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 _____	11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION AT CASTLE ROCK REHABILITATION CENTER	1445 UINTA DRIVE GREEN RIVER, WY 82935

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	**483.15(h)(2) Housekeeping & Maintenance Services** **F.Tag 253** **"Clean and sanitary environment"** Immediate corrective action: The shower rooms #1 and #2 were immediately cleaned and non-essential items removed. The shower rooms were thoroughly dusted, swept, mopped and floors were deep cleaned and buffed. How the facility will identify other residents having the potential to be affected: All residents using these shower areas have the potential to be affected Measures put in place or system changes to ensure correction in this area include: The facility cleaning schedule will be reviewed by the housekeeping Supervisor and Administrator to ensure all facility areas are included on the schedule and cleaned routinely. The Housekeeping staff and designated C.N.A. bath aides will be educated on the updated cleaning and daily cleaning responsibilities by the Housekeeping Supervisor and DON. The Housekeeping Supervisor will ensure all facility areas are correctly cleaned. Who will monitor the new system: The Administrator	11-19-14 12-19-14
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 2 of 2 shower rooms were maintained in a clean and sanitary manner. The findings were: 1. On 11/18/14 at 8:20 AM shower room #1 was observed as the shower aide wheeled a resident into the room and prepared to give the resident a bath. Observation of the room at that time revealed there was dust on the towel warmer and mobile storage unit and brownish yellow stains on the sides of the commode. Further observation revealed dirt, dust, lint and debris were on the floor in the corners and behind the stored equipment in the room. 2. Observation with CNA #1 on 11/18/14 at 8:40 AM of shower room #2 revealed debris and dust	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [illegible] TITLE: Administrator (X6) DATE: 12/12/14

[illegible]ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that [illegible]ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days [illegible]llowing 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 [illegible]ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued [illegible]rogram participation.

DEC 15 2014

Accepted by Lori Kress on 12/ 1/3/15

Healthcare Licensing and Surveys

message left for Bobbi G, NHA

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F 253	Continued From page 1 along the edges of the floor and in the corners. Further observation revealed larger collections of dust and debris behind the equipment stored in the room. At that time the CNA verified staff used both shower rooms for the residents but shower room #2 was not used as often as shower room #1. 3. On 11/20/14 at 9 AM both shower rooms were observed with the administrator, housekeeping supervisor and maintenance supervisor. During that time dust, dirt and debris was observed on the floors and behind the stored equipment. Further observation revealed there was dust on the blanket warmer and mobile storage unit. Interview with the housekeeping supervisor during the observation revealed the housekeeping staff were suppose to clean the shower rooms daily.	F 253	Housekeeping supervisor will report on the effectiveness of the new cleaning schedule monthly by reporting weekly audits to the Administrator and in QUAPI committee meetings for the next 3 months, and then frequency to be determined by the QUAPI Committee depending upon findings. **483.20(d)(3), 483.10(k)(2) Right to Participate Planning Care-Revise CP** **F. Tag 280** **"Care Plans"** Immediate corrective action: Resident #48 This resident's care plan has been updated to reflect the fall prevention interventions that are in place. Resident #27 This resident's care plan has been updated to include the use of the safety wander guard. How the facility will identify other resident's having the potential to be affected: All residents have the potential to be affected. Measures put in place or system changes to ensure correction in this area include:	12-10-14 12-10-14
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280		

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F 280	Continued From page 2 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the care plan was updated to reflect current status for 2 of 13 sample residents (#27, #48). The findings were: 1. Observation on 11/17/14 at 4:45 PM and on 11/18/14 at 8:22 AM revealed resident #48 utilized an alarm in the wheelchair (clip attached to clothing, which would alarm if resident stood up). Further observation on 11/17/14 starting at 5:39 PM revealed the resident utilized a pressure alarm on the bed, and a cushioned mat was placed on the floor next to the bed. Review of the current care plan (revised 11/4/14) showed the chair alarm, bed alarm, or mat on the floor were not included. During an interview on 11/19/14 at 6:22 PM the DON stated the alarms and mat on the floor were interventions for falls. She confirmed the care plan was not updated to include those interventions. 2. On 11/20/14 at 7:10 AM resident #27 was observed walking to the dining room with a wander alert device attached to his/her walker. Review of the August 2014 wander/elopement risk assessment showed the resident was assessed as needing a wander alert device. Review of the care plan showed the wander alert device had not been included in the care plan. Interview on 11/20/14 at 11:30 AM with the DON	F 280	Residents who use wander guards and or have had a fall in the past month will have their care plans audited to ensure that their care plans comprehensively reflect the residents care. Corrections will be made if needed. The MDS and/or designated nurse will be educated on the method to ensure all interventions have been included on each resident's comprehensive care plan. Ongoing, each month four (4) residents care plans will be selected and reviewed for completeness of fall intervention and wander guard placement and monitoring. Who will monitor the new system: DON/designee How frequently will we monitor: Ongoing each month How will we incorporate the new system into our Quality Assurance Performance Improvement system: The MDS Nurse or designee will report the results of the monthly review for the next 3 months, and then at a frequency to be determined by the Committee depending on the findings of the review.	12-30-14

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F 280	Continued From page 3 revealed the device was placed on the resident on 9/15/14, but the care plan had not been updated to include this information.	F 280	**483.65 Infection Control, Prevent Spread, Linens** **F. Tag 441** Infection Control Immediate corrective action: The nurse was immediately educated on the correct method of cleaning the glucometer.	11-20-14
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441	How the facility will identify other residents having the potential to be affected: All residents who have testing with a glucometer have the potential to be affected. Measures put in place or system changes to ensure correction in this area include: All nurses will be educated on the correct method of cleaning glucometers and following manufacturer's recommendations of the cleaning agent by the DON. Each medication cart will be provided with an additional glucometer so that two (2) glucometers are available at all times. One glucometer can be drying while the other is in use. The DON /designee will observe nurses use of glucometers to ensure they are alternating the use of the correctly cleaned glucometer and following manufacturer's recommendations.	11-25-14

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F 441	Continued From page 4 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of label information for a chemical disinfectant, the facility failed to ensure staff effectively disinfected the glucometer (device used to test blood sugar) for 1 of 2 observations of resident testing. The findings were: Observation on 11/20/14 from 7:18 AM to 7:26 AM revealed RN #1 used a glucometer for testing resident #12's blood sugar level. Continued observation revealed the RN wiped the glucometer with a Micro-Kill disposable disinfecting wipe for fifty seconds after she completed the testing. Review of the manufacturer's instructions for use as printed on the label of the Micro-Kill container revealed the product had a required wet exposure time of two minutes for effective disinfection. Interview with the RN during the observation revealed this glucometer was used for other residents and she did not follow the manufacturer's instructions because she did not have a timer. During an interview on 11/20/14 at 11:45 AM, the DON stated the facility policy and procedure for disinfecting the glucometer directed staff to follow the manufacturer's instructions.	F 441	Who will monitor the new system: The DON /designee How frequently will we monitor: Weekly for one month and twice monthly times 2 months. How will we incorporate the new system into our Quality Assurance Performance Improvement system: The DON will report on the findings from the observations of nurses cleaning the glucometer in the correct manner, for the next three (3) months, and then at a frequency to be determined by the Committee depending on the findings. **483.70(c)(2)Essential Equipment, Safe Operating Condition** **F Tag 456** Following manufacturer's recommendations Immediate corrective action: Each wander guard unit was tested and all were in correct working order specific to residents #9, #27, #30, #44, and #50.	11/20/14
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care	F 456		

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F 456	Continued From page 5 equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview and review of manufacturer instructions, the facility failed to implement a system for ensuring proper function of the wander alert device for 2 of 2 sample residents (#27, #50) and 3 non-sample residents (#9, #30, #44) who had this device. The findings were: Review of the Secure Care Transmitter System (wander alert device) User Guide revealed the following instructions for use: "Each day, the aide responsible for the care of the residents utilizing the Secure Care System must ensure that the transmitter is in place. This must be done at each shift change". Documentation of this check should be recorded on a daily checklist for each resident and each wander alert device "should be tested daily to ensure working properly." Observation on 11/17/14 at 5:30 AM revealed a wander alert device was on resident #50's ankle. On 11/20/14 at 7:10 AM resident #27 was observed walking to the dining room with a wander alert device attached to his/her walker. During an interview on 11/20/14 at 10:46 AM, restorative aide #1 stated she tested the door alarm each day by going through the door with a transmitter bracelet that she carried with her. She further stated that there was no routine testing done for each transmitter worn by a resident. During an interview on 11/20/14 at 11:30 AM, the DON stated the only residents in the facility with wander alert devices were residents #9, #27, #30, #44, and #50. At that time she confirmed the	F 456	How the facility will identify other residents having the potential to be affected: All residents who use the wander guard system have the potential to be affected. Measures put in place or system changes to ensure correction in this area include: Each wander guard unit will be identified. A log will be created to document the daily check of each wander guard unit by the restorative aide and/or designee. Licensed nurses will validate that the check occurs. All licensed nurses and restorative aide will be educated on the new system by the DON. Who will monitor the new system: DON / designee How frequently will we monitor: Daily How will we incorporate the new system into our Quality Assurance Performance	12/30/14

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F 456	Continued From page 6 devices were not checked in accordance with the manufacturer's instructions. Review of the September and October 2014 elopement/wandering risk assessments showed staff completed quarterly risk assessments to determine the five residents needed the device, but there was no documentation regarding daily checks for proper function.	F 456	Improvement system: The DON will report on the wander guard logs monthly for the next 3 months, and then at a frequency to be determined by the Committee depending the results.	