

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

PRINTED: 04/27/2018
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 C 02/14/2018
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 A complaint survey was conducted by Healthcare Licensing and Surveys from 2/12/18 through 2/14/18. The survey was prompted by complaint intake(s) WY000002562. The following common abbreviations are used throughout the document: ADON- Assistant Director of Nursing DON- Director of Nursing PT- Physical Therapy/Therapist Less commonly used abbreviations will be annotated in each deficiency.	F 000			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, policy and procedure review, and staff interview, the facility failed to obtain physician orders to provide necessary treatment to promote healing and prevent infection for 1 of 5 sample residents (#58) with wounds. The findings were: 1. Review of the medical record showed resident #58 was admitted to the facility on 12/18/17 from the hospital. Continued review showed the resident had a chronic sacral pressure ulcer.	F 658	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal		3/23/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/09/2018

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.

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F 658	Continued From page 1 Review of the care plan dated 12/18/17 showed the resident had a chronic sacral pressure ulcer and interventions included "physical therapy (PT) to consult for wound treatment." Review of the 12/18/17 "Initial Wound Evaluation", showed the resident was admitted with a sacral wound measuring 2.4 centimeters (cm) in length, 3.4 cm in width, and 1.4 cm in depth. Further review showed the wound edges were "defined, rolled under, and thickened," and "wound bed was "grey, pink (pale), and white," showed no tunneling, had "undermining of 0.2 cm at 6 o'clock," had minimal clear drainage, and did not have an odor. The surrounding skin tissue was "red and indurated (firm)." Review of the "Initial Wound review Summary" showed: "current Alevyn drsg (dressing) c (with) small amt (amount) dard [sic] red drainage noted; wound cleansed c sterile saline and sterile gauze sponges; patted dry; skin prep wipe applied to peri-wound; clean mepilex drsg applied; repositioned off of back." Review of wound documentation dated 12/18/17 through 12/22/17 showed the wound was initially assessed on 12/18/17 upon admission to the facility. Continued review showed PT consulted with the nurses on 12/19/17 and the treatments to be provided included medihoney, strip gauze, sterile foam, and a Tegaderm (transparent dressing). The following concerns were identified: a. Interview with the physical therapist on 2/14/18 at 11:25 AM revealed she was asked to consult on the resident's wound. She stated the wound did not look healthy on admission; the wound was "gooey, grey, had serosanguineous (yellow, with small amount of blood) drainage, had significant peri-wound edema." Additionally, she stated she didn't feel daily dressing changes	F 658	requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. F658 The facility will obtain physician orders to provide necessary treatment to promote healing and prevent infection for residents with wounds. Corrective action: Resident #58 no longer resides at facility. Identification: The facility will review the treatment orders of those Residents who have wounds to ensure interventions, treatment, and services are in place to prevent new wounds from developing and/or assist in healing wounds. On 3/7/18 the Director of Nursing/Designee completed a record review of those residents with wounds to ensure clear treatment orders are in place. Systemic Changes: Beginning 2/19/18, and continuing up until the allegation of compliance the Director of Nursing/Designee will in-service nursing staff on prevention and healing of wounds according to policy and procedure; Residents will be reviewed for their risk of skin breakdown on admission, weekly times 4 weeks after admission, quarterly, annually, and with significant changes in status using the Braden Scale. Licensed nurses will do weekly skin		

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F 658	Continued From page 2 were appropriate, because she did not want to reopen it [the wound] every day, and the facility was going to change the dressings every 1-2 days based on the amount of drainage noted. Further, she was talking with the nurses daily about the state of the wound and was providing guidance as needed. The physical therapist stated she had not discussed the wound with the physician, and since she was not "picking up" the resident for wound care treatment, no orders were obtained for wound care or dressing changes. In addition, she stated a standard order for wound care would be "PT evaluate and treat wound", and she confirmed she did not receive that order. Further, she stated there was a breakdown in communication between herself and the nurses regarding physician orders. b. Interview with the DON and ADON on 2/14/18 at 11:55 AM confirmed they did not have physician orders related to wound care and dressing changes. Further, they revealed they thought because PT was consulting with the wound care, they did not need to get further physician orders. c. Review of the policy and procedure titled "Guidelines For Completion of Admission/Readmission Skin Review Form", revised 3/10/15, showed: "... 4. If a wound is identified, the registered nurse or certified wound care licensed nurse will: Document the findings on the Initial Wound Review form... Notify the physician and obtain treatment orders..."			F 658	assessments on residents residing at facility. Licensed nurses will be in-serviced on communicating any newly identified skin issues to the IDT via the 24 hour report and ensuring there are clear treatment orders in place for any wounds. Residents with wounds will be reviewed daily and the wound progress will be evaluated weekly with corresponding documentation. The Director of Nursing and/or the designee will review records of Residents with wounds weekly to ensure clear treatment orders are in place. Orders will be reviewed in the morning meeting (stand-up) to review new orders for wounds and follow up as needed. Director of Nursing and/or designee will facilitate. Monitoring performance to Ensure Compliance is sustained: The IDT will meet weekly to review records of residents who have wounds to ensure the wounds have been assessed, monitored, and clear treatment orders are in place for the wounds. The DON/Designee will review treatment records for residents that have wounds weekly and prn ongoing to ensure treatments are in place for residents with skin breakdown are in place, results will be reviewed monthly by the QA&A committee to ensure plan is implemented, sustained, and evaluated for its effectiveness.		