STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING _____ B. WING _____	03/12/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 determined to be met on 2/26/20. The findings were: 1. 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 [DATE] and a re-entry MDS assessment dated [DATE]. The following concerns were identified: a. Review of the medical record showed no evidence the resident's representative was notified of the transfer. b. 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. c. 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. 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 2/26/20. b. Disciplinary action to the nurse involved was completed. c. The facility implemented a new process where nursing staff are to call a member of leadership for any transports to the emergency 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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 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 [DATE] 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 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 readmitted from the hospital on [DATE]. 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 [REDACTED]. 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 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.

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

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F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** 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 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 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.