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 _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 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 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure a comprehensive assessment was performed for one (#43) of three residents who utilized a	F 272	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS: The facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. This standard will be accomplished by the following: (including but not limited to): A) A comprehensive assessment and a safety assessment will be completed on resident #43 by the restraint nurse. A quality monitoring tool (Attachment # 1B) will be utilized to ensure that resident # 43 has a completed comprehensive assessment and safety assessment.	4/23/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: administrator — (X6) DATE: 4-3-08

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.

APR 04 2008

4/15/08 POC accepted with agreed to changes with Jodi Kenard, administrator.

Wyoming Department of Health
Licensing and Surveys

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F 272	Continued From page 1 physical restraint. The findings were: Periodic observation throughout the survey showed resident #43 was in bed with two half-side rails up on both sides of the bed. Review of physician's summary orders revealed a 10/16/07 order for side rails under the category of "restraint." The order also documented the resident was at risk of rolling out of bed. Review of the 12/4/07 and 3/2/08 quarterly minimum data set (MDS) assessments showed side rails were used for this resident daily. The following concerns were identified: a. Review of the medical record showed no comprehensive assessment, including a safety assessment, had been conducted for the use of the side rails. b. Interview with the assistant director of nursing on 3/13/08 at 10:53 AM revealed she also could not find a comprehensive assessment. Further interview with the ADON on 3/13/08 at 10:52 AM revealed she contacted the coordinator of the restraint committee. The coordinator told the ADON she was unaware the bed rails were in use and confirmed a comprehensive assessment had not been conducted.	F 272	B) A quality monitoring tool will be completed on two random residents every week regarding Restraints and Assistive Devices which includes evauating comprehensive assessment and safety assessment completion. C) The results of the Quality Monitoring Tool will be reported to the Quality Assurance Committee. bi-annually D) The Director of Nursing Services is responsible for compliance for the above standard.	4/23/08
F 276 SS=D	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure minimum data set (MDS) assessments were performed on	F 276	483.20(c) QUARTERLY REVIEW ASSESSMENT: The facility will assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This standard will be accomplished by (including but not limited to):	4/23/08

4/2/08 POC accepted with agreed to changes with Todd Herrid, Administrator.

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F 276	Continued From page 2 a quarterly basis for one (#2) of 11 open sample residents. The findings were: Record review showed an admission MDS assessment was conducted for resident #2 on 4/20/07. The next quarterly assessment was completed on 10/16/07, almost 6 months after the admission assessment. Interview with the MDS coordinator on 3/11/08 at 3 PM confirmed a quarterly assessment should have been performed in October 2007; however, the assessment was missed.	F 276	A) Resident #2 will receive a comprehensive MDS in order to re-establish her quarterly timeframe. B) A quality measuring tool (Attachment # 2B) will be completed on two residents that are on the MDS schedule every week to assure the timely completion of MDSs as specified by the State and approved by CMS.	
F 356 SS=B	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356	C) The results of the quality monitoring tool will be reported to the Quality Assurance Committee. bi-annually D) The Director of Nursing Services is responsible for compliance with the above standard. 483.30(e) NURSE STAFFING: The facility will post the following information on a daily basis: facility name, the current date, the total number and actual hours worked by the following categories of licensed and un-licensed nursing staff directly rsponsible for resident care per shift (Registered nurses, Licensed practical nurses or Licensed vocational nurses, Certified nurse aides, and resident census. The facility will post the nurse staffaing data specifed above on a daily basis at the beginning of each shift. Data will be posted as follows: clear and readable format and in a prominent place readily accessible to residents and visitors.	4/23/08

4/15/08 POC accepted with regard to changes noted by Todd Tenney, Administrator.

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F 356	Continued From page 3 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, facility record review, and staff interview, the facility failed to maintain a posting of nurse staffing in a readable format which included a census. In addition, the facility failed to retain the daily data for 18 months. The findings were: Observation during the initial tour on 3/10/08 at 3:15 PM revealed the posted staffing board was located at the central nursing station. The board was magnetic, and it did not include the current census. Interview with the director of nursing (DON) on 3/10/08 at 4:19 PM revealed the facility retained a hard copy of the data for a two week period. The DON confirmed the posted board did not include the census. Review of the data the facility currently kept revealed two weeks of data which listed the work shift for each staff member, contained letters next to names but it did not contain a 'key' or definition for these letters, and it lacked the daily census.	F 356	Upon oral or written request the facility will make nurse staffing data available to the public for review at a cost not to exceed the comunity standard. The facility will maintain the posted daily nurse staffing data for aq minimum of 18 months or as required by State law, whichever is greater. This standard will be accomplished by (including but not limited to): A) A larger staffing board was purchased and is displayed on the east hall wall with the information as descriped above. B) Daily nurse staffing information will be posted for review to residents and visitors above the nurse staffing board. Additional nurse staffing hours will be available upon request. The nurse staffing notebook will be indentifed and kept in the ADON's office for review by residents and visitors. C) The Director of Nursing Services is responsible for compliance with the above standard.	4/23/08
F 368 SS=E	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.	F 368	483.35(f) FREQUENCY OF MEALS: The facility will ensure that each resident receives and provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There will be no more than 14 hours	

D.) The facility will maintain the posted daily nurse staffing data for a minimum of 18 months.

E.) The changes in posted Nurse Staffing information will be monitored by the Quality Assurance Committee bi-annually.

4/15/08 POC accepted with agreed to changes with Todd Worrall, Administrator

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F 368	Continued From page 4 The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to offer a bedtime snack to each resident. The findings were: The following concerns were noted with the provision of bedtime snacks: a. Confidential interview with 11 residents on 3/11/08 revealed the residents were not offered a bedtime snack; however, they stated that they could ask staff for a snack if they wanted one. b. Interview with CNA #11 on 3/11/08 at 5:14 PM revealed there was a snack time from 9-10 PM. The CNA further commented that if a resident wanted a snack they "just come down to get it." When asked about residents who were not independent, the CNA stated "They can ask for it." c. Interview with evening/night CNA #12 on 3/12/08 at 2:21 PM revealed bedtime snacks were passed by environmental aides who "passed all snacks." Interview at that time with environmental aide #1 revealed the environmental aides passed only the 10 AM and 2 PM snacks, and no environmental aides worked at bedtime. d. Interview with the registered dietitian (RD)	F 368	between substantial evening meal and breakfast the following day except as provide below: the facility must offer bedtime snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may lapse between a substantial eveining meal and breakfast the following day if a resident group agrees to this meal span and a nourishing snack is served. This standard will be accomplished by (including but not limited to): A) Each resident will be offered a bedtime snack. Documentaion will be required to assure that each resident has been offered a bedtime snack. (see attachment # 3B). B) An in-service will be provided for nursing staff regarding the importance of nutrition in the elderly population. C) The Director of Nursing Services is responsible for compliance with the above standard. D. The information concerning snacks (attachment 3B) will be reported to the Quality Assurance Committee bi-annually.	4/23/08

4/15/08 POC accepted with agreed to changes with Todd Reneer, Administrator.

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F 368	Continued From page 5 on 3/13/08 at 7:50 AM revealed each resident should have been offered a bedtime snack. She further commented that snacks were available for the residents, and the missing piece was for the staff to offer them.	F 368		
F 370 SS=F	483.35(i)(1) SANITARY CONDITIONS - FOOD PROCUREMENT The facility must procure food from sources approved or considered satisfactory by Federal, State, or local authorities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed during one of four days of survey to ensure food served to residents was from an approved source. The findings were: Interview with the activity director on 3/13/08 at 11:35 AM revealed a "potluck" lunch was being served to residents and staff that day. The activity director said dietary staff prepared pigs in a blanket, pork and beans, and pudding. In addition, staff brought in salads that would be offered and served to both residents and staff. The activity director further commented the facility planned a "potluck" every 1 - 2 months and either staff or family members brought food into the facility for the residents. Observation at that time confirmed staff had brought in a variety of eight salads that were being offered and served to the residents. Each salad was different and included items such as fruit with whipped topping and fresh lettuce and carrots. Interview with the RD on 3/13/08 at 1:30 PM	F 370	483.35 (i)(1)SANITARY CONDITIONS-FOOD PROCUREMENT The facility will procure food from sources approved or considered to be satisfactory by Federal, State or local authorities. It is the intention of Castle Rock Convalescent Center to protect residents from food borne illness but residents are provided with a wide variety of activities and may choose to eat foods from a variety of sources. (please see attached minutes from Special Resident Council Meeting of March 28, 2008) 1) The facility has developed a procedure (see attached form #7) related to the procurement of food and beverage items for the residents. An in-service on this procedure will be presented by the Dietary Director at the April 2008 Department Head meeting. 2) The Social Services and Activities departments will discuss the opportunity to participate in food-related activities that may include homemade foods and/or beverages with our present residents and/or their durable power of attorney for healthcare and obtain their consent or their decline within 60 days of the approval of this plan of correction.	4/23/08

4/15/08 POC accepted with agreed to changes with Todd Howard, Administrator.

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F 370	Continued From page 6 revealed dietary staff prepared pigs in a blanket, pork and beans, a salad, and pudding. The RD confirmed staff also brought in a variety of salads that were offered and served to residents. The RD said she thought food served to residents did not have to be from an approved source if the food was part of a planned activity. The RD further commented the facility did not have a policy, or any food safety guidelines, for the resident "potluck" meals.	F 370	~~These consent forms (see attached form #8) will be filed in the each resident's medical record.~~ 3) ~~The physician's will be provided with an opportunity to approve or deny the resident's participation in food-related activities that may include homemade foods and/or beverages through the standing orders form (see attached forms #9 and #9A).~~	
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the ice cream machine was properly sanitized and outdated canned food was discarded. In addition, the food preparation area was not maintained in a sanitary manner and left-over food items were not stored in proper containers. The findings were: 1. Observation in the dining room during breakfast on 3/11/08 between 7 AM and 7:56 AM revealed the ice cream machine was dismantled and the parts to the machine were placed on a bedside stand. Interview with dietary aide #1 at 7:56 AM revealed she was going to apply a lubricant to the parts before putting the machine back together. Further observation at 8:09 AM showed the machine was reassembled and the dietary aide poured a yogurt and an ice cream	F 371	4) ~~The consent forms for each resident will be updated annually by the~~ Activities department. 5) ~~A quality monitoring tool will be implemented to ensure that all residents have been given an opportunity to choose if they wish to participate in food-related activities that may include homemade foods and/or beverages. This monitor will be completed quarterly and reported to the~~ quarterly Quality Assurance Committee meeting. ~~6)~~ The Dietary Director is responsible for the implementation of these procedures. 483.35 (i)(2) SANITARY CONDITIONS-FOOD PREP & SERVICE The facility will ensure that food is stored, prepared, distributed, and served under sanitary conditions.	4/23/08

4/15/08 POC accepted with agreed to changes with Todd Wenrich, Administrator.

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F 371	Continued From page 7 mix into the machine. The following concerns were identified: a. Interview with the dietary aide on 3/11/08 at 8:09 AM revealed that besides adding lubricant to the parts and putting the machine back together, she "did not do anything else" before pouring the mixes into the machine. b. Interview with the dietary manager on 3/11/08 at 8:22 AM revealed the ice cream machine should have been sanitized with a chlorine-based sanitizer after the machine was reassembled and before the mixes were added. c. Interview with the registered dietitian on 3/13/08 at 7:50 AM revealed the dietary aide was not trained on the proper procedure for sanitizing the ice cream machine. 2. Observation in the dry storeroom on 3/10/08 at 2:30 PM revealed 10 cans of low sodium cream of mushroom soup dated June 2007. In addition, there were three cans of low sodium vegetable soup, and one can of low sodium chicken noodle soup, all dated November 2007. Further observation of the dates on the cans and interview with the RD on 3/11/08 at 8:19 AM, confirmed the soup was outdated and should have been discarded. 3. Observation during the preparation of lunch on 3/12/08 at 10:45 AM revealed soup and gravy were being heated on the stove top. Directly above the pots containing the soup and gravy were pipes covered with dangling dust particles. Further observation of the dusty pipes and interview with the RD on 3/13/08 at 7:50 AM, confirmed the pipes were in need of cleaning. According to the 2005 Food Code, U.S. Public Health Service, 4-602.11: "...(C) Nonfood-contact surfaces of equipment shall be	F 371	1. a)The procedure for the proper cleaning, sanitizing and set-up of the ice cream machine has been outlined in writing (see attached forms #10 & #10A). b) An in-service on the proper cleaning, sanitizing and set-up of the ice cream machine will be presented by the Dietary Director at the April 17, 2008 Dietary Department meeting. c) Each current dietary employee, who is responsible for cleaning, sanitizing and/or setting-up the ice cream machine, will be audited (see attached form #11) during April 2008 to ensure they are following the proper steps. d) Each new dietary employee with responsibility for the care of the ice cream machine will be in-serviced on the proper steps to follow for cleaning, sanitizing and set-up. e) Random, quarterly audits will be conducted using a quality monitoring Tool (see attached form #11 and #15) and the results will be reported to the quarterly Quality assurance Committee meeting. f) The Dietary Director is responsible for implementing this procedure. 2. a) The procedure regarding the proper storing and discarding of food items is updated to include the disposal of canned products that are past their expiration date (see attached form #12).	

4/19/08 POC accepted with agreed to changes with Todd Herrid, Administrator.

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F 371	Continued From page 8 kept free of an accumulation of dust, dirt, food residue, and other debris." 4. Observation during the preparation for lunch on 3/12/08 at 10:14 AM revealed re-used cottage cheese containers were used to store left-over tomatoes, beets, and chicken noodle and tomato soup. Interview with cook #1 at that time revealed it was facility practice to re-use cottage cheese containers to store left-over food. According to Food Code 2005, U.S. Public Health Service, 4-502.13: "Single-service and single-use articles may not be reused." The Food Code defines single-use articles as, "...food containers, jars, plastic tubs or buckets..."	F 371	b) The updated procedure will be reviewed with all dietary staff at the Dietary Department meeting on April 17, 2008. c) Checking for out dated food items in dry storage is specifically listed on the weekly duties for the employee assigned to the storeroom (see attached form #13). d). Monitoring of out-of-date canned items in the storeroom is added to the weekly Dietary QA Audit (see attached form #14). e) The results of the Dietary QA Audit are reported to the quarterly Quality Assurance Committee meeting (see attached form #15). f) The Dietary Director is responsible for implementing this procedure.	
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure nursing staff practiced proper hand hygiene during one of two observations of resident meal assistance. The findings were: Observation in the dining room during the evening meal on 3/10/08 between 5:20 PM and 5:44 PM showed CNA #1 was assisting six residents at the two horseshoe shaped tables. The CNA repeatedly handled each resident's utensils and cups that had also been handled by the residents. In addition, at 5::23 PM she adjusted the oxygen	F 444	3. a) The cleaning assignment for the hood is updated to specifically include that the fire suppression pipes are to be cleaned weekly when the hood and filters are cleaned (see attached form #16). b) An in-service on this updated procedure will be presented by the Dietary Director at the Dietary Department meeting on April 17, 2008. c) The weekly Dietary QA Audit is updated to include a check that nonfood contact surfaces of equipment are kept free of accumulation of dust, dirt, food residue, and other debris (see attached form #14). d) The results of the weekly Dietary QA Audit are reported to the quarterly Quality Assurance Committee meeting (see attached form #15). e) The Dietary Director is responsible for implementing this procedure.	

4/15/08 POC accepted with agreed to changes with Todd Wenek, Administrator

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F 444	Continued From page 9 tubing around one of the resident's ears. At 5:24 PM and 5:40 PM, the CNA used her bare hand and handed resident #9 his/her hamburger. The following concerns were identified: a. During this 24 minute observation, the CNA did not perform any hand hygiene between assisting residents. b. Interview with CNA #1 on 3/11/08 at 7:55 AM revealed she usually used an alcohol-based hand rub between assisting residents; however, her bottle of hand rub was empty during the 3/10/08 evening meal. c. Interview with the infection control nurse on 3/13/08 at 8:30 AM revealed nursing staff are expected to follow proper hand hygiene procedures while assisting residents during meals. The nurse further said that in this specific situation, the CNA should have performed hand hygiene between assisting each resident, and before direct hand contact with resident food.	F 444	4.a) Appropriate food storage containers have been purchased and are being used by dietary staff for proper storage of leftover foods. b) A procedure for proper storing of leftovers (see attached form #12) has been implemented and an in-service on this procedure will be presented by the Dietary Director to all dietary staff at the Dietary Department meeting on April 17, 2008. c) The weekly Dietary QA Audit is updated to include a check that only proper storage containers are being used to store leftover foods and that single-service articles are not being reused for storage purposes (see attached form #14). d) The results of the weekly Dietary QA Audit are reported to the quarterly Quality Assurance Committee meeting (see attached form #15). e) The Dietary Director is responsible for implementing this procedure. 483.65(b)(3) PREVENTING SPREAD OF INFECTION: The facility will require staff to wash or sanitize ther hands after direct resident contact for which handwashing is indicated by accepted professional practice. This will be accomplished by (including but not limited to):	4/23/08

4/15/08 QIC accepted with agreed to changes with Todd Ignerd, Administrator

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 _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 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 444	Continued From page 9 tubing around one of the resident's ears. At 5:24 PM and 5:40 PM, the CNA used her bare hand and handed resident #9 his/her hamburger. The following concerns were identified: a. During this 24 minute observation, the CNA did not perform any hand hygiene between assisting residents. b. Interview with CNA #1 on 3/11/08 at 7:55 AM revealed she usually used an alcohol-based hand rub between assisting residents; however, her bottle of hand rub was empty during the 3/10/08 evening meal. c. Interview with the infection control nurse on 3/13/08 at 8:30 AM revealed nursing staff are expected to follow proper hand hygiene procedures while assisting residents during meals. The nurse further said that in this specific situation, the CNA should have performed hand hygiene between assisting each resident, and before direct hand contact with resident food.	F 444	A) An in-servise will be provided to educate the nursing staff regarding infection control, the use of good handwashing techniques and when handwashing should be done. A quality assurance tool (Attachment # 4B) regarding hand washing in the dining room will be done randomily throughout the week to cover all three meals provided in the dining room. (Attachment 5B) B) The results of the quality management tool will be reported to the Quality Assurance Committee. C) The Director of Nursing Services is responsible for compliance with the above standard.	

10B

4/1/08 RAC accepted with agreed to changes with Todd Herald, Administrator.

(B07)