PRINTED: 11/05/2013
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 CONSTRUCTIONS	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING _____ B. WING _____	10/03/2013

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 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure hallway carpets were clean for 4 of 4 (North, South, East, West) resident hallways. The findings were: The following concerns were noticed regarding the cleanliness of the carpet: a. Observation on 10/1/13 at 10:30 AM showed the hallway outside of the dining area had multiple blackened spots on the carpet. Observation on 10/3/13 at 9:20 AM revealed the hallway outside of the dining area continued to be dirty, with multiple blackened spots on the carpet. During an interview with the housekeeping director at that time, he stated the carpets were difficult to clean because they were old and in need of replacement. He stated the maintenance director intended to remove all carpet and change the flooring. b. Observation on 10/3/13 at 9:15 AM showed the edges of the carpets closest to the nursing station (where the carpet ended) for the North, South, East, and West resident hallways had dirty blackened edges. Observation on 10/3/13 at 9:40 AM showed the South resident hallway carpet had multiple faded areas from end to end. c. Observation on 10/3/13 at 11:05 AM of the North resident hallway carpet showed there were multiple dirty darkened areas from end to end. In	F 253	**Reference Tag F253** **The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.** The maintenance supervisor will contract with a professional carpet cleaning company to do a thorough cleaning of the carpet in the front foyer, and nursing hallways North, South, East, and West biannually. In addition the housekeeping staff will do spot cleaning of carpet as needed and indicated. All staff will be notified of the appropriate work order process to report areas of concern for spot cleaning to the housekeeping supervisor. This process will be handled via mailbox in-service. The housekeeping department will add the foyer and nursing hallways North, South, East and West to a monthly shampooing schedule. Castle Rock Hospital District recognizes the need for carpet replacement and has been awarded a 6th penny Bond funding to do so. The preliminary Bond process has been initiated and the maintenance supervisor will ensure completion of carpet replacement entirely in above stated areas as soon as funding and the legal procedural process allows. The carpets will be maintained monthly and regularly by the Housekeeping Supervisor	11-22-13 11-29-13 11-22-13 ~~12-13~~ 1/2/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie [illegible] | TITLE: NHA | (X6) DATE: Nov 5, 2013

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.

Next Page

11/14/13 CT

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F 253	Continued From page 1 addition, there were two tears in the carpet outside of resident rooms #1 and #2. The tears were straight across the hallway over most of the width of the hallway. While the tears did not pose a safety risk at that time, they trapped dirt and could not be adequately cleaned. d. During an interview with the maintenance director on 10/3/13 at 10:40 AM, he confirmed the carpets could not easily be cleaned because they were old and damaged and needed to be removed. He also stated the facility planned to replace the carpets with a non-carpeted surface. However, he confirmed the facility did not have a specific plan or timeframe to remove the carpet and replace the flooring.	F 253	**Reference Tag F278** **The assessment must accurately reflect the resident's status.** **A registered nurse must conduct or coordinate each assessment with appropriate participation of health professionals.** **A registered nurse must sign and certify the accuracy of that position of the assessment.** **Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.**	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual	F 278	The facility will assure the accuracy of the Minimum Data Sets (MDS) for the residents. This standard will be accomplished by the following: (including but not limited to): The MDS coordinator will provide assessments that are reflective of the characteristics of the resident's physical health, functional abilities, cognitive functioning, psychological state, social well-being and past or current use of formal services. This is a multidisciplinary team approach and the MDS coordinator will coordinate with involved staff and gather input from disciplines such as social services,	12-2-13

This POC accepted 11/7/13 with agreed to changes between Bobbi Jo Dowd - Administrater and Tony Maddux, Health Surveyor.

11/7/13

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F 278	Continued From page 2 to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure the accuracy of Minimum Data Set (MDS) assessments for 1 of 2 sample residents (#22) assessed as having a restraint. The findings were: Periodic observation of resident #22 on 9/30/13, 10/1/13, and 10/2/13 revealed the placement of a Lap Buddy (a restraint) on his/her wheelchair on each of those days. Review of the resident's quarterly MDS assessment dated 7/17/13 revealed the resident was assessed as using this restraint "less than daily." Interview with the MDS coordinator on 10/3/13 at 10:45 AM revealed the assessment of the restraint as used less than daily was an error and the restraint was used on a daily basis for this resident.	F 278	activities, dietary, nursing and rehabilitation. Resident # 22 and one to three other residents will be audited quarterly for accuracy on the MDS using the MDS coding audit tool. The focus of the audit will include accuracy of restraint use along with accuracy of reporting in sections G1, G5, J15, J16, and P1. The results of the quality monitoring tool will be reported to the Quality Assurance Committee quarterly. The Director of Nursing is responsible for compliance of the above standard.	

11/7/13