POC accepted 10/5/12, DOC 10/17/12

RECEIVED
WY Dept of Health
OCT 09 2012
Healthcare Licensing and Surveys

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

PRINTED: 09/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	530033	A. BUILDING _____ B. WING _____	PY 08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CENTER	1445 UINTA DRIVE 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 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA Certified Nurse Aide DON Director of Nursing LPN Licensed Practical Nurse MAR Medication Administration Record MDS Minimum Data Set RN Registered Nurse TAR Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE The facility will ensure that a comprehensive assessment of a resident is completed in 14 days after the facility determines that there has been a significant change in the resident's physical or mental condition. This standard will be accomplished by (including but not limited to):	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to conduct significant change assessments for 2 of 8 sample	F 274	(A) Resident #28 had a significant change in regard to weight loss, urinary catheter, and pressure ulcer. Significant change was done on 09/05/12 and sent to CMS by the MDS Coordinator.	09/11/12
			(B) Resident #26 had a significant change in regard to needing assistance with toileting, walking, transfers and bed mobility. Significant change was done on 09/05/12 and sent to CMS by MDS coordinator.	09/05/12
			(C) All residents who have had a change in their status will be reviewed in IDT weekly for recommendations for interventions and reporting to CMS utilizing the Quality Assurance Tool for Significant	10/17/12

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

Bailey Vollmer — Administrator — 9/24/12

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.

RECEIVED
WY Dept of Health
SEP 25 2012
Healthcare Licensing and Surveys

10/5/12 @ 8:45 AM telephone call with Bailey Vollmer, ADON, POC acceptable as submitted. P. Prince, RN

10/14/12 changes made per telephone call with Kathy Kumer DON - J. Hughes MSc, RD, CD

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

PRINTED: 09/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING _____ B. WING _____	PP 08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CENTER	1445 UINTA DRIVE 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 274	Continued From page 1 residents (#26, #28) who required that type of assessment. The findings were: 1. Review of the 3/16/12 annual and 6/15/12 quarterly MDS assessments for resident #28 showed s/he had not experienced significant changes in status and care. This review also showed a significant change in status MDS assessment had not been completed for the changes related to weight loss, placement of a urinary catheter, and the development of a pressure ulcer that occurred after 6/15/12. Review of the nursing documentation, dated 7/10/12, showed an indwelling urinary catheter was inserted as ordered by the physician that day. Review of the August 2012 skin care monitoring records showed staff first noted a stage II pressure ulcer on the resident's right gluteal area on 8/13/12. Review of the 8/22/12 interdisciplinary progress note showed "weight is down 5.95% over past month and 9.61% from three months ago." Observations on 8/30/12 at 11:55 AM revealed the resident had a urinary catheter and pressure ulcer. 2. According to the 4/3/12 admission MDS assessment, resident #26 did not have cognitive impairment and required no assistance with walking in the room and in the corridor, bed mobility, eating, and using the toilet. Comparison of that assessment with the 7/2/12 quarterly assessment showed the resident had declined; s/he required extensive assistance with toilet use, walking, transfers, and bed mobility. Further review of this assessment showed s/he was assessed as being severely cognitively impaired. Observation on 9/28/12 at 9:10 AM revealed CNA #1 assisted the resident with toileting and	F 274	Change in Assessment. (D) The data from the quality assurance tool will be reported monthly or quarterly to the Quality Assurance Committee. Appropriate follow-up actions will be initiated by the Quality Assurance Committee. (E) The Director of Nursing is responsible for compliance of the above standard.	10/17/12 10/17/12

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

PRINTED: 09/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING _____ B. WING _____	PP 08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CENTER	1445 UINTA DRIVE 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 274	Continued From page 2 personal hygiene care. 3. On 6/20/12 at 12:05 PM, MDS coordinator #1 stated the significant change assessments that were needed for residents #26 and #28, had not been done.	F 274	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSON/PER CARE PLAN The facility will ensure that services provided by the facility are provided by a qualified person in accordance with each resident's written plan of care. This standard will be accomplished by the following (including but not limited to):	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 12 sample residents (#25, #33). The findings were: 1. Review of the 7/24/12 quarterly MDS assessment for resident #25 showed s/he was at risk for developing pressure sores. According to the care plan, the resident needed a pressure reducing cushion in the wheelchair. Periodic observations from 8/27/12 to 8/29/12 at various times, revealed the resident sat in the wheelchair without a cushion. During an interview on 8/29/12 at 10:10 AM, LPN #1 confirmed the resident did not have a pressure relieving cushion in the wheelchair. At that time the nurse stated it should have been in the wheelchair because the resident needed it. 2. Review of the 4/19/12 care plan for Resident #33 showed staff were to "facilitate the	F 282	A) Resident #25 will be monitored weekly by the Restorative Nurse, DON, ADON or assigned nursing staff to assure that her pressure reducing cushion is in her wheelchair utilizing the Quality Assurance Tool for Pressure Relieving Device Care Plan Compliance. 10/17/12 B) Three residents will be randomly selected weekly and audited by the Restorative Nurse, DON, ADON or assigned nursing staff utilizing the Quality Assurance Tool for Pressure Relieving Device Care Plan Compliance. 10/17/12 C) Resident # 33 will be monitored weekly for toileting compliance by the Restorative Nurse, DON, ADON or other nursing staff utilizing the 10/17/12	

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

PRINTED: 09/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING _____ B. WING _____	pp 08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CENTER	1445 UINTA DRIVE 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 282	Continued From page 3 opportunity to toilet" every two and a half to three hours. Continuous observations on 8/28/12 from 8:30 AM to 11:55 AM showed staff did not offer assistance or direct the resident to the bathroom during that time. At 11:55 AM, CNA #4 removed the urine soiled disposable brief when she assisted the resident to the bathroom. At that time, the CNA verified the resident had not received toileting assistance from 8:30 AM to 11:55 AM (three hours and twenty-five minutes).	F 282	Quality Assurance Tool for Incontinence Care Plan Compliance. D) Three other random residents will be monitored weekly for compliance to their toileting care plan by the Restorative Nurse, DON, ADON or other assigned nursing staff utilizing the Quality Assurance Tool for Incontinence Care Plan Compliance.	10/17/12
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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, resident and staff interviews and medical record review, the facility failed to ensure 1 of 7 sample residents (#25) and 3 randomly observed residents (#14, #18, #59) who required toileting assistance received this type of assistance in a timely manner. The findings were: 1. A confidential interview with eight residents on 8/29/12 at 1:30 PM, revealed the majority of residents agreed it takes up to an hour and sometimes more for call lights to be answered. One resident stated once he/she got so tired of waiting for staff to assist in a toileting transfer, the resident moved without staff assistance. When a CNA finally did come to answer the call light, the	F 312	E) The data from the quality assurance tool will be reported monthly or quarterly to the Quality Assurance Committee. Appropriate follow-up actions will be initiated by the Quality Assurances Committee. F) The Director of Nursing is responsible for compliance of the above standard. 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS The facility will ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This will be accomplished by the following (including but not limited to):	10/17/12 10/17/12

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

PRINTED: 09/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING _____ B. WING _____	08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CENTER	1445 UINTA DRIVE 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 312	Continued From page 4 resident stated he/she knew the staff would caution against future self transfers, but thought that doing a self transfer would make the next call light wait to be less if there was a possible fall risk involved. Another resident stated waiting for call lights to be answered was most noticeable during meal times. Review of the resident council meeting minutes for 7/21/12 and for 8/28/12 confirmed the residents had expressed their concerns with slow call light response time. 2. Review of the 8/14/12 quarterly MDS assessment for resident #14 showed s/he required extensive assistance with toileting and personal hygiene care. Review of the corresponding care plan showed interventions included providing incontinence care and bathroom assistance as needed. Observation on 8/30/12 at 10:45 AM, revealed the resident was in bed and activated his/her call light to request assistance to the bathroom. CNA #1 responded at 11 AM and told the resident that additional assistance was needed because the transfer required the assistance of two staff. At 11:10 AM CNAs #1 and #2 provided the toileting assistance the resident requested twenty-five minutes earlier. 3. Review of the 7/24/12 quarterly MDS assessment for resident #25 showed s/he had frequent episodes of urinary incontinence and required extensive assistance with toileting and transfers. Observation on 8/29/12 at 9:35 AM revealed the resident was in the bathroom and the bathroom call light had been activated. Continuous observation showed RN #2 and LPN #2 responded to the call light at 9:49 AM (fourteen minutes after the call light was	F 312	A) Resident #14 will be monitored weekly by DON, ADON or assigned nursing staff for adequate response time to call light utilizing the Quality Assurance Tool for Call Light Compliance. B) Resident #25 will be audited weekly by DON, ADON or assigned nursing staff for adequate response time to call light utilizing the Quality Assurance Tool for Call Light Compliance. C) Resident #59 will be audited weekly by DON, ADON or assigned nursing staff for adequate response time to call light utilizing the Quality Assurance Tool for Call Light Compliance. D) Resident #18 will be audited weekly by DON, ADON or assigned nursing staff for adequate response time to call light utilizing the Quality Assurance Tool for Call Light Compliance. E) Three random residents will be audited weekly by DON, ADON or assigned nursing staff for adequate response time to call light utilizing the Quality	10/17/12 10/17/12 10/17/12 10/17/12 10/17/12

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

PRINTED: 09/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536033	A. BUILDING _____ B. WING _____	pp 08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CENTER	1445 UINTA DRIVE 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 312	Continued From page 5 activated). On 8/29/12 at 11:10 AM the resident stated "it seems like a long time when you're sitting in the bathroom waiting, but they always come." 4. Review of the 8/28/12 admission MDS assessment for resident #59 showed s/he was occasionally incontinent of urine, required extensive assistance with mobility, and was totally dependent on staff for toileting and personal hygiene care. Review of the corresponding care plan showed s/he had muscle weakness, impaired mobility and a history of falling. Further review showed staff were to provide the appropriate level of assistance to promote safety. Observation on 8/30/12 at 10:22 AM revealed s/he sat in the bathroom and activated the bathroom call light for assistance. CNA #3 was observed responding to this call for assistance at 10:34 AM (twelve minutes after the call light was activated). 6. Review of the 8/22/12 admission MDS assessment for resident #18 revealed s/he had cognitive impairment and required extensive assistance with toileting, mobility and hygiene care. Review of the care plan, updated on 8/30/12, showed staff were directed to check the resident every two hours and assist with toileting as needed. Observation on 8/30/12 at 10:38 revealed s/he activated his/her call light. The DON was observed responding to the call light at 10:48 AM and assisting the resident to the bathroom (ten minutes after the call light was activated). Interview with the CNAs at that time revealed they were unable to respond to the call light in a timely manner because they were providing care for other residents. Observations	F 312	Assurance Tool for Call Light Compliance. F) The facility will provide education to nursing staff during monthly Nurse/CNA meeting on the importance of answering call lights in a timely manner. G) ~~The facility has contracted to install a new call light system to include personal pagers to be carried by every CNA and RN to aide in improvement of response time to call lights.~~ H) The data from the quality assurance tool will be reported monthly or quarterly to the Quality Assurance Committee. Appropriate follow-up actions will be initiated by the Quality Assurance Committee. I) The data from quality assurance will also be reported quarterly to Resident Council. J) The Director of Nursing is responsible for compliance of the above standard.	9/12/12 ~~Pending-State and Fire Marshal Approval~~ 10/16/12 Removed per discussion with Kathy Kramer DON 12/12/12

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

PRINTED: 09/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING _____ B. WING _____	pp 08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CENTER	1445 UINTA DRIVE 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 312	Continued From page 6 during the time the call lights were activated, confirmed the CNAs were providing care for other residents, however other staff that were not providing care for the residents ignored the call lights. 6. Interview with the DON on 8/30/12 at 4:15 PM, revealed the problems regarding the slow response to call lights had been identified, but the issue had not been resolved.	F 312	483.25 (c) TREATMENT/SCVS TO PREVENT/HEAL PRESSURE SORES The facility will ensure that the standard regarding residents who enter the facility without pressure sores do not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment ad services to promote healing, prevent infection and prevent new sores from developing. This will be accomplished by (including but not all inclusive):	
F 314 SS=D	483.25(c) 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, staff interview, and review of policies and procedures, the facility failed to ensure monitoring and assessments were completed for 1of 2 sample residents (#28) with pressure ulcers. In addition, the facility failed to consistently provide a pressure reducing device for 1 of 12 sample residents (#25) who were at risk for developing pressure ulcers. The findings were: 1. Review of the 3/16/12 annual and 6/15/12 quarterly MDS assessments showed resident #28	F 314	A) Resident #28 will be monitored by DON, ADON, or assigned nursing staff for accurate documentation of wounds weekly utilizing the Quality Assurance Tool for Appropriate Tracking of Wounds. B) One or two random residents will be selected to be audited by DON, ADON, or assigned nursing staff for accurate documentation of wounds weekly utilizing the Quality Assurance Tool for Appropriate Tracking of Wounds. C) Resident #25 will be	10/17/12 10/17/12 10/17/12

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

PRINTED: 09/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536033	A. BUILDING _____ B. WING _____	pp 08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CENTER	1446 UINTA DRIVE 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 314	Continued From page 7 was at risk for developing pressure ulcers. Review of the care plan, updated 8/22/12, showed interventions for implementing preventive skin care measures, but did not address monitoring and reassessing the measures. Review of the July and August 2012 daily wound documentation and wound care review notes, showed staff noted a pressure ulcer on the resident's right gluteal fold on 8/13/12. Review of 8/13/12 wound care review notes showed the pressure ulcer on the gluteal fold was pink, measured 2 centimeters (cm) x 1.75 cm x .1 cm, and had a scant amount of serous drainage. Review of the medical record showed pressure reducing devices in bed and chair were implemented and a nutritional assessment was completed. However, further review showed no additional assessment of the appearance of the pressure ulcer after 8/13/12, nor was there evidence of monitoring for the effectiveness of the treatments and pressure reducing measures. In an interview on 8/29/12 at 11:35 AM, LPN #1 stated the nurses were required to document the appearance of the pressure ulcer every week. At that time she verified the lack of the required documentation, and stated she did not know if the pressure ulcer had improved since 8/13/12. On 8/30/12 at 11:45 AM, RN #1 was observed providing the treatment and dressing change for the pressure ulcer. At that time the measurements were 1 cm x 1 cm x 2 millimeters and the yellow wound bed was surrounded by red tissue. Review of the wound management policy and procedure, revised 11/2/06, revealed all residents	F 314	monitored by Restorative Nurse, DON, ADON, or assigned nursing staff for adherence to care plan intervention regarding pressure reducing cushion in the wheelchair utilizing the Quality Assurance Tool for Pressure Relieving Device Care Plan Compliance. D) Two random residents will be selected weekly to audit for compliance to their care plans for pressure reducing devices using the Quality Assurance Tool for Pressure Relieving Device Care Plan Compliance. E) The data from the quality assurance monitoring tools will be reported monthly or quarterly to Quality Assurance Committee. Appropriate follow-up actions will be initiated by the Quality Assurance Committee. F) The Director of Nurses is responsible for compliance of the above standard.	10/17/12 10/17/12 10/17/12

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

PRINTED: 09/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING _____ B. WING _____	08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CENTER	1445 UINTA DRIVE 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 314	Continued From page 8 with wounds "will have a weekly assessment of wounds done by a Wound Care nurse"..."documentation of characteristics of the wound" should include: "length, width, depth, exudate amount, tissue type, skin surrounding the wound, pain." During an interview on 8/30/12 at 4:20 PM, the DON stated it is the expectation that staff follow the wound care policies and procedures. 2. According to the 7/24/12 quarterly MDS assessment for resident #26, s/he did not have pressure ulcers; but was assessed as being at risk for developing pressure ulcers due to limited ability to reposition independently. Review of the corresponding care plan showed interventions for preventive skin care included a pressure reducing cushion in the wheelchair. Periodic observations on 8/27/12, 8/28/12, and 8/29/12 showed the resident sat in his/her wheelchair without a pressure reducing cushion. During an interview on 8/29/12 at 1:15 PM, the DON stated the pressure reducing cushion was removed on 8/3/12 to facilitate transfers and transport to the fair. She stated the cushion should have been removed then replaced after a brief period of time, but it had not been returned to the wheelchair after that day because it wasn't labeled.	F 314	483.25(d) NO CATHETER, PEVENT UTI, RESTORE BLADDER The facility will ensure that residents who enter the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This will be accomplished by (including but not limited to): A) Resident # 33 will be monitored weekly by DON, ADON, or assigned nursing staff for adherence to the care plan interventions for incontinence utilizing the Quality Assurance Tool for Incontinence Care Plan Compliance. B) Two random residents will be selected weekly to audit for adherence to the care plan interventions for incontinence utilizing the Quality Assurance Tool for Incontinence Care Plan Compliance. C) The data from the tool will be reported monthly or quarterly	10/17/12 10/17/12 10/17/12
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		

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

PRINTED: 09/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING _____ B. WING _____	RP 08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CENTER	1445 UINTA DRIVE 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 315	Continued From page 9 who is incontinant of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staf interview, the facility failed to provide care to promote continence for 1 of 4 sample residents (#33) who had urinary incontinence. The findings were: Review of the 4/13/12 admission MDS assessment for resident #33 showed s/he toatlly dependent on staff for personal hygiene care and required extensive assistance with toileting. This review also showed s/he frequently had urinary incontinence. Review of the 4/19/12 care plan for resident #33 showed staff were to "facilitate the opportunity to toilet" every two and a half to three hours. Continuous observations on 8/28/12 from 8:30 AM to 11:55 AM showed staff did not offer assistance or direct the resident to the bathroom during that time. At 11:55 AM, CNA #4 removed the urine soiled disposable brief when she assisted the resident to the bathroom. At that time, the CNA verified the resident had not received toileting assistance from 8:30 AM to 11:55 AM (three hours and twenty-five minutes).	F 315	to the Quality Assurance Committee. Appropriate follow-up actions will be initiated by the Quality Assurance Committee. D) The Directors of Nursing is responsible for compliance to the above stated standard. F 323 483.25 (h) FREE OF ACCIDENT HAZARDS / SUPERVISION/ DEVICES The facility must- (1) Ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The facility will: A) Replace cracked plant saucer. B) Purchase additional saucers to be available if needed to replace damaged saucers. C) In-service staff to observe unsafe conditions during the weekly plant care activity to look at each planter and saucer to ensure there are not any cracks or breaks, and alert activity director if they	10/17/12 08/27/12 09/03/12 10/01/12
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		

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

PRINTED: 09/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING _____ B. WING _____	08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CENTER	1446 UINTA DRIVE 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 323	Continued From page 10 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe environment for residents, guests, and staff in 1 of 1 aviary area. The finding were: Periodic observations from 8/27/12 at 4:30 PM through 8/30/12 at 8:48 AM revealed a large plant in a glass planter was positioned on the floor in the bird cage area. Under the planter was a glass plate to catch excess water. The plate was broken, revealing a sharp edge. Periodic observations during this time also revealed residents walked and sat in this area. Interview with the administrator on 8/30/12 at 8:48 AM confirmed the exposed edge on the plate represented a safety hazard to anyone in the area.	F 323	see something that needs to be replaced. D) Activity Assistants will do weekly QA Audit. E) The completion of this standard will be reported to safety committee quarterly. F) The completion of this standard will be reported to the Quality Assurance Committee quarterly. Appropriate follow up actions will be initiated by the QI Committee.	09/20/12 10/11/12 09/21/12
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	483.35 (i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must- (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) (2) Store, prepare, distribute and serve food under sanitary conditions The facility will ensure (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and	

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

PRINTED: 09/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536033	A. BUILDING _____ B. WING _____	08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CENTER	1445 UINTA DRIVE 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 371	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the wall behind the three compartment sink was maintained in a sanitary manner. The findings were: Observation on 8/27/12 at 3:48 PM and on 8/30/12 at 8:45 AM, showed the clear plastic wall moulding behind the three compartment sink was pulling away from the wall. The crack in the moulding was being used to hold a plastic food scraper. The area behind the clear plastic moulding was dark with accumulated dirt and debris. An interview with the kitchen manager on 8/30/12 at 8:45 AM confirmed the frequent placement of a dirty food scraper in the cracked moulding would leave an accumulation of organic material and promote an environment of bacterial growth. According to Food Code 2009, U.S. Public Health Service: 4-601.11"... (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371	serve food under sanitary conditions A) Fixed moulding. B) In-service staff on not to use moulding as a holder for any dietary equipment and to watch for cracks in moulding and alert dietary manager if they see something that needs to be fixed. C) Dietitian or dietary manager to do monthly QA Audits D) The completion of this standard will be reported to safety committee quarterly. E) The completion of this standard will be reported to the quality assurance committee quarterly	9/04/12 9/17/12 9/18/12 10/11/12 9/21/12