PRINTED: 12/23/2005
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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure comprehensive assessments of identified problem areas for 5 (#14, #18, #27, #40, #41) of	F 272	483.20, 483.20(b) This facility will ensure that residents receive a comprehensive assessment of their needs. Specifically, the facility will ensure that the residents receive a comprehensive assessment of identified problem areas. This will be accomplished by (including but not limited to): 1. Resident #14 has received a comprehensive pain assessment, including summary documentation. The care plan has been updated based on the results of the comprehensive pain assessment. See resident's with identified pain will be re-assessed. 2. Resident #18, #41 and #27 have received a comprehensive assessment for insomnia, including summary documentation. The care plan has been updated based on the results of the comprehensive assessment, including non-pharmacological interventions. All residents identified with insomnia will be re-assessed. 3. Resident #40 has received a comprehensive restraint assessment, including summary documentation. The care plan has been updated based on the results of the comprehensive assessment. All residents with restraints will be re-assessed.	1/13/06 1/13/06 1/13/06

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

Nancy Bratton Administrator 1/11/06

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. POC was reviewed with corrections and additions made on 1/17/05 @ 1735 by Nancy Bratton, Adm. and Karen Weinreb, RN Health Surveyors.

PRINTED: 12/23/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUM 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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 272	Continued From page 1 14 sample residents. The findings were: 1. Review of the 11/1/05 through 12/31/05 physician's orders for resident #14 revealed he/she had diagnoses including rheumatoid arthritis and had a history of bilateral hip surgeries. Review of the 3/30/05 annual, the 6/28/05 quarterly, and the 9/27/05 quarterly Minimum Data Set (MDS) assessments revealed the resident had moderate joint pain daily. However, review of the entire medical record revealed no comprehensive pain assessment was completed. Interview with the director of nursing (DON) and the assistant director of nursing (ADON) on 12/15/05 at 8:30 AM confirmed there was no evidence a comprehensive assessment for pain was completed. 2. Review of the 11/1/05 through 12/31/05 physician's orders for resident #18 revealed an order for Ambien (hypnotic)10 milligrams (mg) PRN (as needed) every night at bedtime for sleep. Review of the entire medical record revealed no evidence an assessment was completed to determine why the resident was unable to sleep. In addition, there was no evidence of non-pharmacological interventions attempted. Interview with the DON and the ADON on 12/15/05 at 8:30 AM confirmed there was no evidence an assessment for insomnia was completed. 3. Observation on 12/13/05 from 7:30 AM through 10:30 AM revealed resident #40 had a lap buddy (tray across lap while in the wheelchair) restraint. Observation revealed the resident was unable to remove the lap buddy on his/her own. Interview with CNA #14 on 12/14/05 at 3:10 PM confirmed	F 272	4. The Initial Nursing Assessment has been revised to reflect the need for a comprehensive summary assessment. Upon admission, all residents will receive a comprehensive assessment and specialized assessments based upon identified problems. 5. A quality monitoring tool (Attachment 1) will be completed each month regarding completion of assessment of problems (as identified on the RAI). Comprehensive care plans will continue to be monitored with the Care Plan QA tool currently in use. The Quality Assurance committee will monitor these tools and recommend changes. 6. The Director of Nursing Services is responsible for compliance with the standard.	~~1/9/06~~ ~~1/31/06~~ DOC will now be 1/23/06

PRINTED: 12/23/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUM[illegible]N 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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 272	Continued From page 2 the resident was unable to remove the lap buddy on his/her own. Review of the 12/6/05 quarterly MDS assessment revealed the lap buddy was identified as a restraint. Review of the entire medical record revealed no assessment for restraint utilization was completed. Interview with the DON and ADON on 12/15/05 at 8:30 AM revealed the restraint was utilized because of the resident's history of falls and that the assessment that was completed was a Fall Risk Assessment Tool. However, there was no evidence of a restraint assessment. 4. Review of the 11/1/05 through 12/31/05 physician's orders for resident #41 revealed an order dated 10/21/05 for Ambien 10 milligrams (mg) PRN (as needed) every night at bedtime for sleep. Review of the entire medical record revealed no evidence an assessment was done to determine why the resident was unable to sleep. In addition, there was no evidence non-pharmacological interventions were attempted. Interview with the DON and the ADON on 12/15/05 at 8:30 AM confirmed there was no evidence an assessment for insomnia was completed. 5. Review of physician's orders showed resident #27 received Seroquel (antipsychotic) 25 milligrams (mg) at bedtime for insomnia since 3/2/04. Review of the 3/15/05 and 6/1/05 Minimum Data Set (MDS) review notes showed the resident received Seroquel to aid in sleeping. Review of the medical record revealed there was no assessment to determine the cause of the resident's insomnia, nor the reason for the use of Seroquel. During interviews on 12/15/05 at 9:45 AM and 10:30 AM, the administrator stated there was no assessment because the insomnia was a	F 272		

PRINTED: 12/23/2005
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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 272	Continued From page 3 long standing problem for the resident.	F 272		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure physician's orders were followed for one (#41) of 12 sample residents. The findings were: Review of the 11/1/05 through 12/31/05 physician's orders for resident #41 revealed he/she had an order dated 10/21/05 for knee high support hose to both legs every shift. Observation on 12/12/05 at 4:40 PM, on 12/13/05 from 7:30 AM until 10 AM, and on 12/15/05 at 9 AM revealed the resident was not wearing knee-high support hose. Interview with the assistant director of nursing on 12/15/05 at 8:30 AM revealed she did not know why the physician's order was not followed. According to "Clinical Nursing Skills",5th edition, by authors Smith, Duell, and Martin, page 4, the responsibilities of the professional nurse involve a level of performance of the skills and functions that professional nurses perform in daily practice includes "administer treatments per physician's order."	F 281	483.20(k)(3)(i) This facility will ensure that services provided or arranged by the facility are provided by qualified person in accordance with each resident's written plan of care. This will be accomplished by (including but not limited to): 1. Resident interview and interviews with staff indicated that Resident #41 frequently refused the knee high support hose. His/her physician was consulted and the order was discontinued. 1/7/06 2. All nursing staff will receive an inservice reviewing the importance of following the plan of care for all residents. The inservice has been scheduled for 1/18/06. 1/20/06 3. A quality assessment tool (Attachment #2) will be utilized at least monthly to monitor the implementation of physician orders for completeness and accuracy. The Quality Assurance committee will monitor results and make recommendations. 1/11/06 4. The Director of Nursing Services is responsible for compliance with the standard.	
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in	F 282		

PRINTED: 12/23/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUM. ..(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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 282	Continued From page 4 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of the incontinence management programs, and staff and family interviews, the facility failed to provide care in accordance with the written plans of care for six of twelve sample residents (#7, #17, #24, #41, #44, #50). The findings were: 1. Review of the 8/23/05 initial, and 11/16/05 quarterly Minimum Data Set (MDS) assessments for resident #17 revealed he/she was incontinent (all or almost all of the time) of urine. Observation on 12/13/05 at 7:30 AM to 1 PM revealed the resident was not taken to the toilet and did not have his/her incontinence brief checked during that time (5.5 hours). Observation on 12/13/05 at 1 PM revealed the resident's incontinence brief was wet with urine. Review of the 11/17/05 care plan revealed the resident should be assisted to the toilet every 2.5 to 3 hours and as requested. Interview with CNA #3 on 12/13/05 at 1 PM confirmed the resident was to be toileted or checked and changed every 2.5 to 3 hours. 2. Review of the 12/7/05 quarterly MDS assessment for resident #7 revealed he/she was incontinent (all or almost all of the time) of urine. Observation on 12/14/05 from 2:30 PM until 6:30 PM revealed the resident was not taken to the toilet and did not have his/her incontinence brief checked during that time (4 hours). Observation on 12/14/05 at 6:30 PM revealed the resident's incontinence brief was saturated with urine.	F 282	483.20(k)(3)(ii) This facility will ensure that services provided or arranged by the facility are provided by qualified person in accordance with each resident's written plan of care. This will be accomplished by (including but not limited to): 1. All staff caring for resident #7, #17, #24, #41, #44 and #50 have received an individual in-services on the plan of care for that resident, specifically regarding toileting and transfers. 2. All CNA staff are receiving competency re-assessments and skills evaluations with special emphasis on peri-care, the bowel and bladder policy, toileting and transfers as well as reviewing the importance of following the plan of care for all residents. 3. A series of mandatory inservice has been planned for 1/18 - 20/06 to emphasize the importance of following the care plan for all residents. 4. Staff has received in-services regarding the location of up to date information regarding the incontinence management program for each resident. This is included in the individual competency check off lists. Signs will be	1/13/06 1/20/06 1/20/06

PRINTED: 12/23/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUM.. .N 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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 282	Continued From page 5 Further observation revealed the last time the resident's incontinence brief was checked or changed was documented as 11 AM. Interview on 12/14/05 at 6:30 PM with CNAs #13, #18, and #16 confirmed the time documented on the incontinence brief was the last time the resident was changed making the length of time between changing the resident's incontinence brief a total of 7.5 hours. Review of the 12/8/05 care plan revealed the resident was on a scheduled toileting program and was to be taken to the toilet every 2.5 to 3 hours. 3. Review of the 11/1/05 through 12/31/05 physician's orders for resident #41 revealed he/she had an order dated 10/21/05 for knee high support hose to both legs every shift. Observation on 12/12/05 at 4:40 PM, on 12/13/05 from 7:30 AM until 10 AM, and on 12/15/05 at 9 AM revealed the resident was not wearing knee high support hose. Review of the 10/21/05 care plan revealed the resident required assistance with TED (support) hose. 4. a. Review of the 12/7/05 quarterly Minimum Data Set (MDS) assessment showed resident #24 was incontinent of bladder multiple times daily and incontinent of bowel all (or almost all) of the time. Review of the 12/8/05 care plan revealed the resident was to be assisted to the toilet per his/her individual schedule. During an interview on 12/14/05 at 9:15 AM, the restorative nurse stated the resident's schedule was upon rising, after breakfast, before and after lunch, and before and after dinner. Review of the "Incontinence Management Programs" for December 2005 (provided by the restorative nurse) showed the resident was on a "scheduled toileting" program, which was to toilet the resident	F 282	posted to further inform staff of where the information is located.. 5. The order for the knee high support hose for resident #41 has been discontinued. 6. A quality assessment tool (Attachment #3) will be utilized at least monthly to monitor the implementation of resident care plans for completeness and accuracy. The Quality Assurance committee will monitor results and make recommendations. 7. The Director of Nursing Services is responsible for compliance with the standard.	1/20/06 1/7/06 1/11/06

PRINTED: 12/23/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUM.. .N 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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 282	Continued From page 6 every 2.5-3 hours. Observation of the resident on 12/13/05 began at 7:15 AM. At 8:55 AM (after breakfast), certified nurse aides (CNAs) #3 and #7 transferred the resident from the wheelchair into bed. The resident was not offered the toilet, and was not checked for incontinence. At 10:12 AM, CNAs #23 and #7 transferred the resident to the toilet. CNA #23 stated the resident was incontinent of bowel and bladder. Observation of the incontinence brief (staff documented on the brief the time it was checked) and interview with CNA #23 revealed the resident was last checked for incontinence at 6:30 AM (3 hours and 42 minutes). b. Review of the 12/8/05 care plan showed the resident was to be transferred using the E-Z lift (mechanical lift) for all transfers. Interview with the restorative nurse and review of the listing of mandatory lifts on 12/14/05 at 9:15 AM revealed the E-Z lift was to be used for all transfers. However, observation on 12/13/05 at 8:55 AM revealed the resident was transferred to bed manually by CNAs #3 and #7. 5. Review of the 9/28/05 quarterly MDS assessment showed resident #50 was incontinent of bladder multiple times daily. Review of the 10/13/05 care plan showed the resident was on a scheduled toileting program (before putting to bed, when getting out of bed, and as needed). During an interview on 12/14/05 at 9:15 AM, the restorative nurse confirmed the care plan was current. Review of the "Incontinence Management Programs" for December 2005 (provided by the restorative nurse) showed the resident was on a "scheduled toileting" program, which was to toilet the resident every 2.5-3 hours. Observation of the resident on 12/13/05 revealed the resident was not toileted nor checked for	F 282		

PRINTED: 12/23/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HU[illegible]N 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 _____	12/16/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 282	Continued From page 7 incontinence from 7:15 AM until 10:40 AM (3 hours 25 minutes). At that time, CNAs #23 and #3 transferred the resident to the toilet; the resident was incontinent of bladder. On 12/14/05 at 2:45 PM, a family member stated the resident was frequently incontinent, and he/she didn't believe the resident was being toileted frequently enough. 6. Review of the 12/9/05 significant change MDS assessment revealed resident #44 was incontinent of bladder multiple times daily. Review of the 12/8/05 care plan showed the resident was to be toileted every 2.5-3 hours. Observation of the resident on 12/13/05 revealed the resident was not toileted, nor checked for incontinence, from 7:15 AM until 11:25 AM (4 hours 10 minutes), when CNA #3 asked the resident if he/she needed to use the toilet.	F 282		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and family interviews, the facility failed to provide care in a manner which maintained the highest practicable level of well-being for two of twelve sample residents (#24, #50). Resident #50 was not positioned during meals to promote safe swallowing, and resident #24 did not receive care	F 309	483.25 This facility will ensure that each resident receives and is provided the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. This will be accomplished by (including but not limited to): 1. Individual in-services will be completed for all staff working with residents #24 and #50 on 12/14/05 regarding positioning. For this residents & all residents E. positioning issues	1/13/06

PRINTED: 12/23/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUM.. ..I 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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309	Continued From page 8 to promote bowel continence. The findings were: 1. Review of the 4/5/05 significant change Minimum Data Set (MDS) assessment revealed resident #50 had swallowing problems and utilized a feeding tube. Nursing notes revealed the feeding tube was removed on 10/25/05. Review of the results from a 6/9/05 videofluoroscopy (to assess the resident's swallowing abilities) revealed there was penetration of the airway without aspiration during the pharyngeal phase of the swallow. Review of the care plan dated 10/13/05 showed the resident was at risk for aspiration and required monitoring for swallowing concerns. On 12/14/05 at 2:45 PM, a family member stated the resident "choked" on water a lot, but leaning the resident forward in the wheelchair helped. During an interview on 12/13/05 at 9:45 AM, licensed practical nurse (LPN) #1 stated the resident needed to sit upright to prevent choking. The LPN stated the resident liked to lean back in the wheelchair, so staff needed to sit the resident up straight when providing him/her with food or fluids. According to the 2004 Nursing Assistant, A Nursing Process Approach, by Hegner, Acello and Caldwell (9th edition, p 416), the patient should be positioned as upright as possible. The head should face forward, with the neck flexed forward slightly. In addition, according to Nursing Interventions and Clinical Skills by Elkin, Perry, and Potter (2004, p. 192-193), the client should be positioned upright in bed or chair with head slightly flexed forward; this position reduces the risk of aspiration. The following concerns were identified regarding positioning the resident during meals: a. Observation on 12/13/05 from 7:20 AM until 7:45 AM revealed the resident was seated in a wheelchair at the assisted dining table. The	F 309	2. Staff has received individual in-services on the incontinence management program for Resident #24 and all residents with incontinence of Bowel. 1:1 competency will be done with all staff.	1/13/06
			3. A quality monitoring tool (Attachment #3) will be completed each month regarding the knowledge of direct care staff regarding the current incontinence management programs for randomly selected residents. These observations regarding staff knowledge of resident incontinence management programs will be incorporated into the CNA skills checklists. Results will be reported to the QA committee.	1/11/06
			4. The Director of Nursing Services is responsible for compliance with the standard.	

PRINTED: 12/23/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUM. N 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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309	Continued From page 9 resident's buttocks were slid forward in the wheelchair, about eight inches from the back of the wheelchair. The resident's head was tilted back (extended), and resting on the back of the wheelchair. Certified nurse aide (CNA) #23 fed the resident his/her meal while the resident was positioned that way. At 7:35 AM, the resident coughed. No attempt was made to reposition the resident during the meal. At 7:45 AM the resident was finished with the meal and taken out of the dining room. At that time, CNA #23 and restorative aide #1 repositioned the resident so he/she was seated upright. b. Observation on 12/13/05 at 12:30 PM revealed the resident was seated in the wheelchair at the assisted dining table. The resident was slid forward in the wheelchair, and was not seated upright. The resident's head was tilted back, with the chin pointed towards the ceiling, while CNA #23 fed the resident. At 12:36 PM, the resident coughed. At that time, LPN #1 walked by. The LPN told the CNA the resident needed to be repositioned. The LPN and CNA then positioned the resident so he/she was seated upright. 2. Review of the 12/7/05 quarterly MDS assessment showed resident #24 was incontinent of bowel all (or almost all) of the time. Review of the 12/5/05 bowel and bladder progress note revealed the resident was to be taken to the bathroom upon rising, after breakfast, before and after lunch, and before and after dinner. During an interview on 12/14/05 at 9:15 AM, the restorative nurse confirmed the resident was to be toileted after breakfast, and again before lunch. Review of the "Incontinence Management Programs" for December 2005 (provided by the restorative nurse) showed the resident was on a	F 309		

PRINTED: 12/23/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUM..N 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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309	Continued From page 10 "scheduled toileting" program, which was to take his/her to the toilet every 2.5-3 hours. Observation of the resident on 12/13/05 began at 7:15 AM. At 8:55 AM (after breakfast), CNAs #3 and #7 transferred the resident from the wheelchair into bed. The resident was not offered the toilet, and was not checked for incontinence. At 10:12 AM, CNAs #23 and #7 transferred the resident to the toilet. CNA #23 stated the resident was incontinent of bowel. Observation of the incontinence brief (staff documented on the brief the time it was checked) and interview with CNA #23 revealed the resident was last checked for incontinence at 6:30 AM (3 hours and 42 minutes).	F 309		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of policies and procedures, the facility failed to assure staff provided appropriate personal care for two (#14, #41) of five sample residents. The findings were: 1. Review of the 3/30/05 annual, the 6/28/05 and 9/27/05 quarterly Minimum Data Set (MDS) assessments for resident #14 revealed he/she was frequently incontinent (daily with some control present) of urine and required total	F 312	483.25(a)(3) This facility will ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene. This will be accomplished by (including but not limited to): 1. Individual in-services will be completed for all staff working with residents #14 and #41 on 12/13/05. 2. All CNA staff are receiving 1:1 competency re-assessments and skills evaluations with special emphasis on peri-care for all residents 3. Staff has received in-services regarding the location of up to date information regarding the incontinence management program for each resident. Signs will be	1/13/06 1/20/06

PRINTED: 12/23/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUM. 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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 312	Continued From page 11 dependence on staff for personal hygiene. Observation on 12/13/05 at 8:40 AM revealed the resident was incontinent of urine and bowel. Observation further revealed CNA #7 provided perineal care for the resident. Observation of the perineal care provided revealed the CNA used back to front wipes three times to cleanse the perineum. Interview with the CNA at that time confirmed she should have used front to back strokes to cleanse the resident. Review of the facility's policy on perineal care, revised in 2000, revealed staff must "Always use front to back technique." 2. Review of the 10/27/05 initial MDS assessment for resident #41 revealed he/she required extensive staff assistance with personal hygiene. Observation on 12/12/05 at 4:40 PM revealed the resident was incontinent of urine. Observation further revealed certified nurse aide (CNA) #13 provided perineal care for the resident. Observation of the perineal care provided revealed the CNA cleansed the perianal area but not the anterior area of the perineum or thighs. Review of the facility's policy and procedure on perineal care, revised in 2000, revealed staff must "Cleanse pubis area, inner thighs, and perianal area."	F 312	4. posted to further inform staff of where the information is located. 4. A quality monitoring tool (Attachment #3) will be completed each month regarding the knowledge of direct care staff regarding the current incontinence management programs for randomly selected residents. Observations regarding staff knowledge of resident incontinence management programs will be incorporated into the peri-anal care skills checklists. Results will be reported to the QA committee. 5. The Director of Nursing Services is responsible for compliance with the standard.	1/20/06 1/11/06
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314	483.25 (c) This facility will ensure that residents who has a pressure sore receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This will be accomplished by (including but not limited to): 1. The egg crate in the wheelchair of resident #41 has been removed.	12/20/05

PRINTED: 12/23/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HU. .N 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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 314	Continued From page 12 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of policies and procedures, the facility failed to ensure staff provided appropriate interventions for one (#41) of two sample residents who had pressure sores. The findings were: Observation on 12/12/05 at 6:15 PM revealed a "Best Practices Pressure Ulcer Prevention & Treatment" poster provided by Mountain-Pacific Quality Health Care Foundation posted near the nursing station. Best practice recommendations included "Avoid use of ....egg crates" Observation on 12/12/05 at 4:40 PM revealed resident #41 had three pressure sores on the coccyx. Review of the 12/10/05 interdisciplinary progress notes revealed the pressure sores were described as follows: "Deep red area now Approx [approximately] 13 cm [centimeters] x [by] 12 cm original decubitus .... now approx [approximately] 2 cm x 1 cm....New area directly on coccyx now Stage I just under 1 cm in diameter." Observation further revealed the resident was transferred to his/her wheelchair which had an egg crate cushion. Review of the 12/7/05 interdisciplinary progress notes revealed the resident had an egg crate pillow in the wheelchair. Interview with the assistant director of nursing on 12/14/05 at 3:50 PM revealed she was unaware there was an egg crate in the resident's wheelchair. She further stated the facility used the "Best Practices Pressure Ulcer Prevention &	F 314	2. The facility policy and procedure for pressure sore management has been revised to specifically reflect that the use of egg crates is not permitted as a pressure reducing device. 3. Staff has received in-services regarding facility policies and procedures regarding pressure sores. 4. A quality monitoring tool (Attachment #4) will be completed each month regarding wound care treatments and documentation for all residents with pressure sores. Results will be reported to the QA committee. 5. The Director of Nursing Services is responsible for compliance with the standard.	1/11/06 1/20/06 1/11/06

PRINTED: 12/23/2005
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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 314	Continued From page 13 Treatment" recommendations as guidelines for the care and treatment of pressure sores. Interview with the director of nursing on 12/15/05 at 8:30 AM confirmed current nursing practice for the prevention and treatment of pressure ulcers did not include egg crate cushions as a pressure reducing device. Review of the facility's policies and procedures revealed utilization of egg crates as a pressure reducing device was not addressed.	F 314		
F 315 SS=E	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff managed urinary incontinence for four (#7, #17, #24, #50) of 10 sample residents in a manner which promoted dryness. The findings were: 1. Review of the 8/23/05 initial, and 11/16/05 quarterly Minimum Data Set (MDS) assessments for resident #17 revealed he/she was incontinent (all or almost all of the time) of urine. Observation	F 315	483.25(d) This facility will ensure that residents who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. The facility will ensure that staff is familiar with the current incontinence management program and deliver services consistent with that program and in a manner that promotes dryness. This will be accomplished by (including but not limited to): 1. Individual inservices will be completed for all staff working with residents #7, #17, #24, and #50 on 12/13 - 14/05, with specific focus on the incontinence management programs. 2. All CNA staff are receiving 1:1 competency re-assessments and skills evaluations with special	1/13/06 1/20/06

PRINTED: 12/23/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUM . 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 _____	12/15/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 315	Continued From page 14 on 12/13/05 at 7:30 AM to 1 PM revealed the resident was not taken to the toilet and did not have his/her incontinence brief checked during that time (5.5 hours). Observation on 12/13/05 at 1 PM revealed the resident's incontinence brief was wet with urine. Review of the 11/17/05 care plan revealed the resident should be assisted to the toilet every 2.5 to 3 hours and as requested. Interview with certified nurse aide (CNA) #3 on 12/13/05 at 1 PM confirmed the resident was to be toileted or checked and changed every 2.5 to 3 hours. 2. Review of the 12/7/05 quarterly MDS assessment for resident #7 revealed he/she was incontinent (all or almost all of the time) of urine. Observation on 12/14/05 from 2:30 PM until 6:30 PM revealed the resident was not taken to the toilet and did not have his/her incontinence brief checked during that time (4 hours). Observation on 12/14/05 at 6:30 PM revealed the resident's incontinence brief was saturated with urine. Further observation revealed the last time the resident's incontinence brief was checked or changed was documented as 11:30 AM. Interview on 12/14/05 at 6:30 PM with CNAs #13, #18, and #16 confirmed the time documented on the incontinence brief was the last time the resident was changed making the length of time between changing the resident's incontinence brief a total of 7 hours. Review of the 12/8/05 care plan revealed the resident was on a scheduled toileting program and was to be taken to the toilet every 2.5 to 3 hours. 3. Review of the 12/7/05 quarterly MDS assessment showed resident #24 was incontinent of bladder multiple times daily. Review of the 12/5/05 bowel and bladder progress note	F 315	emphasis on peri-care and incontinence management programs. 3. Staff has received inservices regarding the location of up to date information regarding the incontinence management program for each resident. Signs will be posted to further inform staff of where the information is located. 4. A quality monitoring tool will be completed each month regarding the knowledge of direct care staff regarding the current incontinence management programs for randomly selected residents. These observations regarding staff knowledge of resident incontinence management programs will be incorporated into the perianal care skills checklists (Attachment #3). Results will be reported to the QA committee. 5. The Director of Nursing Services is responsible for compliance with the standard.	1/20/06 1/20/06 1/11/06

PRINTED: 12/23/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUM. 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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 315	Continued From page 15 revealed the resident was to be taken to the bathroom upon rising, after breakfast, before and after lunch, and before and after dinner. During an interview on 12/14/05 at 9:15 AM, the restorative nurse confirmed the resident was to be toileted after breakfast, and again before lunch. Review of the "Incontinence Management Programs" for December 2005 (provided by the restorative nurse) showed the resident was on a "scheduled toileting" program, which was to toilet the resident every 2.5-3 hours. Observation of the resident on 12/13/05 began at 7:15 AM. At 8:55 AM (after breakfast), certified nurse aides (CNAs) #3 and #7 transferred the resident from the wheelchair into bed. The resident was not offered the toilet, and was not checked for incontinence. At 10:12 AM, CNAs #23 and #7 transferred the resident to the toilet. CNA #23 stated the resident was incontinent of bladder. Observation of the incontinence brief (staff documented on the brief the time it was checked) and interview with CNA #23 revealed the resident was last checked for incontinence at 6:30 AM (3 hours and 42 minutes). 4. Review of the 9/28/05 quarterly MDS assessment showed resident #50 was incontinent of bladder multiple times daily. Review of the 12/6/05 bowel and bladder progress note revealed the resident was to be toileted upon rising, and before and after meals. Review of the 10/13/05 care plan showed the resident was on a scheduled toileting program (before putting to bed, when getting out of bed, and as needed). During an interview on 12/14/05 at 9:15 AM, the restorative nurse confirmed the care plan was current. In addition, the restorative nurse stated the resident's family had voiced concerns the resident was not being toileted frequently enough.	F 315		

PRINTED: 12/23/2005
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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 315	Continued From page 16 Review of the "Incontinence Management Programs" for December 2005 (provided by the restorative nurse) showed the resident was on a "scheduled toileting" program, which was to toilet the resident every 2.5-3 hours. Observation of the resident on 12/13/05 revealed the resident was not toileted, nor checked for incontinence, from 7:15 AM until 10:40 AM (3 hours 25 minutes). At that time, CNAs #23 and #3 transferred the resident to the toilet; the resident was incontinent of bladder. On 12/14/05 at 2:45 PM, a family member stated the resident was frequently incontinent, and he/she didn't believe the resident was being toileted frequently enough.	F 315		
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the environment was safe and chemicals were not accessible to residents during one random observation. The findings were: Observation of the activity room/independent dining room on 12/13/05 at 10 AM revealed the following concerns: a. One package of Miracle Grow and one package of Jobe plant food sticks was located in the second drawer of the cabinets. The warning on the package labels read "Keep out of reach of children." The drawer was unlocked.	F 323	483.25(h)(1) This facility will ensure that the resident environment remains as free of accident hazards as is possible. This will be accomplished by (including but not limited to): 1. The package of Miracle Grow and package of Job plant food sticks, as well as the bottle of "Clor Out" has been moved to behind a locked door. 2. Signs have been posted to remind staff to watch for hazardous materials In addition, staff will receive an inservice on this safety issue at their inservice on	12/18/05

DEPARTMENT OF HEALTH AND HU. .N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/23/2005
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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 323	Continued From page 17 b. One bottle of "Chlor Out" for the fish tank was located on the first shelf of the cupboard. The warning label read "Keep out of reach of children." The cupboard was unlocked. c. There were three bottles of nail polish remover on the second shelf from the top and two bottles on the third shelf from the top located in the activity closet. The warning labels on all five bottles read "Harmful if ingested. In case of accidental ingestion give fluids liberally and consult with local POISON CONTROL CENTER." "Keep out of reach of children." Interview with the activity assistant on 12/14/05 at 10:35 AM confirmed the drawers and cupboards were not locked. She further stated the activity closet door should be locked when no activity staff were in the room.	F 323	1/18-20/06. 3. New locks have been ordered to be installed on the activity room closet door. 4. The Activity room drawers and cabinets have been added to the monthly QA safety audit and will be reported to the QA committee for review and recommendations for action. (Attachment 5) 5. The Director of Nursing Services is responsible for compliance with the standard.	1/20/06 1/20/06 1/11/06
F 329 SS=D	483.25(l)(1) 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure the drug regimen was free of unnecessary drugs for two (#18, #41) of four sample residents who received hypnotic or antianxiety medications. The findings	F 329	483.25(I)(1) This facility will ensure that residents will be free of unnecessary drugs. This will be accomplished by (including but not limited to): 1. Policy and procedure regarding psychotropic medications , including trial reductions have been revised in consultation with the Medical Director and Consulting Pharmacist. RN/LPN staff have received individual in-services on the facility policy and procedure regarding psychotropic medications.	1/11/06

PRINTED: 12/23/2005
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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 329	Continued From page 18 were: 1. During an interview on 12/14/05 at 6:40 PM, the administrator stated she was aware there were issues with psychotropic medication use in the facility. The administrator stated facility staff had not gotten together as a team to discuss residents on psychotropic medications since March 2005. The administrator stated the facility was not doing what is should be regarding psychotropic medications, such as assuring the medications were appropriate and dose reductions occurred as needed. 2. Review of the 11/1/05 through 12/31/05 physician's orders showed resident #18 received Ambien (hypnotic) 10 milligrams (mg) PRN (as needed) every night for sleep. According to the 2005 Physician's Desk Reference (PDR) Nurse's Drug handbook, page 1333, Ambien is a drug used for the short term treatment of insomnia. According to the 2005 PDR under indications and usage, "Hypnotics should generally be limited to 7 to 10 days of use, and reevaluation of the patient is recommended if they are to be taken for more than 2 to 3 weeks. Ambien should not be prescribed in quantities exceeding a 1-month supply." The following concerns were identified: a. Review of the November and December 2005 Medication Administration Records (MARs) revealed the resident received Ambien 21 of 30 days in November and eleven times during the first thirteen days of December. b. Review of the medical record revealed there was no evidence an assessment was done to determine the cause of the resident's insomnia. c. Review of the medical record revealed there was no evidence that non-pharmacological interventions were attempted to address the	F 329	2. Residents #18 and #41 have received an assessment for the identified problem of insomnia. The care plan for residents #18 and #41 have been updated to reflect the use of non-pharmacological interventions for insomnia. Drug reductions or discontinuations have been initiated as per the physician. 3. The IDT, Director of Nursing and the Medical Director will continue to review the reports of the Consulting Pharmacist. The QA activity monitoring the physician response to the IDT/Pharmacist recommendations will be re-instituted and continued for a minimum of one year. Results will be reported to the QA committee. (Attachment 6) 4. The Director of Nursing Services is responsible for compliance with the standard. 5. All Residents receiving hypnotics or antianxiety medications will be reviewed - DOC 1/28/06	~~1/13/06~~ ~~1/11/06~~

PRINTED: 12/23/2005
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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 329	Continued From page 19 resident's insomnia d. According to the facility's sedative/hypnotic monthly record, "Any PRN used 3 or more times per week needs review". Review of the entire medical record and interview with the director of nursing (DON) and assistant director of nursing (ADON) on 12/15/05 at 8:30 AM revealed no evidence a review was done. Interview with the DON and ADON on 12/15/05 at 8:30 AM confirmed no assessment was done to determine the cause of the resident's insomnia. Further review of the 11/1/05 through 12/31/05 physician's orders showed the resident also received Ativan (antianxiety/hypnotic) 1 mg at 5 AM and 1 PM and 2 mg at bedtime daily. The following concerns were identified: a. Review of the medical record revealed there was no evidence that non-pharmacological interventions were attempted to address the resident's anxiety. b. There was no evidence of a drug evaluation with consideration of a dose reduction was done since 7/22/04. Interview with the DON and ADON on 12/15/05 at 8:30 AM confirmed there was no evidence non-pharmacological interventions were attempted. 3. Review of the 11/1/05 through 12/31/05 physician's orders showed resident #41 received Ambien (hypnotic) 10 mg at bedtime daily. According to the 2005 PDR Nurses' Drug handbook, page 1333, Ambien is a drug used for the short term treatment of insomnia. The following concerns were identified: a. Review of the medical record revealed there was no evidence an assessment was done to determine the cause of the resident's insomnia.	F 329		

PRINTED: 12/23/2005
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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 329	Continued From page 20 b. Review of the sedative/hypnotic monthly records revealed there was no evidence of monitoring done during November 2005. c. Review of the sedative/hypnotic monthly records revealed there was no evidence non-pharmacological interventions were attempted to address the resident's insomnia during November or December 2005. Interview with the director of nursing and assistant director of nursing on 12/15/05 at 8:30 AM confirmed there was no evidence of assessment, monitoring, or non-pharmacological interventions done.	F 329		
F 330 SS=D	483.25(l)(2) ANTIPSYCHOTIC DRUGS 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. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure there was adequate indication for the use of antipsychotics for three of five sample residents who were started on antipsychotics (#24, #27, #40). The findings were: 1. During an interview on 12/14/05 at 6:40 PM, the administrator stated she was aware there were issues with psychotropic medication use in the facility. The administrator stated facility staff	F 330	483.25(1)(2)Based on a comprehensive assessment, this facility will 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. This will be accomplished by (including but not limited to): 1. The facility Policy and Procedure for psychotropic medication has been reviewed and updated with the input of the Medical Director and Consulting Pharmacist. As per policy a response will be received for all residents. 2. RN/LPN staff have been re-educated on the facility Policy and Procedure for psychotropic medications. 3. A updated risk/benefit analysis of the use of Zyprexa for resident #24 has been received from his/her attending physician.	1/11/06 1/13/06 1/9/06

PRINTED: 12/23/2005
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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 330	Continued From page 21 had not gotten together as a team to discuss residents on psychotropic medications since March 2005. The administrator stated the facility was not doing what it should be regarding psychotropic medications, such as assuring the medications were appropriate and dose reductions occurred as needed. 2. Review of physician orders showed resident #24 received Zyprexa (antipsychotic) 2.5 milligrams (mg) at bedtime since 1/21/04. The diagnosis associated with the use of the drug was depressive disorder. Review of the behavior monitoring sheets showed the resident was being monitored for combativeness and refusals of care. Review of the October, November, and December 2005 sheets showed the resident did not exhibit any behaviors. Review of a pharmacist report dated 4/5/05 showed the pharmacist was recommending an acceptable diagnosis for the use of Zyprexa. The physician did not act upon the report. Review of another pharmacist report dated 10/4/05 showed "...Depression is an inappropriate diagnosis for an antipsychotic medication and will be a survey tag for the facility." The physician did not act upon the report. Review of the facility's antipsychotic flow sheets showed "...antipsychotic drugs should not be used when the only indication is one or more of the following:....depression..." Review of the medical record revealed no documentation to show why an antipsychotic medication was appropriate and necessary for the resident. On 12/15/05 at 10:30 AM, the administrator confirmed there was no documentation to clearly show why the resident was on the medication, nor a risk/benefit statement from the physician. 3. Review of physician's orders showed resident	F 330	4. Resident #17 has received an assessment for the identified problem of ~~insomnia~~ Error. The care plan has been updated to reflect the results of the assessment and non-pharmaceutical interventions. 5. A response to the pharmacist consultation has been received for resident #27. He/She has received an assessment for insomnia and the care plan has been updated as per the physician orders and assessment results. 6. Resident #40 has received an assessment for the use of Haldol as prescribed, including an updated DISCUS assessment tool. Physician orders have been received and the care plan updated. 7. The IDT will continue to review the reports of the Consulting Pharmacist. The QA activity monitoring the physician response to the IDT/Pharmacist recommendations will be re-instituted and continued for a minimum of one year. Results will be reported to the QA committee. (Attachment #6) 8. The Director of Nursing Services is responsible for compliance with the standard.	1/13/06 1/13/06 1/13/06 1/11/06

PRINTED: 12/23/2005
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUM.. .N 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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 330	Continued From page 22 #27 received Seroquel (antipsychotic) 25 milligrams (mg) at bedtime for insomnia since 3/2/04. Review of the 3/15/05 and 6/1/05 Minimum Data Set (MDS) review notes showed the resident received Seroquel to aid in sleeping. Review of the 3/12/04 pharmacist report showed "...Seroquel for insomnia?" Review of the facility's antipsychotic flow sheets showed "...antipsychotic drugs should not be used when the only indication is one or more of the following:....insomnia..."Review of the medical record revealed there was no assessment to determine to the cause of the resident's insomnia, and the reason for the use of Seroquel. During interviews on 12/15/05 at 9:45 AM and 10:30 AM, the administrator stated there was no assessment because the insomnia was a long standing problem for the resident. The administrator stated prior to admission, the resident took Ambien (sedative-hypnotic) to help sleep, and she wasn't sure why the resident was now prescribed an antipsychotic. The administrator confirmed there was no documentation to clearly show why the resident was on the medication, nor a risk/benefit statement from the physician. 4. Review of the 11/1/05 through 12/31/05 physician's orders for resident #40 revealed he/she received Haldol (antipsychotic) for symptoms of abnormal weight loss since 2/22/05. Review of the November and December 2005 antipsychotic monthly records revealed the resident was being monitored for refusal to eat and refusal of medications. Review of the 10/4/05 consultation report from the pharmacy showed the pharmacist was requesting an acceptable diagnosis for the use of Haldol. Review of the facility's antipsychotic monthly record flow sheets showed "antipsychotic drugs should not be used when the only indication is one or more of the	F 330		

PRINTED: 12/23/2005
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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 330	Continued From page 23 following:.....uncooperativeness..." In addition, review of the 10/4/05 consultation report showed the pharmacist recommended discontinuation of the Haldol and a re-evaluation of the resident's need for antipsychotic drug therapy. The pharmacist recommended that if the resident did need antipsychotic drug therapy, treatment with an atypical antipsychotic would have less risk of extrapyramidal symptoms (side effects of antipsychotic medications such as tremors) than Haldol. Observation at dinner on 12/12/05 and at breakfast on 12/13/05 revealed the resident had significant hand tremors which made eating difficult. Review of the entire medical record revealed the most recent DISCUS-Dyskinesia Identification System: Condensed User Scale (a tool used to monitor antipsychotic medication side effects) was done on 12/18/03. Interview with the administrator on 12/14/05 at 11:05 AM confirmed there was no evaluation to show why the resident was on the Haldol, nor was there a review by a physician since 3/10/05.	F 330		
F 331 SS=D	483.25(l)(2)(ii) ANTIPSYCHOTIC DRUGS Based on a comprehensive assessment of a resident, the facility must ensure that 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 by: Based on staff interview and medical record review, the facility failed to ensure one (#7) of five	F 331	483.25(1)(2)(ii) This facility will ensure that residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue the use of these drugs. This will be accomplished by (including but not limited to): 1. The facility Policy and Procedure for psychotropic medication has been reviewed and updated with the input of the Medical Director and Consulting Pharmacist.	1/11/06

PRINTED: 12/23/2005
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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 331	Continued From page 24 sample residents using antipsychotic medication received gradual dose reductions. The findings were: 1. During an interview on 12/14/05 at 6:40 PM, the administrator stated she was aware there were issues with psychotropic medication use in the facility. The administrator stated facility staff had not gotten together as a team to discuss residents on psychotropic medications since March 2005. The administrator stated the facility was not doing what is should be regarding psychotropic medications, such as assuring the medications were appropriate and dose reductions occurred as needed. 2. Review of the 11/1/05 through 12/31/05 physician's orders for resident #7 revealed an order dated 12/30/04 for Zyprexa (antipsychotic) 5 milligrams (mg) daily. Review of the entire medical record revealed there was no dose reduction attempted and no documentation as to why a dose reduction was contraindicated. Further review of the medical record revealed the Zyprexa was not evaluated by a physician or the facility since 3/16/05.	F 331	2. RN/LPN staff have been re-educated on the facility Policy and Procedure for psychotropic medications. 3. The use of Zyprexa by resident #7 has been evaluated by her physician and documentation has been completed. 3a. All Residents receiving Psychotropics will have gradual dose reductions unless contra-indicated. 4. The IDT will continue to review the reports of the Consulting Pharmacist. The QA activity monitoring the physician response to the IDT/Pharmacist recommendations and will be re-instituted and continued for a minimum of one year. An additional QA activity will be reported quarterly that monitors all residents receiving a psychotropic medication and the status of dose reduction efforts. Results will be reported to the QA committee. (Attachment #6) 5. The Director of Nursing Services is responsible for compliance with the standard.	1/13/06 1/13/06 1/11/06
F 430 SS=D	483.60(c)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities 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 assure the pharmacist's reports were acted upon by the	F 430		

PRINTED: 12/23/2005
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 _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 430	Continued From page 25 physician for two of fourteen sample residents (#24, #40). The findings were: 1. Review of the medical record for resident #24 revealed the pharmacist had made recommendations to the physician regarding the use of Zyprexa (antipsychotic) on 4/5/05 and again on 10/4/05. There lacked evidence the physician had acted upon either report. On 12/14/05 at 6:40 PM, the administrator confirmed the reports were not acted upon by the physician. 2. Review of the 11/1/05 through 12/31/05 physician's orders for resident #40 revealed he/she received Haldol (antipsychotic) for symptoms of abnormal weight loss since 2/22/05. Review of the drug regimen review for 5/6/05 revealed a recommendation by the pharmacist to clarify the diagnosis of abnormal loss of weight for Haldol. Review of the 10/4/05 consultation report from the pharmacy showed the pharmacist was again requesting an acceptable diagnosis for the use of Haldol. In addition, the 10/4/05 consultation report showed the pharmacist recommended discontinuation of the Haldol and a re-evaluation of the resident's need for antipsychotic drug therapy. There was no physician response to the 5/6/05 and 10/4/05 pharmacy recommendations. Interview with the administrator on 12/14/05 at 11:05 AM confirmed there was no evaluation to show why the resident was on the Haldol, nor was there a review by a physician since 3/10/05.	F 430	483.25(1)(2)(ii) This facility will ensure that the pharmacist will report any irregularities and these reports must be acted upon. This will be accomplished by, but not limited to: 1. The pharmacy recommendations regarding the use of Zyprexa by resident #24 has been acted upon by the physician and documentation placed in the chart. 2. The pharmacist recommendations regarding the use of Haldol for resident #40 have been acted upon by the physician and documentation placed in the chart. 3. Resident #40 has received an assessment for the use of Haldol. The care plan has been updated based on the results of the assessment. 4. The IDT will continue to review the reports of the Consulting Pharmacist. The QA activity monitoring the physician response to the IDT/Pharmacist recommendations will be re-instituted and continued for a minimum of one year. Results will be reported to the QA committee. (Attachment 6) 5. The Director of Nursing Services is responsible for compliance with the standard.	1/9/06 1/13/06 1/13/06 For all residents 1/11/06