PRINTED: 08/23/2011
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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING _____ B. WING _____	06/09/2011

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 and acronyms are used throughout this document: RN-Registered Nurse ADON-Assistant Director of Nursing CNA-Certified Nursing Assistant MDS-Minimum Data Set PRN-as needed Less commonly used abbreviations will be annotated in each deficiency.	F 000	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE PLAN: The facility will ensure that every resident that requests to self-administer medications is determined to be safe to self-administer medications by the interdisciplinary team. This standard will be accomplished by the following (including but not limited to):	07/09/11
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the facility's policy and procedures, the facility failed to ensure an assessment for self administration of medications was performed for 1 of 1 sample residents (#15) who had medications for self administration at the bedside. The findings were: Review of the medical record for resident #15 showed s/he had diagnoses including Alzheimer's disease versus multi infarct dementia and blindness in the right eye along with visual problems in the left eye secondary to macular degeneration. Review of the 11/18/10 initial MDS assessment summary showed the resident was	F 176	A) Resident # 15 has been evaluated by the Castle Rock Convalescent Center's (CRCC) interdisciplinary team to self-administer medications. The tool utilized is the CRCC Evaluation for Self-Administration of Medication. B) At this present time resident #15 is the only resident in the facility that is self-administering medications. The interdisciplinary team and nurses will review the facility's policy on self-administering medications. Future residents with orders to self-administer will be evaluated with the CRCC Evaluation for Self-	

Accepted

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

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: CVON11 Facility ID: WY0004 If continuation sheet Page 1 of 16

RECEIVED
Wyoming Dept of Health
JUL 18 2011
Office of Healthcare Licensing and Surveys

conversation with Robby Jo Drozd on 18 July 11 at 1130 AM - corrections to be made - hand written - POC accepted
Kathryn A May

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F 176	Continued From page 1 Incapable of making decisions. Review of 11/13/10 physician's orders showed an order for Refresh tear drops, may have at the bedside. Review of the 11/24/10 physician's orders showed an order for Cortisone cream daily, apply to upper ankles, may keep at bedside, Lotrimin AF 24 Gram 1% cream daily, apply above the ankles PRN, may keep at bedside. Continued review of physician's orders showed on 11/30/10 the physician ordered Travantan 0.004% solution PRN, use as directed on package, may keep at bedside. The following concerns were identified: a. Review of the medical record showed no evidence the resident was assessed for safety of self administering medications. Interview with the ADON on 6/9/11 at 9 AM revealed no formal assessment for self administration was performed. She said staff just followed physician's orders when bedside medications were ordered. b. Review of the facility's policy on self administering medications, effective date 12/1/07, revealed instructions that "For those residents for which self-administration of drugs is safe and appropriate, the Facility should educate residents in an effort to meet the following objectives; "...The resident should be able to state the name, dose, strength, frequency, and purpose for use of his/her medications...The resident should understand the possible side effects of his/her medications and should understand that he/she should notify Facility staff if he/she experiences any such side effects...The resident should be capable of correctly administering, injecting or applying his/her medications...The resident should be capable of correctly storing his/her medications in a locked compartment....If a resident self-administers his/her medications, the	F 176	Administration of Medication. The interdisciplinary team will review quarterly or with significant change in status. C) The completion of this standard will be reported to the Quality Assurance Committee quarterly. with follow-up as required KM D) The Director of Nursing is responsible for compliance of the above standard.	

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F 176	Continued From page 2 Facility, in conjunction with the interdisciplinary team, should routinely assess the resident's cognitive, physical and visual ability to carry out this responsibility per Facility policy..."	F 176		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225	483.13 Investigate/Report Allegations/Individuals District Employment Policy entitled "Pre-Employment Requirements" has been updated to include Verification of the State Nurse Aide Registry as a requirement for all C.N.A.s employed at Castle Rock Convalescent Center. Human Resources will be responsible for accessing the registry. If a prospective C.N.A. is not found when accessing the registry, he or she will not be hired until they are. Human resources has verified that Certified Nurse Aides #1 and #2, noted in tag F225, are on the Wyoming C.N.A. registry. If a nurse aide is hired by Castle Rock within 120 days of passing their C.N.A. class, they will be required to also be listed on the State registry within that same 120 days. Should they fail to gain access onto the registry within 120 days of employment, they will be taken off of the schedule until they are registered.	7/11/11

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F 225	Continued From page 3 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of personnel records and staff interview, the facility failed to ensure the State nurse aide registry was accessed when hiring 2 of 2 CNAs licensed in Wyoming (#1,#2) . The findings were: 1. Review of the personnel file for CNA #2 revealed a date of hire of 4/6/11 and that she was licensed in the State of Wyoming. Further review showed no verification the State nurse aide registry was accessed to check for findings of abuse, neglect, or misappropriation of property. 2. Review of the personnel file for CNA #1 revealed the CNA was licensed in the State of Wyoming and was hired by the facility on 2/28/11. Further review showed no verification the State nurse aide registry was accessed to check for findings of abuse, neglect, or misappropriation of property. 3. Interview on 6/9/11 at 9 AM with Human Resource employee #1 revealed she did not know about the State nurse aide registry and did not access it when hiring CNAs.	F 225	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY PLAN: The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This standard will be accomplished by the following (including but not limited to): A) A quality monitoring tool will be utilized to assure that the resident's dignity and respect in full recognition of his or her individuality is honored. Resident #31 and other residents in the dining room will be monitored regarding this standard. The quality assurance tool will be utilized randomly at Breakfast, Dinner and Supper once each week. The name of the tool being utilized is Quality Assurance Tool for Providing Dignity of Residents in the Dining Room. The audit will be performed by the DON, ADON, or assigned staff nurse and immediate follow up will be done with employee and documented on tool. Education will also be provided in staff meetings.	7/09/2011
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241		

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F 241	Continued From page 4 enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, the facility failed to ensure dignity was maintained for 1 non-sample resident (#31). The findings were: Observation on 6/6/11 from 5:10 PM to 6:15 PM revealed non-sample resident #31 required assistance with the evening meal. Observation showed RN #1 would walk over to the resident and give him/her a bite of food then walk off to assist another resident. The RN stood to feed the resident each time she gave him//her a bite to eat then would walk off to assist someone else. This practice was observed three different times throughout the meal. Interview with the ADON on 6/9/11 at 9 AM revealed staff should always sit to assist a resident with their meal.	F 241	B) The Nursing Staff will be educated regarding 483.15(a) Dignity at the next nurse meeting on 7/06/11. C) The results of the quality-monitoring tool will be reported to the Quality Assurance Committee quarterly. with follow-up action as required KRM D) The Director of Nursing is responsible for compliance of the above standard.	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279	483.20(d), 483.20(k) (1) DEVELOP COMPREHENSIVE CARE PLANS: PLAN: The facility will ensure that the results of the assessment are used to develop, review and revise the resident's plan of care. The comprehensive care plan for each resident will include measurable objectives and timetables to meet each resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan will describe the services that are to be furnished to	

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F 279	Continued From page 5 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure an individualized care plan was developed in a variety of areas for 12 of 13 sample residents (#2, #5, #13, #15, #17, #19, #24, #37, #38, #43, #44, #49). The findings were: 1. Review of the current care plan for resident #13 showed the resident had a problem with routine personal care. The goal was listed as "Routine personal care will be provided." The goal was not measurable. Review of the associated interventions for this problem included "oral hygiene" with no specifics such as denture care or brushing, "dressing/grooming" with no further instructions regarding the amount or type of assistance needed, "bladder if no BM. C =Continent I=Incontinent (#times)", "pericare (Indep/Depen/Assist)," "mental status (awake/Sleep) (Coop/Uncoop)", and "Mobility (Bed/Chair/Ambulatory)." 2. Review of the current care plan for resident #15 revealed routine bathing was identified as a problem. The goal was to receive a bath twice weekly and PRN (as needed). Interventions included were tub bath daily, shower bath daily,	F 279	attain or maintain the resident's highest practicable physical, mental and psychological well being as required under 483.25; and services that would otherwise be required under 483.25 but are not provided due to the resident's exercise of rights under 483.10 including the right to refuse treatment under 483.10(b) (4). These standards will be accomplished by the following (including but not limited to): A) A quality-monitoring tool will be utilized to assure that resident #13's care plan regarding routine personal care will have a measurable goal. The care plan will be changed to reflect timed, measurable and individualized goals and interventions. The care plan will be updated quarterly by the MDS coordinator or department specific member of the interdisciplinary team or when a change in status has occurred. The care plans will be reflective of the resident as an individual and generate the Routine Cares using the CNA Care flow sheet. These documents are extensions of the care plan. The interventions will be individualized to resident #13 in regard to oral hygiene, dressing/grooming including if	7/09/11

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F 279	Continued From page 6 manicure daily, pedicure daily, shave daily, shampoo hair daily, and style hair daily. Interventions were not individualized to meet the resident's specific needs nor were they consistent with the goal of a bath twice weekly. 3. A review of the current care plan for resident #43 showed problems identified included alteration in comfort (pain) with a goal of "Resident will develop effective coping strategies to help adapt to pain." The goal was not measurable and did not include pain relief (comfort) but that the resident should "adapt" to the pain. Interview with the ADON on 6/9/11 at 9 AM revealed the goal was not appropriate. A goal should have been written for pain relief, not just tolerance. 4. Medical record review for resident #2 revealed an admission MDS completed on 5/11/11. Review of the MDS showed the resident needed extensive assistance with personal hygiene, bathing, and toileting. Further review revealed generic care plans for routine personal care and routine bath care that were not individualized to meet the resident's needs. 5. Medical record review for resident #5 revealed a quarterly MDS completed on 3/21/11. Review of the MDS showed the resident was totally dependent with personal care. Further review revealed a generic care plan for routine personal care that was not individualized to meet the resident's needs. 6. Medical record review for resident #17 revealed a significant change MDS completed on 5/31/11. The MDS showed the resident was totally dependent in personal care and bathing. Further review revealed generic care plans for	F 279	assistance is provided. In addition, interventions for toileting and cares will be addressed regarding the independence of the resident. Mental status and mobility interventions will be developed addressing the resident's individuality. Three other residents will be randomly selected each week for review. The ADON, DON or assigned staff nurse will conduct audit and immediately update care plan. The name of the tool is; Quality Assurances Tool, CRCC Care plan Documentation. B) A quality measuring tool will be utilized for resident #15 to assure that the care plan addresses the resident as an individual. The interventions in regard to the goals regarding personal cares will be individualized and address the following areas; frequency of the bath, (twice weekly and PRN as needed), what type of bath, when manicure provided (manicure on the Personalized Plan Of Care will be changed from stating manicure to hand care including care of the nails), when pedicure (manicure on the Personalized Plan Of Care will be	

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F 279	Continued From page 7 personal care and bathing that were not individualized to meet the resident's needs. 7. Medical record review for resident #38 revealed an admission MDS completed on 4/10/11. Review of the MDS showed the resident needed extensive assistance with personal care and bathing. Further review revealed generic care plans for personal care and bathing that were not individualized to meet the resident's needs. 8. Medical record review for resident #49 revealed an admission MDS completed on 3/4/11. The MDS showed the resident was totally dependent upon staff for personal care and bathing. Further review revealed generic care plans for personal care and bathing that were not individualized to meet the resident's needs. 9. Review of the medical record for resident #19 showed s/he had diagnoses which included depression. Review of the 3/24/11 quarterly MDS assessment showed the resident took antidepressant medications, and the physician's orders showed a 6/25/10 order for citalopram and a 9/28/10 order for trazodone (antidepressants). Review of the resident's care plans showed they were not individualized to meet the resident's needs in this area, but only referred to the medications ordered. 10. Review of the medical record for resident #24 showed s/he had diagnoses which included depression, dementia, and anxiety disorder. Review of the 3/24/11 quarterly MDS assessment showed antipsychotic and antidepressant medications. Review of the physician's orders showed a 6/14/10 order for citalopram	F 279	changed from stating manicure to foot care including care of nails), when shave provided, when shampoo provided and when hair is styled. In addition each area will address the specific needs of the resident. C) A quality measuring tool will be utilized for resident #43 to assure that the care plan addresses the resident as an individual. The nursing diagnosis of "Alteration in Comfort (pain) with a goal of "Resident will develop effective coping strategies to help adapt to pain" will be changed to be measurable and the interventions will address how pain relief will be achieved. D) A quality measuring tool will be utilized for resident #2 to assure that the care plan addresses the resident as an individual. Routine personal care routine bath care will be individualized to meet resident #2's needs as addressed in sections A and B. E) A quality measuring tool will be utilized for resident #5 to assure that the care plan addresses the resident as an individual. Routine personal care routine bath care	

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F 279	Continued From page 8 (antidepressant), a 7/19/10 order for quetiapine fumarate (antipsychotic), and a 5/29/11 order for alprazolam (antianxiety). Review of the resident's care plans showed they were not individualized to meet the resident's needs in these areas, but only referred to the medications ordered. 11. Review of the medical record for resident #37 showed s/he had diagnoses which included depression. Review of the 2/26/11 annual MDS assessment showed the resident took antidepressant medication, and the physician's orders showed a 3/2/09 order for citalopram (antidepressant). Review of the resident's care plans showed they were not individualized to meet the resident's needs in this area, but only referred to the medication ordered. 12. Review of the medical record for resident #44 showed s/he had diagnoses which included depression. Review of the 3/27/11 quarterly MDS assessment showed the resident took antidepressant medication, and the physician's orders showed a 7/8/09 order for citalopram (antidepressant). Review of the resident's care plans showed they were not individualized to meet the resident's needs in this area, but only referred to the medication ordered. 13. Interview with the ADON on 6/9/11 at 9 AM revealed care plans were computer generated and staff were supposed to individualize them for each resident.	F 279	will be individualized to meet resident #5's needs as addressed in sections A and B. F) A quality measuring tool will be utilized for resident #17 to assure that the care plan addresses the resident as an individual. Routine personal care routine bath care will be individualized to meet resident #17's needs as addressed in sections A and B. G) A quality measuring tool will be utilized for resident #38 to assure that the care plan addresses the resident as an individual. Routine personal care routine bath care will be individualized to meet resident #38's needs as addressed in sections A and B. H) A quality measuring tool will be utilized for resident #49 to assure that the care plan addresses the resident as an individual. Routine personal care routine bath care will be individualized to meet	
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	F 280		

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F 279	Continued From page 8 (antidepressant), a 7/19/10 order for quetiapine fumarate (antipsychotic), and a 5/29/11 order for alprazolam (antianxiety). Review of the resident's care plans showed they were not individualized to meet the resident's needs in these areas, but only referred to the medications ordered. 11. Review of the medical record for resident #37 showed s/he had diagnoses which included depression. Review of the 2/26/11 annual MDS assessment showed the resident took antidepressant medication, and the physician's orders showed a 3/2/09 order for citalopram (antidepressant). Review of the resident's care plans showed they were not individualized to meet the resident's needs in this area, but only referred to the medication ordered. 12. Review of the medical record for resident #44 showed s/he had diagnoses which included depression. Review of the 3/27/11 quarterly MDS assessment showed the resident took antidepressant medication, and the physician's orders showed a 7/8/09 order for citalopram (antidepressant). Review of the resident's care plans showed they were not individualized to meet the resident's needs in this area, but only referred to the medication ordered. 13. Interview with the ADON on 6/9/11 at 9 AM revealed care plans were computer generated and staff were supposed to individualize them for each resident.	F 279	resident #49's needs as addressed in sections A and B. I) A quality measuring tool will be utilized for resident #19 to assure that the care plan addresses the resident as an individual. The care plan and interventions will be changed to reflect the individual needs of resident # 19 in regard to depression. J) A quality measuring tool will be utilized for resident #24 to assure that the care plan addresses the resident as an individual. The care plan and interventions will be changed to reflect the individual needs of resident # 24 in regard to depression, dementia, and anxiety disorder. K) A quality measuring tool will be utilized for resident #37 to assure that the care plan addresses the resident as an individual. The care plan and interventions will be changed to reflect the individual needs of resident # 37 in regard to depression.	
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	F 280		

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	535033	A. BUILDING _____ B. WING _____	06/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 8 (antidepressant), a 7/19/10 order for quetiapine fumarate (antipsychotic), and a 5/29/11 order for alprazolam (antianxiety). Review of the resident's care plans showed they were not individualized to meet the resident's needs in these areas, but only referred to the medications ordered. 11. Review of the medical record for resident #37 showed s/he had diagnoses which included depression. Review of the 2/26/11 annual MDS assessment showed the resident took antidepressant medication, and the physician's orders showed a 3/2/09 order for citalopram (antidepressant). Review of the resident's care plans showed they were not individualized to meet the resident's needs in this area, but only referred to the medication ordered. 12. Review of the medical record for resident #44 showed s/he had diagnoses which included depression. Review of the 3/27/11 quarterly MDS assessment showed the resident took antidepressant medication, and the physician's orders showed a 7/8/09 order for citalopram (antidepressant). Review of the resident's care plans showed they were not individualized to meet the resident's needs in this area, but only referred to the medication ordered. 13. Interview with the ADON on 6/9/11 at 9 AM revealed care plans were computer generated and staff were supposed to individualize them for each resident.	F 279	L) A quality measuring tool will be utilized for resident #44 to assure that the care plan addresses the resident as an individual The care plan and interventions will be changed to reflect the individual needs of resident # 44 in regard to depression. M) The results of the quality monitoring tool will be reported to the Quality Assurance Committee quarterly. N) The Director of Nursing is responsible for compliance of the above standard.	
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	F 280		

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F 279	Continued From page 8 (antidepressant), a 7/19/10 order for quetiapine fumarate (antipsychotic), and a 5/29/11 order for alprazolam (antianxiety). Review of the resident's care plans showed they were not individualized to meet the resident's needs in these areas, but only referred to the medications ordered. 11. Review of the medical record for resident #37 showed s/he had diagnoses which included depression. Review of the 2/26/11 annual MDS assessment showed the resident took antidepressant medication, and the physician's orders showed a 3/2/09 order for citalopram (antidepressant). Review of the resident's care plans showed they were not individualized to meet the resident's needs in this area, but only referred to the medication ordered. 12. Review of the medical record for resident #44 showed s/he had diagnoses which included depression. Review of the 3/27/11 quarterly MDS assessment showed the resident took antidepressant medication, and the physician's orders showed a 7/8/09 order for citalopram (antidepressant). Review of the resident's care plans showed they were not individualized to meet the resident's needs in this area, but only referred to the medication ordered. 13. Interview with the ADON on 6/9/11 at 9 AM revealed care plans were computer generated and staff were supposed to individualize them for each resident.	F 279		
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	F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE-CP: PLAN: The facility will ensure that 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. These standards will be accomplished by the following (including but no limited to):	

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F 280	Continued From page 9 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 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure the care plan was updated to reflect the current needs for 1 of 13 sample residents (#43). The findings were: Review of the 5/11/11 re-entry MDS assessment for resident #43 showed s/he was always incontinent of urine and bowel. Review of the care plan for the resident showed s/he was on a "scheduled toileting program." Review of the facility's policy, dated 2/8/05, revealed the scheduled toileting program included taking the resident to the bathroom at scheduled times as determined by a three day elimination monitor. Interview with CNA #3 and CNA #4 on 6/7/11 at	F 280	A) A quality measuring tool will be utilized to assure that resident #43's care plan reflects the current status of the resident's bowel and bladder program. The Restorative Nurse, DON, ADON or other assigned nurse will complete the monitoring tool. Three other random residents will be selected once a week to monitor comprehensive care plans B) The results of the quality measuring tool will be reported to the Quality Assurance Committee quarterly. with follow up as required KR C) The Director of Nursing is responsible for compliance of the above standard.	7/09/11

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F 280	Continued From page 10 10:50 AM revealed this resident was trialed on a scheduled toileting program but was unsuccessful. Due to the lack of success with the scheduled program the resident was placed on a check and change every two hour program. The care plan was not updated to reflect the current status of check and change every two hours for this resident.	F 280	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS PLAN: The facility will assure that each resident's drug regimen is free from unnecessary drugs The residents will be monitored for unnecessary drugs (including duplicate therapy); or for excessive duration; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This standard will be accomplished by the following: (including but not limited to):	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329	A) Our Pharmacist is auditing gradual dose reductions (GDR) for anti-depressants and antipsychotic medications through pharmacy data base. The report generated will be part of his monthly pharmacy review and consults. The physician consults are sent to each resident's physician for review. We are up-dating our policy for Psychotropic Medication review. Resident #19's medications for citalopram (anti-depressant and trazadone (anti-depressant) will be evaluated for appropriate diagnoses, effectiveness and a	7/09/11

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F 329	Continued From page 11 by: Based on staff interview and medical record review, the facility failed to ensure the drug regimen was free of unnecessary drugs for 5 of 12 sample residents (#19, #24, #37, #43, #44) who received psychoactive medications. The findings were: 1. Review of the medical record for resident #19 showed s/he had diagnoses which included depression. Review of the physician's orders showed the resident had a 6/25/10 order for citalopram (anti-depressant) 20 mg daily, and a 9/28/10 order for trazodone (anti-depressant) 50 mg daily. Review of the physician's progress notes showed there was no attempt at a gradual dose reduction for either medication. Review of the medical records showed no rationale was given to explain why no gradual dose reduction was attempted, or why two anti-depressant medications were indicated. 2. Review of the medical record for resident #24 showed s/he had diagnoses which included depression and anxiety disorder. Review of the physician's orders showed the resident had a 6/14/10 order for citalopram (anti-depressant) 20 mg daily, and a 7/19/10 order for quetiapine fumarate (antipsychotic) 25 mg each morning and 100 mg at time of sleep. Review of the physician's progress notes showed there was no attempt at a gradual dose reduction for either medication and no rationale was provided to explain why no gradual dose reduction was attempted. 3. Review of the medical record for resident #37 showed s/he had diagnoses which included	F 329	GDR will be addressed. We monitor these medications quarterly or when a change in status has occurred. These reviews are also sent to IDT for further review quarterly or when a change in status occurs. A quality monitoring tool (Psychotropic Log), will be utilized to assure psychotropics are be monitored routinely. An additional monitoring tool will be utilized (~~attachment #8~~) to assure that providers address psychotropic medications (unnecessary drugs). In addition, tracking of this standard will be monitored for QA with our New Multi-disciplinary Data Collection Tool quarterly. B) Resident #24 will be evaluated for possible side effects, interactions, or adverse consequences for citalopram and seroquel. PCP review resident chart and noted that previous dose reductions were unsuccessful. Resident to be reviewed by psychotropic nurse manager and facility pharmacist for further complications.	

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F 329	Continued From page 12 depression. Review of the physician's orders showed the resident had a 3/2/09 order for citalopram (anti-depressant) 20 mg daily. Review of the physician's progress notes showed there was no attempt at a gradual dose reduction, and no rationale was given to explain why no gradual dose reduction was attempted. 4. Review of the June 2011 physician's orders for resident #43 showed s/he had received Xanax 0.25 milligrams (mg) twice daily with an additional order for PRN between the scheduled doses, and Restoril (sedative-hypnotic) 15 mg every night at bedtime since 12/16/09 with no gradual dose reductions attempted. Review of the medical record showed no evidence the physician described why a dosage reduction was clinically contraindicated. Interview with the ADON on 6/9/11 at 9 AM revealed some physicians were not good about documenting why he or she did not want a dosage reduction attempted. 5. Review of the medical record for resident #44 showed s/he had diagnoses which included depression. Review of the physician's orders showed the resident had a 7/8//09 order for citalopram (anti-depressant) 20 mg daily. Review of the physician's progress notes showed there was no attempt at a gradual dose reduction, and no rationale was provided to explain why no gradual dose reduction was attempted. 6. During an interview with the ADON on 6/9/11 at 9:45 AM, she confirmed the physicians had not attempted a dose reduction and had not given any rationale for continuing residents #19, #24, #37, #43, and #44 on their current medications for depression, anxiety, psychosis, and insomnia.	F 329	C) Resident #37 has been evaluated by facility pharmacist on 6/10/2011 and with this review a gradual dose reduction has been sent to the PCP for review. With PCP review this will be sent to IDT for additional review D) Resident #43 will be evaluated for possible side effect, interactions, or adverse consequences by the facility pharmacist. With this evaluation a review will be sent to the PCP for review and sent to IDT for additional review. PCP will also review medications for potential complications. E) Resident #44 a gradual dose reduction has been completed on this resident and will be sent to IDT for evaluation. F) The results of the quality monitoring tool will be reported to the quality assurance committee quarterly. An assigned management nurse reviews every resident's anti-psychotic medications quarterly and follow up is done in IDT quarterly., with follow up as required	

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F 329	Continued From page 12 depression. Review of the physician's orders showed the resident had a 3/2/09 order for citalopram (anti-depressant) 20 mg daily. Review of the physician's progress notes showed there was no attempt at a gradual dose reduction, and no rationale was given to explain why no gradual dose reduction was attempted. 4. Review of the June 2011 physician's orders for resident #43 showed s/he had received Xanax 0.25 milligrams (mg) twice daily with an additional order for PRN between the scheduled doses, and Restoril (sedative-hypnotic) 15 mg every night at bedtime since 12/16/09 with no gradual dose reductions attempted. Review of the medical record showed no evidence the physician described why a dosage reduction was clinically contraindicated. Interview with the ADON on 6/9/11 at 9 AM revealed some physicians were not good about documenting why he or she did not want a dosage reduction attempted. 5. Review of the medical record for resident #44 showed s/he had diagnoses which included depression. Review of the physician's orders showed the resident had a 7/8//09 order for citalopram (anti-depressant) 20 mg daily. Review of the physician's progress notes showed there was no attempt at a gradual dose reduction, and no rationale was provided to explain why no gradual dose reduction was attempted. 6. During an interview with the ADON on 6/9/11 at 9:45 AM, she confirmed the physicians had not attempted a dose reduction and had not given any rationale for continuing residents #19, #24, #37, #43, and #44 on their current medications for depression, anxiety, psychosis, and insomnia.	F 329	G) The Director of Nursing is responsible of compliance to the above standard.	

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F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure monthly medication regimen reviews (MMRs) were appropriately completed for 5 of 12 sample residents (#19, #24, #37, #43, #44). The findings were: 1. Review of the medical record for resident #19 showed s/he had diagnoses which included depression. Review of the physician's orders showed the resident had a 6/25/10 order for citalopram (anti-depressant) 20 mg daily, and a 9/28/10 order for trazodone (anti-depressant) 50 mg daily. Review of the 2010-2011 MMRs showed the facility failed to identify and report the duplicate medications as irregularities, or evaluate the medications to determine possible side effects, interactions, or adverse consequences. 2. Review of the medical record for resident #24 showed s/he had diagnoses which included	F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON PLAN: The facility assures that the drug regimen of each resident must be reviewed al least monthly by a licensed pharmacist. This standard will be accomplished by the following (including but not limited to): A) Our Pharmacist is auditing gradual dose reductions (GDR) for anti-depressants and antipsychotic medications through the pharmacy data base. The report generated will be part of his monthly pharmacy review and consults. The back hall has been completed and in July the front hall will be completed and then with each subsequent visit. He will consult with psychotropic nurse manager and coordinate follow-up regarding GDRs. We are up-dating our policy for Psychotropic Medications. Resident #19's medications for citalopram (anti-depressant and trazadone (anti-depressant) will be evaluated for appropriate diagnosis and effectiveness and a GDR will be addressed. We monitor these medications quarterly or with a change in	7/09/11

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F 428	Continued From page 14 depression and anxiety disorder. Review of the physician's orders showed the resident had a 6/14/10 order for citalopram (anti-depressant) 20 mg daily, and a 7/19/10 order for quetiapine fumarate (antipsychotic) 25 mg each morning and 100 mg at time of sleep. Review of the 2010-2011 MMRs showed the facility failed to evaluate the medications to determine possible side effects, interactions, or adverse consequences. 3. Review of the medical record for resident #37 showed s/he had diagnoses which included depression. Review of the physician's orders showed the resident had a 3/2/09 order for citalopram (anti-depressant) 20 mg daily. Review of the 2009, 2010, and 2011 MMRs showed the facility failed to evaluate the medication to determine possible side effects, interactions, or adverse consequences. 4. Review of the June 2011 physician's orders for resident #43 showed s/he had received Xanax 0.25 milligrams (mg) twice daily with an additional order for PRN between the scheduled doses, and Restoril (sedative-hypnotic) 15 mg every night at bedtime since 12/16/09 with no gradual dose reductions attempted. Review of the 2011 MMRs showed the facility failed to evaluate the medication to determine possible side effects, interactions, or adverse consequences. 5. Review of the medical record for resident #44 showed s/he had diagnoses which included depression. Review of the physician's orders showed the resident had a 7/8//09 order for citalopram (anti-depressant) 20 mg daily. Review of the 2009, 2010, and 2011 MMRs showed the facility failed to evaluate the medication to	F 428	status. These reviews are also sent to IDT for further review. B) Resident #24 will be evaluated for possible side effects, interactions, or adverse consequences for citalopram and seroquel. PCP reviewed resident chart and noted that previous dose reductions were unsuccessful. Resident to be reviewed by psychotropic nurse manager quarterly and facility pharmacist for further complications. C) Resident #37 has been evaluated by facility pharmacist on 6/10/2011 and with this review a gradual dose reduction has been sent to the PCP for review. With PCP review this will be sent to IDT for additional review quarterly. D) Resident #43 will be evaluated for possible side effect, interactions, or adverse consequences by the facility pharmacist. With this evaluation a review will be sent to the PCP for review and sent to IDT for additional review quarterly. PCP will also review chart for potential complications.	

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F 428	Continued From page 15 determine possible side effects, interactions, or adverse consequences 6. During an interview with the assistant DON on 6/9/11 at 9:45 AM, she stated that the pharmacist had not evaluated the current medications for depression, anxiety, psychosis, and insomnia ordered for residents #19, #24, #37, #43, and #44 to determine possible side effects, interactions, or adverse consequences.	F 428	E) Resident #44 a gradual dose reduction has been completed on this Resident and will be sent to IDT for evaluation quarterly. F) The results of the quality monitoring tool will be reported to the quality assurance committee quarterly. with follow-up as required KR	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure laboratory tests were performed as ordered for 1 of 13 sample residents (#13) who had laboratory tests ordered. The findings were: Review of the 11/30/10 physician orders for resident #13 showed a ferritan laboratory test was ordered. Review of the entire medical record showed this test was not performed as ordered. Interview with the ADON on 6/9/11 at 10 AM confirmed the test was not performed.	F 502	G) The Director of Nursing is responsible of compliance to the above standard. 483.75(j) (1) ADMINISTRATION PLAN: The facility will assure that laboratory services meet the needs of our residents. The facility assumes responsibility for quality and timeliness of the services. This standard will be accomplished by the following (including but not limited to): A) Resident's labs are monitored for completion by the Care Management Nurse when received. When orders are received for labs they are put into the lab calendar. The graveyard	7/09/11

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

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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 _____	06/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CENTER	1448 UINTA DRIVE GREEN RIVER, WY 82935

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