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

PRINTED: 02/03/2017
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 _____	01/20/2017

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 A recertification survey was conducted by Healthcare Licensing and Surveys on 1/17/17 through 1/20/17. The following common abbreviations are used throughout this document: CAA- Care Area Assessment DON- Director of Nursing Services MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	**483.10(i)(2) HOUSEKEEPING AND MAINTENANCE SERVICES** **F Tag 253** **1.** The chip on the inside jam of the activity room door will be sanded and painted to create a smooth surface that can be effectively cleaned.	3-6-17
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) 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 6 of 8 resident areas (north hall, east hall, south hall, west hall, activity room, tub room) were clean and in good repair. The findings were: 1. Observation on 1/19/17 at 2:17 PM showed the activity room door had a chip at the inner bottom of the door that measured 13 inches, and created a surface that could not be cleaned effectively. 2. Observation on 1/19/17 at 2:18 PM showed three 4 inch by 4.5 inch ceramic tiles at the activity room fireplace were cracked or broken, which created a surface that could not be cleaned	F 253	**2.** The cracked tiles on the activity room fireplace hearth will be replaced in order to create a surface that can be effectively cleaned. **3.** The flooring in room 7 will be replaced in order to create a surface that can be cleaned effectively. **4.** The crack in the west hall shower room will be repaired in order to create a surface that can be effectively cleaned. **5.** The flooring in room 12 will be replaced in order to create a surface that can be cleaned effectively.	3-6-17 3-6-17 3-6-17 3-6-17

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

Administrator 2/14/17

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
FEB 15 2017
Healthcare Licensing and Surveys

Plan of Correction accepted on 2/15/17.
Spoke with Bobbi Jo Drozd on 2/16/17 @ 2:39 pm
Jean Hamm

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F 253	Continued From page 1 effectively. 3. Observation on 1/19/17 at 2:25 PM showed room 7 in the east hall had three floor tiles that measured 12 inches by 12 inches that were cracked, chipped, or broken, which created a surface that could not be cleaned effectively. 4. Observation on 1/19/17 at 2:37 PM showed the tub room by the west hall had a wall in the shower area with cracked and chipped paint that measured 23 inches, and created a surface that could not be cleaned effectively. 5. Observation on 1/19/17 at 2:40 PM showed room 12 in the south hall had five floor tiles that measured 12 inches by 12 inches and were cracked, chipped, or broken, which created a surface that could not be cleaned effectively. 6. Observation on 1/19/17 at 2:41 PM showed room 14 in the south hall had four floor tiles that measured 12 inches by 12 inches and were cracked, chipped, or broken, which created a surface that could not be cleaned effectively. 7. Observation on 1/19/17 at 2:41 PM showed room 11 in the south hall had a bathroom sink with a peeled-off veneer that measured 30.5 inches by 1.5 inches, which exposed underlying wood and created a surface that could not be cleaned effectively. 8. Observation on 1/19/17 between 2:53 PM and 3 PM showed the hallway lighting fixtures between rooms 16 and 18 (south hall), 24 and 26 (west hall), 27 and 29, and 32 and 34 (north hall) were visibly dirty with dust.	F 253	**6.** The flooring in room 14 will be replaced in order to create a surface that can be cleaned effectively. **7.** The vanity in bathroom 11 will be replaced in order to create a surface that can be cleaned effectively. **8.** The lighting fixtures between rooms 16 and 18 (south hall), 24 and 26 (west hall), 27 and 29 and 32 and 34 (north hall) were taken apart and cleaned immediately All surfaces, doors, tiles, walls and lights in the building have the potential to be affected. Measures put into place in order to ensure correction in these areas include: The Maintenance Supervisor, Housekeeping Supervisor and or designee will do monthly audits to address repairs in the physical plant as well as cleaning and dusting. In addition all staff will be educated regarding the importance of reporting findings	3-6-17 3-6-17 3-6-17

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F 253	Continued From page 2 9. Interview on 1/19/17 at 4:30 PM with the maintenance supervisor and DON confirmed the broken items needed to be fixed, and the lighting fixtures cleaned. Further, it was revealed the facility did not have a plan to correct any of the damaged areas.	F 253	in the Maintenance Log in order that repairs be addressed accordingly. Education will be completed with all housekeeping staff enforcing the importance of dusting all lighting fixtures. The larger lights in the hallways indicated will be taken apart a minimum of once per month and thoroughly cleaned. All audit findings will be reported in the Quality Assurance meeting quarterly, the team will monitor and make recommendations. The Maintenance Supervisor and or Housekeeping Supervisor are responsible for the compliance of this tag and reporting.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENT F Tag 272** The MDS nurse and assistant RN were immediately educated on the importance of ensuring all	

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F 272	Continued From page 3 care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the comprehensive assessment was completed in a variety of areas for 2 of 13 sample residents (#52, #54). The findings were: 1. Review of the 3/1/16 annual MDS assessment showed resident #52 triggered for additional assessment of the following care areas: ADL Functional/Rehabilitation Potential, Urinary Incontinence, Pain, Falls, Pressure Ulcer, Psychotropic Drug Use, Communication, and Dental Care. Further record review showed no additional assessment related to these areas. 2. Review of the 10/24/16 significant change MDS assessment showed resident #54 triggered for additional assessment of the following care areas: Cognitive Loss/Dementia, ADL Functional/Rehabilitation Potential, Urinary Incontinence, Pain, Pressure Ulcer, Falls, Dental	F 272	documentation to support comprehensive assessments is completed. A Care Area Assessment Summary has been run on all annual assessments and or Comprehensive assessment for the past 12 months, whichever was completed most current. DON and or designee will conference all triggers with care plans based on cross-reference of report. All resident assessments have the potential to be affected. **1.** The annual MDS assessment dated 3/1/16 was reviewed and corrected for resident #52. Assessment was updated to reflect ADL Functional/Rehabilitation Potential, Urinary Incontinence, Pain, Falls, Pressure Ulcer, Psychotropic Drug Use, Communication, and Dental Care. A corrected and updated assessment will be submitted and care plans have been updated. **2.** The significant change MDS dated 10/24/16 for resident #54	3-6-17

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F 272	Continued From page 4 Care, and Psychotropic Drug Use. Further record review showed no additional assessment related to these areas. 3. Interview with the MDS coordinator on 1/19/17 at 3:45 PM verified she was unable to locate any documentation of additional assessment of these areas in the residents' records. She further revealed these MDS assessments had been completed while she was out on leave.	F 272	was reviewed and corrected. The following triggered assessments were addressed in Cognitive Loss/Dementia, ADL Functional/Rehabilitation Potential, Urinary Incontinence, Pain, Falls, Pressure Ulcer, Falls, Dental Care, and Psychotropic Drug Use. A corrected and updated assessment will be submitted and care plans have been updated. A quality monitoring tool will be completed each month regarding assessment completion. Comprehensive care plans will continue to be monitored with a Care Plan QA tool currently in use and the DON will report findings of tool to the Quality Assurance team monthly, the tea will monitor these tools and recommend changes. The Director of Nursing Services is responsible for compliance with the standard.	3-6-17
F 279 SS=E	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 279		

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F 279	Continued From page 5 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 4 of 13 sample residents (#17, #19, #32, #46) had care plans that addressed the care area concerns identified in their comprehensive MDS care area	F 279	**483.20 (d);483.21(b)(1)** **DEVELOP COMPREHENSIVE CARE PLANS** **F Tag 279** The MDS nurse and assistant RN were immediately educated on the importance of ensuring all care plans are updated to support comprehensive assessment findings and current plan of care. A Care Area Assessment Summary has been run on all annual assessments and or Comprehensive assessment for the past 12 months, whichever was completed most current. DON and or designee will conference all triggers with care plans based on cross-reference of report. All residents have the potential to be affected. This facility will ensure that each resident has a comprehensive care plan that includes measurable objectives and timetables to meet	

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F 279	Continued From page 6 assessments (CAA). The findings were: 1. Review of the 6/14/16 significant change MDS assessment showed resident #17 triggered for additional assessment related to dental care. Review of the CAA notes for dental care showed the resident had full upper and lower dentures; however, did not wear the bottom denture because it "doesn't fit." A decision to proceed to care plan was made. Review of the resident's care plan failed to show dental issues were addressed. 2. Review of the 2/10/16 annual MDS assessment showed resident #19 triggered for additional assessment related to dental care. Review of the CAA notes for dental care showed the resident had upper and lower dentures, a decision to proceed to care plan was made. Review of the resident's care plan failed to show dental issues were addressed. 3. Review of the annual MDS assessment dated 11/18/16 showed resident #32 triggered for additional assessment related to hydration. Review of the CAA notes for hydration showed the resident had a risk for dehydration, and a decision to proceed to care plan was made. Review of the resident's care plan failed to show hydration issues were addressed. 4. Review of the significant change MDS assessment dated 5/18/16 showed resident #46 triggered for additional assessment related to hydration. Review of the CAA notes for hydration showed the resident had a risk for dehydration, and a decision to proceed to care plan was made. Review of the resident's care plan failed to show hydration issues were addressed.	F 279	a resident's medical, nursing, and mental and psycho-social needs that are identified in the comprehensive assessment. This will be accomplished by (including but not limited to the following): 1. Resident #17 and #19's care plans were immediately updated to reflect current dental plan addressing dental issues. 2. Residents #32 and #46 care plans were immediately updated to reflect plan identified in CAA addressing hydration issues. Each resident's care plan will be reviewed and updated at least quarterly by members of the IDT and will be signed off by the IDT during the IDT conference. The RD will update care plans regarding nutrition and hydration. In addition, care plan updates will be entered as needed by members of the staff.	1-20-17 1-20-17 3-6-17

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F 279	Continued From page 7 5. Interview with the MDS coordinator on 1/20/17 at 9:24 AM verified the care plans for these residents did not address these issues that were determined to need care-planning.	F 279	A quality assessment tool will be utilized at least monthly to monitor the resident care plans for completeness and accuracy. The DON will report audit findings to the Quality Assurance team monthly, the team will monitor results and make recommendations. The Director of Nursing Services is responsible for compliance with the standard.	
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure food service equipment was maintained in a sanitary manner in 1 of 1 kitchens. The findings were:	F 371	**483.60 (i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY** **F Tag 371** The community will ensure that all equipment is maintained in a sanitary manner. The Registered Dietician has done a full review of equipment and educated all dietary care partners on the importance of reporting and removing items that cannot be	

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F 371	Continued From page 8 Observation on 1/17/17 at 2:16 PM and 1/19/17 at 12 PM showed a water dispenser used for residents and staff was in poor condition. The plastic surface was scratched and scored around the interior of the dispenser. Observation on 1/19/17 at 11:25 AM showed there were 2 frying pans stored on a rack. The pans were in poor condition. The interior coating of the pans was worn and flaking. Additionally, there were 4 cutting boards stored on a rack. The cutting boards were deeply scored from use. Interview with the registered dietitian and the lead cook on 1/19/17 at 12 PM verified these items were in poor condition and needed to be replaced. According to Food Code 2013, U.S. Public Health Service: 4-101.11 "Materials that are used in the construction of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT may not allow the migration of deleterious substances or impart colors, odors, or tastes to FOOD and under normal use conditions shall be: (A) Safe; (B) Durable, CORROSION-RESISTANT, and nonabsorbent; (C) Sufficient in weight and thickness to withstand repeated WAREWASHING; (D) Finished to have a SMOOTH, EASILY CLEANABLE surface; and (E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition."	F 371	maintained from a sanitary perspective. All equipment has the potential to be affected. **1.** The plastic water dispenser was immediately removed and a stainless steel dispenser has been ordered for replacement. **2.** The two frying pans and 4 scored cutting boards were removed. New pans and cutting boards have been ordered for replacement. The RD will audit equipment at least monthly and review findings with kitchen care partners at monthly dietary meeting and report to Quality Assurance team monthly. The Quality Assurance team will monitor audit results and make recommendations. The RD/Dietary Manager is responsible for compliance with the standard.	3-6-17