

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

PRINTED: 09/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535033		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/12/2020	
NAME OF PROVIDER OR SUPPLIER MISSION AT CASTLE ROCK REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 from 3/9/20 to 3/12/20. Also reviewed in the course of the survey were complaint intakes WY00002954 and WY00003041. The following common abbreviations are used throughout this document: BIMS- Brief Interview for Mental Status DON- Director of Nursing MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.			F 000			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the			F 580			8/3/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/03/2020

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.

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F 580	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the resident representative was notified of a decision to transfer the resident for 1 of 5 sample residents (#29) with an accident or significant change. This failure resulted in past non-compliance. Corrective measures were implemented by the facility prior to the survey and compliance was	F 580	Past noncompliance: no plan of correction required.		

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F 580	Continued From page 2 determined to be met on 2/26/20. The findings were: - Review of a progress note dated 2/4/20 at 2:12 PM showed resident #29 had a fall in the dining room that morning. During the nursing assessment, the resident appeared more drowsy and the resident's blood pressure was "70's/40's." The note indicated the physician was notified, and gave an order to send the resident to the emergency room. Review of the MDS assessments showed a discharge, return anticipated assessment dated 2/4/20 and a re-entry MDS assessment dated 2/7/20. The following concerns were identified: - Review of the medical record showed no evidence the resident's representative was notified of the transfer. - Review of a progress note dated 2/5/20 at 1:20 PM revealed the DON and the social services designee met with the resident's family, who had concerns about not being notified of the resident's transfer to the hospital. - During an interview on 3/12/20 at 8:39 AM the DON confirmed the facility staff had not notified the resident's family of the transfer. She stated the hospital called the family once the resident was taken there. - Review of facility documentation and interview with the DON on 3/12/20 at 8:39 AM revealed the facility took the following actions to prevent re-occurrence: - Education to staff took place on 2/26/20. - Disciplinary action to the nurse involved was completed. - The facility implemented a new process where nursing staff are to call a member of leadership for any transports to the emergency	F 580			

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F 580	Continued From page 3 room or hospital so they can ensure the resident's family was notified. d. The facility has developed a notification log for any transfers to the emergency room. e. This corrective action is being monitoring through the facility's quality assurance program.	F 580			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure MDS assessment information was an accurate reflection of resident status for 3 of 20 (#10, #26, #31) sample residents. The findings were: 1. Review of the 2/11/20 significant change MDS assessment showed resident #26 had not been assessed for the section "C- Cognitive Patterns." The section was coded as "not assessed." Review of the previous quarterly MDS assessment dated 1/11/20 showed the resident was assessed for this section and was able to complete the BIMS with a score of 13 out of 15 (cognitively intact). 2. Review of the 1/5/20 quarterly MDS assessment showed resident #10 had not been assessed for the section "C - Cognitive Patterns." The section was coded as "not assessed." Review of the 8/19/19 admission MDS	F 641	F. Tag. F641 Immediate corrective action: The facility shall complete resident assessments which accurately reflect the resident's status at the time of assessment. The MDS for resident # 10, #26 and #31 were re-opened, reviewed and updated to accurately reflect the residents' ability to be interviewed at the time of the assessment. How the facility will identify other residents having the potential to be affected: An audit was conducted of all MDS' from January 2020 through March 12, 2020 by the Nursing Administration. Corrections were made as needed to reflect an accurate assessment. Measures put in place or system correction in this area include: The Nursing Administration completed an	8/5/20	

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F 641	Continued From page 4 assessment showed the resident was assessed for this section and the resident was able to complete the BIMS with a score of 1/15 (severely impaired). 3. Review of the 2/9/20 annual MDS showed resident #31 had not been assessed for the section "C - Cognitive Patterns." The section was coded as "not assessed." Review of the previous quarterly MDS dated 11/9/19 showed the resident was assessed for this section and the resident was able to complete the BIMS with a score of 00 (severely impaired). 4. Interview with the MDS coordinator on 3/12/20 at 9:17 AM verified the coding of the significant change MDS was inaccurate for resident #26. She stated at the time of the assessment the resident may not have been able to complete the interview, however, the staff assessment for mental status should have been completed. She then stated there had been other resident assessments with this same issue and education was needed related to the coding. 5. According to the MDS 3.0 Resident Assessment Instrument (RAI) version 1.17.1, page 23: ..."The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. The MDS 3.0 is part of that assessment process and is required by CMS..."	F 641	in-service with all staff who participate in the MDS process regarding accuracy of assessments and timely completion of interviews on 8/5/2020. Who will monitor the new system: MDS Coordinator, DON, or Designee How frequently will we monitor: Nursing Administration will review all MDS' weekly prior to final signature to ensure that the MDS accurately reflects the resident at the time of the assessment. How will we incorporate the new system into our QAPI system: Identified Trends will be reviewed/ reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate.		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		8/3/20	

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F 690	Continued From page 5 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff and resident interviews, the facility failed to ensure a timely consult to assess for possible removal of a	F 690	Past noncompliance: no plan of correction required.		

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F 690	Continued From page 6 catheter for 1 of 2 sample residents (#29) with a catheter. This failure resulted in past non-compliance. Corrective measures were implemented by the facility prior to the survey and compliance was determined to be met on 3/3/20. The findings were: 1. Review of the MDS assessments showed resident #29 was re-admitted from the hospital on 2/7/20. Review of the hospital discharge summary showed the physician discussed the case with staff at the facility and informed them the resident would need a postvoid bladder scan to evaluate for potential bladder outlet obstruction. Review of admission orders dated 2/7/20 showed "Consider d/c'ing [discontinuing] Foley catheter on Monday and checking post-void bladder scans to rule out urinary retention..." The orders also stated "Continue Foley until 2/10/20 or until bladder scan can be completed." Review of the progress note dated 2/8/20 at 2:06 PM revealed per the physician, "...the foley catheter is to remain in place; bladder scan/urology appt [appointment] to be scheduled & findings will determine necessity for catheter." The following concerns were identified: a. Review of the medical record showed no evidence an appointment with the urologist or a bladder scan had been done up until 2/26/20. b. Review of the progress note dated 2/26/20 and timed 2:58 PM showed the nurse spoke to the resident's son related to his concern that his [father/mother] had not had a bladder scan done yet. The nurse indicated there was communication to nursing leadership regarding this, but as explained, they did not follow through timely and an apology was made. c. Review of the social services progress not dated 2/26/20 showed the social services spoke	F 690			

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F 690	Continued From page 7 with the resident's son regarding the bladder scan. The son was concerned about the length of time that his [parent] had the catheter placed. The urologist office was contacted and an appointment was set up. Further review of the medical record showed the resident had an appointment with the urologist on 2/28/20. d. During an interview on 3/10/20 at 10:25 AM the resident stated s/he was hoping to get the catheter out. e. During an interview on 3/12/20 at 8:39 AM the DON stated they tried to schedule the bladder scan with the hospital, but the hospital said they couldn't do it, and then "I forgot." The DON confirmed there was a delay in getting the resident to the urologist. 2. Review of facility documentation and interview with the DON on 3/12/20 at 8:39 AM revealed the facility took the following actions to prevent re-occurrence: a. Education to staff took place on 3/3/20. b. The facility implemented a new process where detailed information is given to the transportation aide, who schedules the appointments. The aide documents attempts at making appointments, and the tracking sheet is maintained by the providers. c. The tracking sheet is to be reviewed during rounds with the providers, to ensure appointments have been made, and weekly checks are also done. d. This corrective action monitored through the facility's quality assurance program.	F 690			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		8/3/20	

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F 812	Continued From page 8 The facility must - §483.60(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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of temperature logs, and staff interview, the facility failed to ensure food handling and sanitation processes were followed related to glove use, sanitizing food preparation surfaces, and recording food temperatures in lot 1 food preparation areas. The census was 46. The findings were: 1. Observation on 3/11/20 at 11:11 AM to 12:15 PM showed the following concerns: a. At 11:31 AM cook #1 took a drink from her personal beverage cup. The cook did not remove her gloves and perform hand hygiene prior to returning to the service line. She proceeded to handle the serving utensils and served food. b. At 11:33 AM dietary aide #1 used her gloved hands to handle the walk-in refrigerator door and the reach-in refrigerator door retrieving food items. The aide failed to remove her gloves	F 812	F812 Immediate Corrective Action: Cook #1 was immediately educated on proper hand hygiene and drinking in service line area. Dietary Aide #1 was immediately educated on proper hand hygiene, donning and doffing of gloves. Cook #2 and Cook #1 were immediately educated on proper sanitizer solution concentration and new strips and a log for tracking were implemented. A specific area was created on the production sheet to log temps for mechanical soft and pureed food. All staff have the potential to make above stated errors. An all staff in-service was conducted to review proper hand hygiene,		

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F 812	Continued From page 9 and perform hand hygiene. She then proceeded to handle clean articles, and food. c. At 11:46 AM cook #2 cleaned off the preparation table where he was working prepping food for the evening meal. He used a wet towel from the sanitizer solution in the bucket. When asked if the solution had been tested for chemical concentration he was unsure, and stated he had not prepared the bucket. On 3/11/20 at 11:48 AM when tested, the chlorine concentration of the solution in the bucket showed about 10 parts per million (ppm). There was no odor of bleach/chorine detected. d. At 11:52 AM cook #2 prepared a new solution by pouring some bleach into the bucket and added water. At that time he stated no one taught him how to measure it, and he did not know what to look for with a test strip. Not finding any more test strips, he asks the supervisor and was told there were none available. Interview with cook #1 on 3/11/20 at 11:53 AM revealed she had prepared the solution that morning, but had not completed any test for concentration. 2. Review of the previous week temperature log (3/1/20 to 3/7/20) showed there were no temperatures recorded for mechanical soft foods or pureed foods. Interview with the dietary manager on 3/11/20 at 11:37 AM verified temperatures for the mechanically altered foods were not usually recorded. She stated these temperatures should be tested and recorded to ensure proper holding temperatures. 3. Interview with the dietary manager and the assistant dietary manager on 3/11/20 at 12:15 PM verified there was education needed related to the preparation and use of the sanitizer solution. The dietary manager stated she was unable to	F 812	proper mixing of sanitation fluids and strip testing and a log was created to monitor. In addition all staff were educated on proper documentation and temping of mechanical soft food and pureed food. A required in-service of all dietary staff was conducted to review the above stated changes new processes on 6-22-20. Who will monitor: The dietary manager or designee will conduct a weekly audit to look specifically at the areas of concern as well as overall kitchen operation. Who will monitor: Dietary manager will identify trends or areas of concern and provide immediate education and corrective action. How frequently: Audits will be conducted weekly How will we incorporate the new system in QUAPI: Audits will be reported monthly to the QUAPI committee until which time the committee feels that the issue has been resolved or recommended changes are made.		

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F 812	Continued From page 10 locate any chlorine test strips at that time, however, would get some in. She and the assistant dietary manager verified hand washing and glove use education had been done in the past and needed to be reinforced. 4. According to Food Code 2017, U.S. Public Health Service: 2-301.14 "FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLE and: ...(D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands." 5. According to Food Code 2017, U.S. Public Health Service: "4-702.11 Before Use After Cleaning. UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT shall be SANITIZED before use after cleaning."			F 812			