and		

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F 309 SS-2	Continued From page 8 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and review of policies and procedures, the facility lacked evidence nursing staff provided the necessary assessments, monitoring, and nursing measures to ensure adequate pain management for 2 (#38, #47) of 8 sample residents who had pain. The facility also failed to ensure staff appropriately assessed the vital signs for 3 of 6 sample residents (#6, #37, #47) prior to administering anti-hypertensive medications. Finally, the facility failed to ensure adequate positioning for 1 of 1 sample resident (#39) who required specialized positioning devices in the wheelchair. The findings were: 1. Review of the diagnosis detail sheet for resident #38 showed s/he had diagnoses including Rheumatoid arthritis, osteoarthritis, lumbago, prostate cancer and cancer of the oral cavity and mouth. Review of the 12/19/10 pain review tool showed the resident's acceptable level of pain was rated as two on a one to ten pain scale (2/10) with ten being the worst. Continued review of this document showed the resident had frequent, intermittent pain in the shoulders and head. Review of the 3/2/11 pain review tool showed the resident had persistent and constant pain in the arms, hands, fingers, neck and had headaches. Review of the April 2011 physician's recapitulation of orders showed the resident was ordered hydrocodone/APAP 5	F 309	plan of care. Corrective Action: 1. For Resident #38 when receiving PRN pain medications the nurses are now documenting effectiveness. 2. For Resident's #47, #6, and #37 - Blood Pressure medications are only being giving if Blood Pressures are with in the Parameters ordered by the Physician. 3. For Resident #39 - her arm trough is now included on the care plan, and the C.N.A care plan. Resident #39 now has her arm trough on when she is up in her wheelchair. Identification of other Residents who may be at Risk 1. Residents who receive PRN pain medication are at risk. Facility can not go back and correct earlier professional Standards deficient practice related to documenting effectiveness of PRN pain medication. The facility will ensure going forward the nurses follow physician's orders regarding blood pressure parameters. 2. Resident's who currently receive Blood Pressure Medication with Parameters are at risk. Facility can not go back and correct	05/25/11 05/25/11 05/25/11	

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NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 HOWELL AVENUE WORLAND, WY 82401		
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F 309	Continued From page 9 milligrams (mg) every evening and wore a Duragesic patch 25 micrograms continuously for pain. In addition, continued review showed the resident had Tylenol 325 mg, two tablets, ordered every four hours PRN (as needed) for breakthrough pain. The following concerns were identified: a. Review of the March 2011 MAR showed the resident received Tylenol 325 mg, two tablets for pain on 3/1/11, 3/7/11, 3/12/11, 3/24/11, 3/25/11, 3/28/11, and twice on 3/27/11 without evidence a re-assessment was performed to determine the effectiveness of the medication in resolving the resident's breakthrough pain. In addition, there was no description of the pain intensity. b. Review of the April 2011 MAR showed the resident was administered Tylenol 325 mg, two tablets, for pain on 4/2/11, 4/3/11, 4/4/11, 4/5/11, 4/7/11, 4/8/11, 4/9/11, 4/19/11, 4/20/11, 4/21/11, 4/26/11, 4/28/11, and 4/27/11. There was no evidence the resident's pain was re-assessed to determine effectiveness of the medication in relieving the pain on any of these days. c. Interview with the DON and house supervisor on 4/28/11 at 8:25 AM revealed staff were educated on the need to perform a follow-up assessment after administration of all PRN medications. d. Review of the facility's policy on pain management, dated 5/6/09, page 2, revealed instructions to "Review pain level prior to administration of "PRN" and standard scheduled pain medications and after administration for effectiveness of medication." 2. Review of the April 2011 physician's recapitulation of orders for sample resident #47	F 309	earlier professional Standards deficient practice related to Blood pressure parameters. The facility will ensure going forward the nurses follow physician's orders regarding blood pressure parameters. 3. Resident's who reside at facility and require adaptive equipment on their chair are at risk. On or before the allegation of compliance the Interdisciplinary Team will review Resident's care plans to ensure that assistive devices in use are on the care plan, and visualizes residents who require adaptive equipment to ensure that the adaptive equipment is in place. Issues Identified will be corrected at that time. Systemic Changes 1. Licensed Nursing Staff will document effectiveness of PRN pain medication per facility policy. On or before the allegation of compliance the DON/Designee will in-service the licensed Nursing Staff on the Pain Risk Review and management Policy Number CL-NUR-1201 to include the importance of documenting effectiveness of PRN pain medication. An attendance sheet will be utilized and reconciled		

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F 309	Continued From page 10 showed s/he had diagnoses including hypertension. Further review of this document showed a 8/10/10 order instructing staff to call the physician if the resident's blood pressure (B/P) was greater than 180/110. If the systolic B/P reading was less than 90, medications were not to be administered and the physician was to be notified. Review of the physician protocols signed by the resident's physician in January 2011 showed the order referred to anti-hypertensive medications. Interview with the DON on 4/28/11 at 8:26 AM confirmed this order was in reference to the B/P medications only. Review of a physician's order dated 6/10/10 showed an order for Lisinopril 20 mg daily for blood pressure. Review of the April 2011 monthly blood pressure check sheet showed a B/P reading of 87/40 on 4/14/11. Review of the April 2011 MAR showed the Lisinopril was administered on that day (4/14/11) even though the systolic reading was below 90. In addition, there was no evidence the physician was notified as ordered. Review of the April 2011 MAR showed this resident, #47, received Tylenol 650 mg on 4/16/11 and again on 4/22/11 for unidentified, undescribed pain without evidence of a re-assessment to determine the effectiveness of the medication. On 4/23/11, the resident received Tylenol 650 mg for complaint of a headache. The MAR also showed, again, that there was no evidence a re-assessment was performed to determine the effectiveness or need for alternatives to address the resident's headache. 3. Review of the April 2011 physician's recapitulation of orders for sample resident #6 showed s/he had diagnoses including hypertension. Further review of this document	F 309	the Licensed Nursing Staff Roster and those staff unable to attend will be provided 1:1 education. 2. Licensed Nursing Staff will follow Physician orders specific to Blood Pressure Parameters. On or before the allegation of compliance the DON/Designee will in-service the licensed Nursing Staff on the importance of following the blood pressure parameters as ordered. Blood pressure Parameters will be located on the resident's MARS for those Resident's that require them per physician's orders. An attendance sheet will be utilized and reconciled the Licensed Nursing Staff Roster and those staff unable to attend will be provided 1:1 education. 3. When a resident requires an assistive device on his/ her wheelchair it will be on the Resident's Care plan and the C.N.A plan of care. The MDS Coordinator/ designee will update the care plan with changes as indicated. The Licensed Nurses staff and C.N.A staff will be reeducated on the importance of following the Resident's plan of care and ensure adaptive equipment is in place. An attendance sheet will be utilized and reconciled C.N.A		

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F 309	Continued From page 11 showed a 12/22/10 order instructing staff to call the physician if the resident's blood pressure (B/P) was greater than 180/110 and if the systolic B/P reading was less than 90, medications were not to be administered and the physician notified. Review of the physician protocols signed by the resident's physician in January 2011 showed the order referred to anti-hypertensive medications. Interview with the DON on 4/28/11 at 8:25 AM confirmed this order was in reference to the B/P medications only. Review of a physician's order dated 6/10/10 showed an order for Lisinopril 40 mg daily for blood pressure. The following concerns were identified: a. Review of the February 2011 monthly blood pressure check sheet showed the resident's systolic reading on 2/6/11 was 76/54. Review of the February MAR showed the Lisinopril was administered on that day. Additionally, there was no evidence the physician was contacted as ordered. b. Review of the March 2011 monthly blood pressure check sheet showed the resident had a systolic blood pressure reading of less than 90 on 3/20/11 and again on 3/22/11. Review of the March 2011 MAR showed the resident was administered the Lisinopril on both days and there was no evidence the physician was notified as required. c. Review of the April 2011 monthly blood pressure check sheet showed a systolic blood pressure reading of 72/44 on 4/6/11 and 88/42 on 4/24/11. According to the April 2011 MAR, the resident received the Lisinopril on both days. Review of the record showed no evidence the physician was notified. 4. Review of the medical record showed that	F 309	and the Licensed Nursing Staff Roster and those staff unable to attend will be provided 1:1 education. Monitoring to ensure ongoing Compliance 1. The DON/Designee will Review Medication Administration Records 3 times weekly and as necessary to identify issues with following the Blood Pressure Parameters. Issues identified will be reviewed with the nurse responsible and Reeducation will occur. If the same nurse continues to have ongoing issues progressive discipline per company policy will begin. The DON/Designee will reports issues in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness. Issues identified will be corrected at that time and the DON/Designee will report issues in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness. 2. The DON/Designee will Review Medication Administration Records 3 times weekly and as necessary to identify issues with following the Blood Pressure Parameters. Issues identified will be reviewed with the nurse responsible and Reeducation will		

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NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 HOWELL AVENUE WORLAND, WY 82401		
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F 309	Continued From page 12 resident #37 had an 8/4/10 physician's order to hold all medications, and call the physician if the resident's systolic blood pressure dropped below a reading of ninety millimeters of mercury. Further review showed the resident had a 2/22/11 order for Dyazide (antihypertensive) 25/37.5 milligrams to be given by mouth every other day. Review of the resident's vital signs and weight record showed s/he had a systolic blood pressure of eighty-six on 3/14/11. Review of the resident's March 2011 medication administration record showed staff failed to hold medications on 3/14/11, and gave the resident all medications which included Dyazide. Further review showed the facility failed to notify the physician of the blood pressure reading. Review of the 2010 Lexi-Comps Drug Information Handbook for Nursing showed side effects of Dyazide included hypotension. 5. Review of the 4/5/11 admission MDS assessment revealed resident #39 had hemiplegia (paralysis of one side of the body). Review of a 3/31/11 occupational therapy progress report revealed "...have placed padded back with lateral supports and L [left] arm trough for improved positioning in wc [wheelchair]...Caregiver education continued with CNAs and family for positioning in wc and in bed. Have emphasized importance of positioning/protecting L UE [left upper extremity] secondary to completely flaccid with intermittent pitting edema." The following concerns were identified: a. Review of the current care plan, dated 4/12/11, revealed positioning in the wheelchair (including the arm trough) was not addressed. b. Observation on 4/28/11 from 7:32 AM until	F 309	occur. If the same nurse continues to have ongoing issues progressive discipline per company policy will begin. The DON/Designee will report issues in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness. 3. The DON/Designee will do facility rounds 3 times weekly and as necessary observing care to ensure staff are following the resident's plan of care and ensuring that the resident's who require adaptive equipment have their equipment in place. Issues Identified will be corrected at that time and The DON/Designee will report issues in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/28/2011
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 HOWELL AVENUE WORLAND, WY 82401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 13 8:30 AM revealed the resident's left arm was laying in his/her lap. The arm trough was not attached to the wheelchair. At 8:30 AM, CNA #2 pushed the resident in the wheelchair back to his/her room, when another CNA asked where the arm trough was. CNA #2 replied "in [his/her] room." CNA #2 took the resident to his/her room to get ready for a doctor's appointment. During an interview at that time, the CNA stated she was the one who got the resident up that morning. When asked if the arm trough was supposed to be used whenever the resident was in the wheelchair, she replied "no...just during the day, if going to an appointment or something." o. During an interview on 4/28/11 at 10:32 AM, the house supervisor stated she checked with the occupational therapist, and the arm trough was to be used whenever the resident was in the wheelchair. She further stated the arm trough should have been included in the care plan.	F 309			
F 314 SS=D	483.25(o) TREATMENT/SVCS TO PREVENT/HEAL 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,	F 314	F 314 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 pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 635048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/28/2011
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 HOWELL AVENUE WORLAND, WY 82401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 14 and staff and family interviews, the facility failed to ensure preventative measures were consistently implemented to prevent pressure sores for 1 of 9 sample residents (#39) who were at risk for the development of pressure sores. The findings were: Review of the 4/5/11 admission MDS assessment revealed resident #39 was at risk for pressure sores. According to the 4/19/11 Braden Scale, the resident was at high risk for the development of pressure sores. The interventions staff identified (listed on the back of the Braden Scale form) included "...Keep linens clean and dry, wrinkle free." Observation on 4/28/11 at 10:25 AM revealed CNA #2 and the occupational therapist transferred the resident to the bed using a Hoyer lift. The sling that was used during the transfer was left underneath the resident in bed, which did not provide a wrinkle free surface. During an interview on 4/27/11 at 3:25 PM, a family member stated the sling was sometimes left under the resident in bed. During an interview on 4/28/11 at 9:50 AM, the DON and house supervisor both stated slings should be removed when not in use. The DON stated it was a standard of practice because "you don't want wrinkles."	F 314	Corrective Action: Resident #39 does not have the lift sling under her when up in wheelchair or when in bed. Licensed Nursing staff and C.N.A.'s have been re educated on the potential for increased pressure when leaving lift sling under the Resident. Identification of other Residents who may be at Risk Resident's who reside at facility and require transfer using the lift are at risk. Systemic Changes The Lift Slings will be removed from under the Resident when the resident is in bed or when the resident is sitting up in wheelchair. On or before the allegation of compliance the DON/Designee will Licensed Nursing staff and the C.N.A.'s on Pressure Ulcer Prevention to include the importance of removing lift slings after transfers. An attendance sheet will be utilized and reconciled with the C.N.A. and the Licensed Nursing Staff Roster and those staff unable to attend will be provided 1:1 education.	05/25/11	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN 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.	F 318	Monitoring to ensure ongoing Compliance The DON/ Designee will do facility Rounds Three times weekly and as necessary to ensure the lift slings are		

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NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 HOWELL AVENUE WORLAND, WY 82401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 14 and staff and family interviews, the facility failed to ensure preventative measures were consistently implemented to prevent pressure sores for 1 of 9 sample residents (#39) who were at risk for the development of pressure sores. The findings were: Review of the 4/6/11 admission MDS assessment revealed resident #39 was at risk for pressure sores. According to the 4/19/11 Braden Scale, the resident was at high risk for the development of pressure sores. The interventions staff identified (listed on the back of the Braden Scale form) included "...Keep linens clean and dry, wrinkle free." Observation on 4/26/11 at 10:25 AM revealed CNA #2 and the occupational therapist transferred the resident to the bed using a Hoyer lift. The sling that was used during the transfer was left underneath the resident in bed, which did not provide a wrinkle free surface. During an interview on 4/27/11 at 3:25 PM, a family member stated the sling was sometimes left under the resident in bed. During an interview on 4/28/11 at 9:50 AM, the DON and house supervisor both stated slings should be removed when not in use. The DON stated it was a standard of practice because "you don't want wrinkles."	F 314	removed out from under residents when up in wheelchairs or lying in bed. Issues identified will be corrected at that time and the DON/Designee will report issues in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness.		
F 318 SS-D	483.25(e)(2) INCREASE/PREVENT DECREASE IN 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.	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.		

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NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 HOWELL AVENUE WORLAND, WY 82401		
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F 318 532D	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure restorative services were provided as planned for 3 of 3 sample residents (#8, #46, #50) with ROM limitations who received restorative services. The findings were: 1. Review of the diagnosis detail sheet for resident #8 revealed s/he had diagnoses including osteoporosis and osteoarthritis. Review of the 12/24/10 and 3/28/11 quarterly MDS assessments showed the resident had functional limitation in ROM on both sides in the upper and lower extremities. Review of the restorative care plan showed the resident required AAROM (active assisted range of motion) restorative exercises three times per week. The following concerns were identified: a. Review of the February 2011 nursing restorative care flow record showed the resident received restorative services two times the first week (days 1 through 7), two times during week three (days 15 through 21), and two times during the last week (days 23 through 28). Review of the February 2011 restorative progress notes revealed the resident only refused services one time, on 3/12/11. b. Review of the March 2011 nursing restorative care flow record showed the resident received no restorative services during the first week of March. Continued review showed the resident was provided restorative services two times during the third and fourth weeks of March. Review of the restorative progress notes for March 2011 showed the resident did not refuse	F 318	Corrective Action: 1. Resident #6 is now receiving Range of Motion per her Restorative plan. 2. Resident #46 is now receiving Range of Motion per her Restorative plan. 3. Resident #50 is now receiving Range of Motion per her Restorative plan Identification of other Residents who may be at Risk Resident's who reside at facility and require Restorative for Range of Motion are at risk. Systemic Changes Residents who enter the facility with limitations of motion or residents who have primary risk factors for decreased range of motion will be identified via the data collection tool, and the MDS/RAI process. Risk factors include: Immobilization (bedfast, casts, weakness) Deformities and Increased muscle tone. Nursing will perform baseline assessment on admission, quarterly and for change in condition of range of motion. Nursing to assess for change in condition or change in risk factors on an ongoing basis. Nursing will then follow through with contracture prevention or management program developed by Therapy or Restorative Nurse	05/25/11 05/25/11 05/25/11	

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NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 HOWELL AVENUE WORLAND, WY 82401		
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F 318	Continued From page 16 restorative services during the entire month. a. Review of the April 2011 nursing restorative care flow record showed the resident had restorative services one time during the first week (days 1 through 7) and two times during the second week (days 8 through 14). Review of the April 2011 restorative progress notes showed the resident refused exercises only on 4/12/11. 2. Review of the medical record for resident #46 showed s/he had diagnoses that included paralysis agitans, degenerative diseases of the basal ganglia, osteoporosis, hemiplegia, and hemiparesis. Review of the 1/18/11 quarterly MDS assessment showed the resident had ROM impairment to the upper and lower extremities on both sides. Review of occupational therapy restorative referral documentation, dated 8/30/10, showed ROM was to be performed per the restorative nursing program on a one-to-one basis to extremities three times a week. The goal was noted to maintain or increase ROM to the left upper extremity for self-feeding skills. Review of physician progress notes dated 10/7/10, 12/2/10, and 4/7/11 showed the resident's contractures were getting worse. During observations of the evening meal on 4/23/11 and the lunch meal on 4/27/11, the resident was totally dependent upon staff for assistance with feeding. The resident could not cut food or lift utensils or cups. Review of the February, March, and April 2011 nursing restorative care flow records revealed the following concerns: a. On the February 2011 documentation, the facility failed to document ROM three times per week on the second week, which was documented twice.	F 318	Incorporating range of motion activities. The R.N.A will follow the Resident Restorative plan which includes positioning residents appropriately in bed and wheelchair to inhibit, maintain, or prevent abnormal positioning, performing ROM exercises actively, assisted actively, or passively as indicated, maximizing functional level in bed mobility, transfers, WC mobility, and ambulation and Encouraging independence in ADL's. Range of Motion Program will be documented according to the Residents plan of care. Monitoring to ensure ongoing Compliance The DON/ Designee will review Restorative documentation Three times weekly and as necessary to ensure no gaps in the restorative documentation occur. Issues identified will be corrected at that time and the DON/Designee will reports issues in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 885040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/28/2011
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 HOWELL AVENUE WORLAND, WY 82401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 318	Continued From page 17 b. On the March 2011 documentation, the facility failed to document ROM three times per week on the first week, which was documented once. Also, there was no documentation for days 20-31. c. On the April 2011 documentation, the facility failed to document ROM three times per week for the first and third weeks, which were documented twice each. d. During an interview with the restorative services nurse on 4/26/11 at 2:20 PM, she stated that the resident had not received an updated evaluation since the 9/30/10 occupational therapy documentation that referred the resident to restorative therapy for ROM exercises. Interview with the occupational therapist on 4/28/11 at 11:10 AM revealed that even with staff involvement, the resident would decline in ROM due to his/her diagnosis of disease of the basal ganglia. 3. Review of the medical record for resident #50 showed s/he had diagnoses which included multiple sclerosis and osteoporosis. Review of the 2/9/10 physical therapy and occupational therapy restorative referral documentation showed ROM was to be performed per the restorative nursing program to extremities three times a week, with a goal to maintain or increase current strength and ROM. Review of the 12/25/10 annual and 3/27/11 quarterly MDS assessments showed the resident had ROM impairment to both lower extremities. Review of the February, March, and April 2011 nursing restorative care flow records showed the resident was to receive ROM to all extremities three times a week as documented under the prescription area. The following concerns were noted:	F 318			

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NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 HOWELL AVENUE WORLAND, WY 82401		
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F 318	Continued From page 18 a. On the February 2011 documentation, the facility failed to document ROM three times per week for all weeks, and documented as follows: week one was documented twice; week two was documented once; week three was documented twice; and week four was documented twice. b. On the March 2011 documentation, the facility failed to document ROM three times for the first week, with no documentation for that week. c. On the April 2011 documentation, the facility failed to document ROM three times per week for all weeks, and documented as follows: the first week was documented once; and weeks two and three were documented twice each. 4. Interview with the restorative nurse and restorative aide on 4/28/11 at 2:25 PM revealed once or twice per month the restorative aides were unable to provide restorative services to the residents because they were required to work the nursing units. Interview also revealed the first week of the month the restorative aides were required to weigh each resident and this took a long time. Consequently, sometimes the restorative exercises were not provided. Finally, the restorative nurse said she did not routinely review restorative documentation to ensure services were provided as needed.	F 318			
F 325 SS=E	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition	F 325	F325 Based on a resident's comprehensive assessment, the facility will ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels unless the resident's clinical condition demonstrates that this is not possible; and receives a therapeutic diet when there is a nutritional problem.		

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F 325 SS: S	Continued From page 19 demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure nutrition-related information was evaluated and interpreted by a qualified dietitian for 6 of 7 sample residents. Findings were: 1. Review of the 8/5/10 admission MDS assessment for resident #14 revealed the area of nutritional status triggered, requiring a comprehensive assessment. Review of the 8/5/10 Resident Assessment Protocol (RAP) for nutrition revealed it had been completed by the dietary manager instead of the registered dietitian (RD). 2. Review of the 4/5/11 admission MDS assessment for resident #38 showed nutritional status triggered, which required a comprehensive assessment. Review of the 4/1/11 CAA for nutrition revealed it had been completed by the dietary manager instead of the RD. 3. Review of the 3/23/11 significant change MDS assessment for resident #47 showed s/he triggered for a comprehensive assessment in regard to nutrition. Review of the CAA revealed the nutrition comprehensive assessment was completed by the dietary manager instead of an RD as required.	F 325	Corrective Action: The Dietary Director has been re-educated on her scope of practice and the CAA's will be completed by the Dietician/Designee. Identification of other Residents who may be at Risk Resident's residing at Facility who required a CAA for Nutrition are at Risk. Facility can not go back and correct earlier professional Standards deficient practice related to The Dietary Manager Signing the Nutritional CAA which is outside her scope of Practice. The facility will ensure going forward the Dietary Manager does not sign CAAs. Systemic Changes The Nursing Home Administrator/Designee will reeducate the Dietary Manager on her scope of Practice which does not allow her to sign the Nutritional CAAs. Monitoring to ensure ongoing Compliance The MDS Coordinator/ Designee will do random reviews of the Nutritional CAA's to ensure the Dietary Manager is not signing them. Issues identified will be corrected at that time and reviewed with the Dietary Manager and Reeducation will occur. The DON/Designee will reports issues in QA&A to ensure plan is	05/25/11

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NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1901 HOWELL AVENUE WORLAND, WY 82401			
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F 325	Continued From page 20 4. Review of section V of the 3/30/11 significant change MDS assessment for resident #29 showed s/he triggered for comprehensive assessment in the area of nutrition. Review of the CAA dated 3/25/11 showed it was completed by the dietary manager instead of the RD as required. 5. Review of the 11/28/10 admission MDS assessment for resident #37 showed nutritional status triggered, requiring further assessment. Review of the 11/28/10 nutritional CAA showed that it was completed and signed by the dietary manager instead of the RD. 6. Review of the 12/25/10 annual MDS assessment for resident #60 showed nutritional status triggered, requiring a comprehensive assessment. Review of the 12/25/10 nutritional CAA showed that it had been completed and signed by the dietary manager instead of the RD. 7. Interview with the MDS coordinator on 4/27/11 at 10 AM revealed she was unaware the nutrition assessment had to be performed by an RD. 8. According to the 2008 Standards of Practice for Registered Dietitians in Nutrition Care, published by the American Dietetic Association, Standard 1: Nutrition Assessment, The registered dietitian (RD) uses accurate and relevant data and information to identify nutrition-related problems. Rationale: Nutrition Assessment is the first of four steps of the Nutrition Care Process. Nutrition Assessment is a systematic process of obtaining, verifying, and interpreting data in order to make decisions about the nature and cause of	F 325	implemented, sustained, and evaluated for its effectiveness.				

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(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 GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	Continued From page 21 nutrition-related problems. It is initiated by referral and/or screening of individuals ...for nutrition risk factors. ...It provides the foundation for Nutrition Diagnosis, the second step of the Nutrition Care Process. Further, the 2008 Standards of Practice specifically state: "The RD does not delegate the nutrition care process, but may assign certain tasks for the purpose of providing the RD with needed information (e.g., screens, gathering of data and other information) or communicating with and educating patients."	F 325			
F 329 SS=D	483.25(i) DRUG REGIMEN IS FREE FROM 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. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F 329 Each resident's drug regimen will be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indication 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. Corrective action: The Facility now documents effectiveness of PRN Xanax for Resident #47. Identification of other Residents who may be at Risk Resident's receiving PRN psychoactive medications are at risk. Licensed nurses will be reeducated on or before the allegation of compliance on ensuring the effectiveness of the PRN	05/25/11	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 033046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2011
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 HOWELL AVENUE WORLAND, WY 82401	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329 SS=D	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medication regimens for 1 of 8 sample residents (#47) who received psychoactive medications were free of unnecessary drugs due to lack of monitoring. The findings were: According to the April 2011 medication administration record (MAR), resident #47 received the anti-anxiety medication Xanax 0.25 milligrams nine times for episodes of anxiety. The resident received Xanax at 8 PM on 4/9/11, 4/10/11, and on 4/11/11 without evidence a follow-up assessment was performed to determine the medication's effectiveness. On 4/22/11, the MAR notes described the resident as "inconsolable" with increased anxiety. Yet, there was no evidence the resident was re-assessed or offered other alternatives to address his/her anxiety. Interview with the DON on 4/28/11 at 8:25 AM revealed staff should always do a follow-up assessment to determine the effectiveness of PRN (as needed) medications. 483.76(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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	F 329	psychoactive medication is documented. Systemic Changes Each resident is reviewed on admission, quarterly, annually, and with significant change for the use of psychoactive medications (antidepressants, anti-psychotics, sedatives/hypnotics, and anti-anxiety agents). For residents who are prescribed PRN psychoactive medications, clinical record documentation will be reviewed to ensure: target behaviors, interventions, outcome and medication side effects and PRN effectiveness are monitored daily. On or before the date of alleged compliance, the DON/Designee will in-service licensed nursing staff on monitoring of behaviors and ensuring the effectiveness of PRN psychoactive medications is documented. An attendance sheet will be utilized and reconciled with the list of active licensed nurses and Nurses unable to attend will be provided 1:1 education. Monitoring: The Nursing Leadership team will review the Medication Administration records of the resident residents receiving psychoactive medications 3 times weekly and as necessary to ensure	
F 514 SS=B		F 514		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 836048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/28/2011
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 HOWELL AVENUE WORLAND, WY 82401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medication regimens for 1 of 8 sample residents (#47) who received psychoactive medications were free of unnecessary drugs due to lack of monitoring. The findings were: According to the April 2011 medication administration record (MAR), resident #47 received the anti-anxiety medication Xanax 0.25 milligrams nine times for episodes of anxiety. The resident received Xanax at 8 PM on 4/9/11, 4/10/11, and on 4/11/11 without evidence a follow-up assessment was performed to determine the medication's effectiveness. On 4/22/11, the MAR notes described the resident as "inconsolable" with increased anxiety. Yet, there was no evidence the resident was re-assessed or offered other alternatives to address his/her anxiety. Interview with the DON on 4/28/11 at 8:25 AM revealed staff should always do a follow-up assessment to determine the effectiveness of PRN (as needed) medications.	F 329	the effectiveness of medication is being monitored per facility policy and other required documentation is in place. Issues identified will be reviewed at QA & A to ensure plan has been implemented, sustained and evaluated for effectiveness.		
F 514 SS-B	483.75(l)(1) RES RECORDS-COMplete/ACCURate/ACCESSIB LE 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	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.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2011
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 HOWELL AVENUE WORLAND, WY 82401	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514 SS-3	Continued From page 23 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 and staff interview, the facility failed to assure medical record notations were accurate in regard to medication administration for 2 of 15 sample residents (#38, #47). The findings were: 1. According to the April 2011 medication administration record (MAR), resident #47 received the anti-anxiety medication Xanax 0.25 milligrams nine times for episodes of anxiety. The resident received Xanax at 8 PM on 4/9/11, 4/10/11, 4/11/11 and on 4/24/11 without documentation of it being administered on the PRN flowsheet. Review of the April 2011 MAR showed this resident, #47, received Tylenol 650 mg on 4/16/11 and again on 4/22/11 for pain, however the administration of these medications was not documented on the PRN flowsheet. 2. Review of the March 2011 MAR for resident #38 revealed s/he received Tylenol 650 mg for pain on 4/24/11, 4/25/11, and on 4/26/11. Review of the March 2011 PRN flowsheet revealed these medications were not documented as given on those three days. Review of the PRN flowsheet showed the resident received Tylenol 650 mg for a headache on 3/28/11. Review of the March 2011 MAR revealed no evidence this medication was administered. Review of the April 2011 MAR	F 514	Corrective Action 1) Resident #38 - Staff consistently documenting use of pain medication on the Medication Administration Record. 2) Resident #47 - Staff consistently documenting use of pain medication on the Medication Administration Record. Identification of other Residents who may be at Risk Residents that reside in the facility are potentially at risk. (A review of medication administration records (including the pain flow sheet) will be completed to identify other residents that may not have had use of PRN medications documented.) Systemic changes On or before the allegation of compliance the DON/Designee will Re-educate the Licensed Nurses on Administration on PRN pain medication, specifically the importance of insuring the Medication is appropriately documented on the Medication Administration Record. A sign sheet will be utilized and reconciled with the active roster of Licensed nurses and those unable to attend will be provided with 1:1 education.	05/25/11 05/25/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/28/2011
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 HOWELL AVENUE WORLAND, WY 82401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	Continued From page 24 showed the resident received Tylenol 650 mg for pain on 4/21/11, 4/3/11, 4/4/11, 4/8/11, 4/9/11, 4/20/11, and 4/21/11, none of which were documented as given on the PRN flowsheet. 3. Interview with the DON and house supervisor on 4/28/11 at 8:25 AM revealed staff had been educated on proper and accurate documentation on forms. They stated the inaccuracies should not have occurred.	F 514	Monitoring DON/Designee will monitor through review of medication and treatment administration records 3 times weekly and as necessary. These identified issues will be tracked and trended and results will be included in the DON's/designee's monthly QA and A report to assure that correction is implemented, achieved, sustained and evaluated for its effectiveness. The DON will be responsible for follow up on identified problems/trends.		