POC accepted 3/8/07 JC

FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING _____ B. WING _____	C 01/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1448 UINTA GREEN RIVER, WY 82935

(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 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff and resident interview, the facility failed to notify the physician of a change of condition for one (#13) of one sample resident with constipation which	F 157	483.10(b)(11) This facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention This will be accomplished by (including but not limited to): 1. Staff will be in-serviced on notifying physicians in a timely manor of any change in status including but not limited to constipation, changes such as decline or improvement, acute conditions, falls, injuries or family request. Staff will document notification to physicians on appropriate forms. Resident #13s physician will be notified of her bowel status at the time of the stated incident and informed of her present bowel status. 2. Nursing staff will notify resident's family members or responsible parties of changes in status, new medical diagnoses, medication changes, injuries or accidents. 3. Administrator and Director of Nurses will review Incident Reports on all residents to track appropriate notification of physicians.	3/11/07 3/11/07 3/11/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2-27-07

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

Received FEB 27 2007

POC accepted. Case to Kathy Kunzler, DON on 3/28/07 @ 1300. JL

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: SGB411 Facility ID: WY0004 If continuation sheet Page 1 of 8

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F 157	Continued From page 1 resulted in a fecal impaction. The findings were: Review of the January 2007 care plan flow sheet showed resident #13 had a bowel movement on 1/4/07, but then not another one until 1/14/07 (10 days later). Review of the January 2007 BM (bowel movement) tracking form located at the nurses' station showed the resident went 10 days (1/4/07-1/13/07) without a bowel movement. Further review showed the resident had a bowel movement on 1/14/07 and 1/15/07, then not another one until 1/19/07. Review of nursing notes dated 1/22/07 at 11:59 AM revealed: "res [resident] had fecal impaction...medium amount of hard impaction digitally removed...resident very vocal about neglect "I've never been in such shape. It is pure neglect". During an interview on 1/25/07 at 12:26 PM, the resident stated ten days elapsed between bowel movements. The resident further stated, "They had to dig it out of me two nights ago...it hurt me so bad I cried." During an interview on 1/25/07 at 2:30 PM, the ADON stated nursing staff should be using the bowel tracking sheet to monitor for constipation in order to implement the bowel protocol. The ADON stated it was concerning that nursing staff had documented 10 days without a bowel movement for this resident, but did not document any interventions. Review of the medical record revealed no evidence the facility notified the physician the resident experienced 10 days without a bowel movement. There was also no evidence the facility notified the physician of the residents fecal impaction. On 1/25/07 at 2:30 PM, the ADON and DON stated they were not aware of the fecal impaction.	F 157	f. Tracking of notification of physicians will be reported at the Quarterly Quality Assurance Committee meeting. g. Director of Nursing Services is responsible for compliance with the standard.	3/11/07 3/11/07
F 309	483.25 QUALITY OF CARE	F 309		
SS=G				

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F 309	Continued From page 2 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 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and resident interview, the facility failed to implement interventions for one (#13) of one sample resident with constipation, which resulted in an avoidable fecal impaction. The findings were: Review of the ongoing diagnoses listing in the medical record showed resident #13 had had a diagnosis of constipation since 3/31/02. Review of a bowel assessment dated 11/16/06 revealed the resident had constipation. The assessment also documented the resident had "numerous pain meds/constipation/end confusion." On 1/25/07 at 2:30 PM, the assistant director of nursing (ADON) stated the resident was on a lot of pain medications, which would contribute to constipation. Review of the facility's "Bowel Protocol for Constipation" (dated 7/7/05) showed if a resident had not had a bowel movement by the end of day three then the bowel protocol would be implemented on day four per physician's standing orders. The protocol for day 4 was "1) administer Milk of Magnesia (MOM) 30-60 ml [milliliter]...or 2) Administer Dulcolax (bisacodyl) 5-15 mg [milligrams] ..or 3) Administer Senokot (senna, sennosides) 1-9 tabs/day or 1/2 4 tsp. of	F 309	F483.25 The facility will provide the necessary care and service to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with comprehensive assessment and plan of care. This will be accomplished by (including but not limited to): 1. Staff will be in-serviced on Bowel Management Program. (i.e Bowel Board. how to utilize, review and implement bowl protocol; staff responsible for documenting BMs; where to record information; who makes the bowel list; who makes bowel list for resident's interventions; what interventions to be implemented by nurse; where to record interventions utilized; when to notify the physician). 2. Bowel and Bladder nurse will review the bowel board five days a week to identify residents with bowel issues. The Bowel and Bladder nurse will communicate with the nursing staff to verify that the Bowel Protocol has been implemented. Resident # 13's is being evaluated per the bowel board and if needed the bowel protocol is implemented.	3/11/07 3/11/07 3/11/07

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F 309	Continued From page 3 granules...; rect supp [rectal suppository] 1-2 h.s [at bedtime]...; syr [syrup]1-4 tsp.[teaspoon] hs, 7.5 -15 ml 3/4 oz [ounces] dissolved in 2.5 oz liquid...". Day 5 protocol was "Administer Dulcolax Rectal Supp [suppository], 5 mg or 10 mg..." and the day 6 protocol was "Fleet Enema (fleet phospho-soda) 118 ml, per rectum...". Review of the January 2007 care plan flow sheet showed the resident had a bowel movement on 1/4/07, but then not another one until 1/14/07 (10 days later). Review of the January 2007 bowel movement tracking form that was located at the nurses' station revealed ten days (1/4/07-1/13/07) elapsed between bowel movements for resident 13. The bowel tracking form did not indicate any actions were taken by nursing staff. Review of the medication administration record (MAR) for January 2007 confirmed no interventions (such as MOM, Dulcolax, Senekot, suppository, or enema) were provided. There was one notation on the MAR on 1/9/07, which was the sixth day of now bowel movement for this resident. The not stated at that the resident refused a Dulcolax suppository at 4 AM because, "I need to sleep." There was no other mention of interventions tried, or another attempt at another time. The bowel tracking form and MAR revealed nursing staff did not follow the facility's bowel protocol. Further review showed the resident had a bowel movement on 1/14/07 and 1/15/07, then not another one until 1/19/07. Review of nursing notes dated 1/22/07 at 11:59 AM revealed: "res [resident] had fecal impaction...medium amount of hard impaction digitally removed...resident very vocal about neglect "I've never been in such shape. It is pure neglect". During an interview on 1/25/07 at 12:26 PM, the resident stated he/she has had problems with	F 309	3. Nursing staff will notify physician if resident does not have results with use of bowel protocol. Nursing staff will notify DON, ADON and Bowel and Bladder nurse of any residents having severe constipation or fecal impaction and what nursing interventions have been utilized up to this point and if physician was notified. All residents will have an initial four day bowel and bladder assessment, quarterly or as change in status. The data from the assessments will be reviewed quarterly and addressed in QA if needed. 4. Resident # 13 has received a bowel and bladder assessment. Care Plan Audit sheet is to be implemented every shift by nursing staff and to be reviewed by Administrator and DON daily. Care plan will reflect changes in bowel and bladder status and constipation status. 5. Bowel and Bladder nurse will utilize the QA Bowel Assessment Monitoring Tool once week on three random residents. See attached document. Director of Nurse and Bowel and Bladder nurse will review audits weekly and discuss appropriate interventions.	3/11/07 3/1107 3/11/07

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F 309	Continued From page 4 constipation and used to take something to make his/her bowels move. The resident stated the staff did not "know anything about me," and was not receiving anything to help with constipation resident stated he/she experienced ten days without a bowel movement. The resident further stated, "They had to dig it out of me two nights ago...it hurt me so bad I cried." During an interview on 1/25/07 at 2:30 PM, the ADON stated nursing staff should be using the bowel tracking sheet to monitor for constipation in order to implement the bowel protocol. The ADON stated it was concerning that nursing staff had documented the resident experienced ten days without a bowel movement, but did not document any interventions. During the same interview, the ADON and DON stated they were not aware of the fecal impaction.	F 309	6 Bowel Assessment Monitoring Tool and Care Plan Audit will be reported at the Quarterly Quality Assurance Committee meeting. 7. Director of Nursing Services is responsible for compliance with the standard.	
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to assure one of three (#13) sample residents who received a room tray received assistance with eating. The findings were: Review of the 1/15/07 significant change Minimum Data Set (MDS) assessment showed resident #13 required limited physical assistance with eating. Review of nursing notes revealed that	F 312	483.25(a) (3) The facility will assure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and oral hygiene. This requirement will be met by the following (including but not limited to): 1. Resident # 13 will receive a Restorative Meal Assessment. See attached document. Documentation will be completed and interventions will be communicated to the dietary department. Appropriate assistance in accordance with the assessment data will be implemented. 3/11/07 2. Resident # 13's Care Plan will be up-dated according to assessment findings. 3/11/07	

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F 312	Continued From page 5 on 1/17/07 the resident was found on the floor. On 1/18/07 the physician ordered a splint to the right wrist. Review of a dietary note dated 1/16/07 revealed the resident ate in his/her room by choice, and meal intakes had decreased. Review of the 1/15/07 Resident Assessment Protocols (RAPs) for vision and activities of daily living (ADLs) revealed the resident was legally blind and had poor nutritional and fluid intake. Review of the registered dietitian's evaluation revealed 1/15/07 the resident ate in his/her room, and required a plate guard. The resident's feeding ability was documented as "independent," "tray preparation," and "maximum assist." Review of the January 2007 meal intake record for the 1st through the 25th showed the resident's average meal intake was 31% for breakfast, 38% for lunch, and 23% for supper. The intake record showed during the 25 days, the resident "refused" (ate 0%) 18 meals. The following concerns were identified: a. Review of nursing notes showed on 1/19/07 the resident's son requested staff be in the resident's room while the resident was eating because the resident could not manage by himself/herself. Review of nursing notes dated 1/20/07 revealed the resident's son was very upset because he had requested one on one feeding. "...Advised not possible as we are not equipped [with] enough staff for 1 on 1 in room..." b. Observation on 1/25/07 at 11:55 AM revealed certified nurse aide (CNA) #1 delivered a room tray to the resident's room. The tray was placed on the bedside table over the resident's lap (the resident was in bed). The CNA provided set-up assistance, and then left the room. At 12 noon, a staff member answered the resident's call light, gave the resident some juice, and then left. During an interview at 12:03 PM, the resident	F 312	3. Restorative nurse will do Restorative Meal Assessments on all new residents; quarterly and when a change in status is identified. 4. Restorative nurse will meet with the DON quarterly and as needed to review Restorative Dining Assessments. Interventions will be discussed and brought to the IDT team. 5 Care plan audits will be reported at the Quarterly Quality Assurance Committee meeting. 6. Director of Nursing Services is responsible for compliance with the standard.	3/11/07 3/11/07 3/11/07

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F 312	Continued From page 6 stated his/her wrist hurt (the right wrist had a splint on it), and also stated the injured wrist was on his/her dominant side. The resident stated staff did not assist him/her with eating, and said, "I could eat more if somebody helped me." Observation during that meal revealed no staff checked in on the resident, and the resident was not eating. During another interview with the resident at 12:26 PM, the resident complained of wrist pain, and observation revealed the resident had not eaten. The resident asked the surveyor "Can you help me?...Where is my milk?..Can you pour it...my wrist hurts so..." At 12:45 PM, licensed practical nurse (LPN) #1 went into the resident's room, and said, "You didn't eat much." The LPN asked the resident if he/she wanted to eat more; the resident said no. Then the LPN removed the tray. Observation showed the resident only ate bites of the meal. On 1/25/07 at 12:50 PM., the LPN stated the resident did not eat much. c. Review of the care plan dated 1/15/07 showed it did not address how much assistance the resident required with eating. The care plan included the intervention to provide a plate guard, and indicated the resident was "legally blind, but can see some colors, shapes, etc." Observation on 1/26/07 revealed the resident was not provided with a plate guard. d. Review of a restorative meal assessment dated 1/22/07 revealed the resident needed some help with meals due to poor eyesight, but could feed himself/herself. The assessor recommended the resident have finger foods and yogurt in a cup with handles so it would be easier to eat. The assessment documented nursing would continue to monitor due to the family's request the resident be fed. However, review of the care plan showed the recommendations were not included and	F 312	483.25(c)The facility will ensure residents are fed according to their individualized meal cards/care plans. This requirement will be met by the following (including but not limited to): C. 1.The Registered Dietitian, Dietary Manager or designated staff will observe each meal tray served to Resident #13 and complete the Meal Card Audit (copy attached). This audit will continue until her meal tray is served without correction for 14 consecutive days. If the meal is not served correctly, immediate in-servicing and corrective action will be taken.	

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F 312	Continued From page 7 observation of the noon meal on 1/25/07 showed the recommendations were not implemented.	F 312	C. Within the next 45 days, the Registered Dietitian or Dietary Manager will in-service dietary employees on each resident's meal card/care plan explaining how to read the information and how to follow the meal card/care plan so each meal tray is served correctly. 3. A quality monitoring tool will be used to ensure that all residents are receiving their meals according to their individualized meal cards/care plans on an on-going basis. Random audits of all residents will be completed monthly by the Registered Dietitian or Dietary Manager. If the meal is not served correctly, the error will immediately be corrected and dietary staff will be in-serviced immediately. Audit results will be reported at the Quarterly Quality Assurance Committee meeting. D. 1. Following a Restorative Dining Assessment, any care plan changes will be made on the care plan by the Restorative staff. Restorative will communicate with Dietary any meal card changes. Care plan and meal card changes will be communicated to staff and implemented. 2. The Registered Dietitian or Dietary Manager will conduct a weekly care plan audit of dietary	03/11/07

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F 312	Continued From page 7 observation of the noon meal on 1/26/07 showed the recommendations were not implemented.	F 312	interventions for Resident #13. The weekly audit will be completed for four consecutive weeks and then quarterly and prn. 3. Within the next 45 days, the Registered Dietitian will update all resident care plans with a copy of the current meal card. Going forward, when the meal card is changed a copy will be included with the care plan. 4. A quality monitoring tool will be used to ensure that all dietary interventions are included on the individual care plans. Random care plan audits will be completed weekly so that within each quarter all resident care plans will be reviewed for accuracy. Audit results will be reported at the Quarterly Quality Assurance Committee meeting.	03/11/07