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Wyoming Department of Health
Office of Healthcare Licensing and Surveys

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Office of Healthcare Licensing and Surveys

NAME OF FACILITY		DATE OF SURVEY
ASPEN WIND	4010 N. COLLEGE DRIVE CHEYENNE, WYOMING 82001	6/30/09
SUMMARY OF DEFICIENCY	FACILITY PLAN OF CORRECTION Susan	FACILITY COMPLETION DATE
Wyoming Department of Health Aging Division Rules For Program Administration of Assisted Living Facilities. Chapter 12 Section 7. Assisted Living Facility (ALF) Core Services. (b) Resident Assessment and Services. (iv) Frequency of assessment. An assessment must be conducted: (B) Immediately upon any significant change in the resident's mental or physical condition. **This REQUIREMENT was not met as evidenced by:** Based on observation, resident and staff interview, and medical record review, the facility failed to assess significant declines in function for 2 of 2 sample residents (#1, #2) who had been transferred to an acute care facility, and for 4 of 4 sample residents (#3, #4, #6, #7) who were residing in the facility at the time of the survey The findings were: Refer to Section 8, Services Which Cannot Be Provided By The Level I Assisted Living Facility Staff, for details related to the failure of the facility to assess significant changes in resident status in the following situations: 1. Resident #1 required routine staff assistance for six months due to a loss of independence regarding catheter care. In addition, the resident declined in transfers/mobility ability and required	Section 7. Assisted Living Facility (ALF) Core Services. The facility will ensure that resident assessments will be conducted immediately upon any significant change in resident's mental or physical condition by: A)Director of Assisted Living, Kelly Milatzo, RN will conduct an assessment immediately upon any significant change of residents mental or physical condition. Executive Director to monitor for compliance. Quality audit review team to meet quarterly to monitor for compliance. B) Director of Assisted Living, Kelly Milatzo, RN. has followed LaVida Communities policy # CPO1-002 which states level of care assessments will be completed upon admission, 30 days after admission, quarterly, and upon any change of condition lasting 7 days or longer. Executive Director will monitor for compliance. Quality audit review team to meet quarterly to monitor for compliance. 1)Resident #1 transferred to Acute care facility. Significant changes should have been addressed and a	8/4/09

Administrator's Signature 8/3/09 Date

Accepted POC 8/4/09 8/5/09 @ 1PM w/ Susan Sparks, Manager. Exit Held 8/5/09 8/7/09

routine staff assistance for two months prior to being transferred to another facility due to an acute condition. 2. For a six month period, resident #2 exhibited safety concerns due to falls and elopement. In addition, the resident became incontinent of urine and stool and required routine incontinence care for a period of two months prior to being transferred to another facility due to an emergency medical condition. 3. For at least the last year, resident #3 experienced increased confusion and increased wandering. 4. For the last six months, resident #4 had safety issues related to increased wandering. 6. For the last four months, resident #6 had safety issues regarding increased falls and increased confusion. 7. For the last six months, resident #7 required routine staff assistance due to increased confusion and incontinence. Section 8. Services Which Cannot Be Provided By The Level I Assisted Living Facility Staff.	(30) day written notice to transfer to higher level of care should have been instituted. 2)Resident #2 transferred to Acute care facility. Significant changes should have been addressed and a (30) day written notice to transfer to higher level of care should have been instituted. 3)Resident #3- Family has been given a (30) day written notice to transfer resident #3 to higher level of care. State guidelines and company policies will be complied with. 4)Resident #4- Family has been given a (30) day written notice to transfer resident #4 to higher level of care. State guidelines and company policies will be complied with. 6)Resident #6 transferred to Alzheimer's care unit. (30) day written notice to transfer should have been instituted regarding the significant changes. 7)Resident #7- Family has been given a (30) day notice to transfer resident #7 to higher level of care. State guidelines and company policies will be complied with. Section 8. Services which cannot be provided by level 1 Assisted Living facility staff. The facility will ensure that accurate assessments will be conducted to determine a residents appropriateness for Assisted Living Level I services by: A) Director of Assisted Living Kelly	8/4/09
(a) The following services cannot be provided: (i) Continuous assistance with transfer and mobility; (iv) Provision of catheter or ostomy care; e.g., changing of catheter or irrigation of ostomy; total assist with appliance care/changing; (vi) Care of residents whose wandering jeopardizes the health and safety of the resident; (vii) Incontinence care by facility staff; (x) Care of the resident with inappropriate social behavior; e.g., frequent aggressive, abusive, or disruptive behavior. **This REQUIREMENT was not met as evidenced by:** Based on observation, resident and staff		

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interview, and medical record review, the facility failed to comply with the limitations of assisted living services for 2 of 2 residents (#1, #2) who were recently transferred due to acute medical conditions. In addition, a higher level of care than could be provided by assisted living facility staff was provided to 5 of 9 sample residents (#3, #4, #5, #6, #7) who were currently residing in the facility. The findings were: 1. According to the closed medical record, resident #1 was admitted on 5/16/05 with a suprapubic catheter. Review of the 4/8/08 ALF102 showed the resident was independent with mobility. The following concerns were noted with facility staff providing routine catheter care and assisting the resident with transfers and mobility: a. Review of the 4/22/09 needs and services plan showed a 5/13/09 note that documented the resident routinely required two staff members to assist with transfers. The plan also documented the resident required "total assist" with toileting and staff assistance each shift to empty the resident's foley catheter. The plan further documented routine staff assistance was required to change the resident's catheter bags, and to rinse and hang the bags to dry. b. Review of narrative charting dated 4/18/09 documented staff performed catheter care for the resident. Narrative charting dated 4/20/09 documented two caregivers had to lift and transfer the resident. c. During interviews with caregivers #1 on 6/11/09 at 9 AM, #3 on 6/12/09 at 5:12 AM, #2 on 6/12/09 at 5:22 AM, and #5 on 6/29/09 at 6:05 PM, each caregiver stated the resident required total assistance with transfers/mobility and urinary catheter needs. In addition, caregivers #3 and #5 stated the	Milatzo, RN will conduct initial, no earlier than one (1) week prior to admission and at a minimum annually an accurate standardized reproducible assessment of each residents functional capacity, physical assessment and immediately upon any significant mental and physical condition. Executive Director to monitor for compliance. Quality audit review team to meet quarterly to monitor for compliance. B) Director of Assisted Living Kelly Milatzo, RN has followed LaVida policy CPO1-OO6 change in condition and reporting protocol. If after 7 days the residents status has not improved, the level of care assessment is revised and the Executive Directorto monitor for compliance. Quality audit review team to meet quarterly to monitor for compliance. 1)Resident #1 transferred to acute care facility.	

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resident had required routine catheter assistance and care for "about six months." Caregiver #5 further stated the resident had required two staff members to assist with his/hers transfers/mobility for a period of two months. d. Medical record review showed no assessment for the significant decline noted during the last six months, or indication the facility had considered alternative placement to a higher level of care. The resident was discharged from the facility on 5/14/09 due to an acute medical condition.		
2. According to the closed medical record, resident #2 was admitted on 1/4/08 with diagnoses that included dementia. Review of the 1/8/08 ALF102 showed the resident exhibited appropriate behavior, and was motivated and capable of performing activities of daily living. The resident was also assessed as continent of bowel and bladder, independent with mobility, and exhibited appropriate behavior. The following concerns were identified regarding the resident's safety and decline in independence due to wandering and aggressive behaviors, falls, and incontinence: a. Review of the 7/1/08 ALF102 showed the resident had experienced a decline in cognition as evidenced by intermittent confusion and agitated behavior. Review of the 1/28/09 needs and services plan showed the resident required "reminders" due to wandering. In addition, staff intervention was required to distract and redirect the resident due to confusion and falls. b. Review of a12/23/08 note to the physician showed the resident was found outside the facility trying to get into a car. The resident stated	Resident #2 transferred to acute care facility.	

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s/he was "trying to get the heck out of here." The note also documented the resident's hands were very cold. The following day, 12/24/08, a progress note documented the resident was very confused and a "high flight risk." The note further documented the resident could not communicate well and did not make sense. A 12/28/08 note to the physician documented the facility received a phone call informing the statff that a resident was walking down the street. The note further documented the resident was found walking down the street, and the physician was notified. Narrative charting dated 2/3/09 documented the resident was found outside of the building without a coat, shoes, or other appropriate clothing.

c. Review of progress notes dated 12/24/08, 12/29/08, and 1/27/09 revealed the resident "yelled" at staff when they attempted to take vital signs. Narrative charting dated 5/10/09 documented the resident "hit" another resident with a knife and "yelled" at him/her during breakfast. A note to the physician on 5/28/09 documented the resident was found in another resident's room and "screamed", "yelled", "cussed", and then "smacked" the caregiver across the face. The note further documented the resident's behavior had "changed drastically," and "the resident hit other residents and yelled at everyone." A note to the physician dated 6/1/09 documented a change in the resident's condition citing increased combative behavior toward staff and "yelling for people who were not at the facility." Narrative charting dated 4/15/09 documented the resident stated s/he was dying and felt people were trying to poison her/him. Narrative

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charting dated 5/17/09 showed the resident was found sleeping in the wrong room and bed, and thought it was his/her room.

d. Review of notes to the physician and/or narrative charting dated 4/13/09, 4/18/09, 4/26/09, and 5/17/09 showed the resident was found on the floor in various locations within the facility. Another note to the physician on 5/16/09 showed the resident was found on the floor in the hallway "using shoes as a pillow." During interviews on 6/29/09 with caregivers #5 at 6:05 PM, and #6 at 6:20 PM, they both stated the resident had experienced an increase in falls for a period of six months.

e. Review of narrative charting dated 5/12/09, 5/13/09, 6/5/09, and 6/8/09 showed the resident was saturated with urine and, at times, would not allow staff assistance with incontinence care. Narrative charting dated 5/18/09 documented the resident was incontinent of stool, which had become "usual" with the resident. The note further documented the resident "yelled and screamed at staff and sometimes was very abusive."

f. Interviews with caregiver #1 on 6/11/09 at 9 AM, #3 on 6/12/09 at 5:12 AM, #2 on 6/12/09 at 5:22 AM, #5 on 6/29/09 at 6:05 PM, and #6 on 6/29/09 at 6:20 PM revealed the resident required routine incontinence care. Caregivers #5 and #6 also stated the resident had experienced an increase of incontinence during the last two months.

g. Record review showed no assessment for the decline in functional status. Also, there was no indication the facility had considered alternative placement to a higher

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level of care prior to the resident being transferred from the facility on 6/9/09 due to an acute emergency medical condition.

3. According to the medical record, resident #3 was admitted on 1/4/08 with diagnoses of dementia and post cerebral vascular accident. The following safety concerns were noted in regard to the resident's confusion and wandering:
   a. Review of the 1/29/09 needs and services plan showed the resident required "reminders" from staff for person, place, and time due to confusion.
   b. Review of narrative charting and notes to the physician documented the following safety issues: On 9/7/08 the physician was notified concerning the resident's elopement from the building. On 1/17/09 the resident was found outside the building and stated s/he was "looking for the new baby." On 2/22/09 the resident wandered outside the building and was assessed as confused. On 5/25/09 a passerby came to the facility and asked if a person who was outside was one of the residents. The note further documented that resident #3 was found outside, north of the facility and across the high traffic street.
   c. During interviews on 6/29/09 with caregivers #5 at 6:05 PM and #6 at 6:20 PM, both caregivers stated the resident was not safe outside because s/he could not independently return to the facility. Caregiver #5 also stated that over the last year the resident had exhibited increased wandering behaviors and confusion.
   d. Medical record review showed no assessment for the significant decline in the resident's safety awareness, or indication the facility had considered

(30) day written notice for resident #3 to transfer to higher level of care has been instituted. State guidelines and company policy will be complied with.

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a higher level of care for the resident. 4. According to the medical record, resident #4 was admitted on 3/30/07 with a diagnosis of dementia. Review of the 1/30/09 needs and services plan showed the resident required staff "reminders" due to confusion. The following safety concerns related to wandering were noted: a. Medical record review showed narrative charting and a note to the physician dated 3/27/09 that documented the resident was found outside at 10:45 PM on the sidewalk, with no coat or walker, and needed staff assistance to return inside. A 3/29/09 physician's note showed the resident was diagnosed with dementia. Narrative charting on 6/9/09 documented the resident was found outside the building. Narrative charting on 6/15/09 documented the resident was "more and more confused" and was found wandering the halls in his/her underwear.	(30) day written notice for resident #4 to transfer to higher level of care instituted. State guidelines and company policy will be complied with.
Narrative charting on 6/24/09 documented the resident was found in the facility's north parking lot. The resident was assessed as confused and incontinent of urine. b. Interviews on 6/29/09 with caregivers #5 at 6:05 PM and #6 at 6:20 PM revealed the resident would leave the facility to look for family members. The resident was not aware of the outside environment and dressed inappropriately for the weather. Both caregivers stated the resident had exhibited the wandering behavior for about six months. Both caregivers also stated the resident was not safe outside because s/he could not independently return to the facility. c. Medical record review showed no evidence of an assessment for the	

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decline in the resident's safety due to increased confusion and wandering, nor had the facility considered a higher level of care for the resident.	
5. According to the medical record, resident #5 was admitted on 4/21/09 with diagnoses which included dementia. The following safety concerns were noted due to wandering and inappropriate social behavior: a. Review of a 5/4/09 note to the physician documented the resident eloped from the facility and was outside for an "unknown period of time." b. Review of a 4/28/09 note to the physician showed the resident was in another resident's room and put on the other resident's clothing. The documentation also showed resident #5 "pushed" the other resident. Review of a 4/30/09 note to the physician documented the resident went into another resident's room and removed his/her clothing down to the underwear. In addition, the resident was "up all night looking for a little red dot on a box all over the building." Review of a 5/21/09 note to the physician revealed the resident followed a child into another resident's room. When asked to leave, resident #5 refused, grabbed another resident's walker, and refused to give it back. Review of narrative charting on 5/22/09 showed the resident had "increased behaviors of dementia and sundowners." A 5/23/09 note to the physician stated the resident was "making threatening gestures toward staff." The note also documented the resident "was becoming very hard to redirect and became argumentative when staff attempted redirection." c. During interviews on 6/29/09 with caregivers #4 at 5:45 PM, #5 at 6:05	(30) day written notice for resident #5 to transfer to higher level of care has been instituted. State guidelines and company policy will be complied with.

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PM, and #6 at 6:20 PM, each stated the resident had been confused since admission. In addition, caregivers #4 and #6 stated the resident often wandered into other residents' rooms, and was sometimes verbally aggressive.

d. Review of the resident's 4/21/09 needs and services plan showed wandering and inappropriate social behavior was not addressed.

e. Medical record review showed no assessment of the resident's wandering or inappropriate aggressive social behavior. In addition, there was no evidence the facility had considered a higher level of care for the resident.

6. According to the medical record, resident #6 was admitted on 2/1/08 with diagnoses which included dementia. Review of the ALF102 dated 1/21/09 showed the resident was occasionally incontinent and intermittently confused. The following concerns were noted concerning safety, inappropriate social behavior, and staff performance of incontinence care:

Resident #6 transferred to Alzheimer's care facility.

a. Review of the 2/18/09 needs and services plan showed the resident required standby assistance for toileting, and staff was to check and assist the resident every two hours with his/her incontinence brief.

b. A note to the physician on 4/24/09 documented the resident fell three times that day and a certified nurse aide assisted the resident with his/her brief due to urinary incontinence. A note to the physician on 4/25/09 documented the resident had fallen four times in 24 hours. In addition, a note to the physician dated 5/14/09, and narrative charting on 6/18/09, showed the resident also fell on those days.

c. Review of a 6/2/09 note to the

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physician revealed the resident was more confused, and ambulated in the halls without wearing an incontinent brief or pants. Narrative charting dated 6/14/09 showed the resident was "verbally aggressive" toward staff. Narrative charting on 6/15/09, 6/16/09, and 6/17/09 documented the resident had wandered into other residents' rooms, sometimes late at night. Narrative charting on 6/19/09 and 6/20/09, further documented the resident was found in other residents' rooms and was aggressive toward staff. In addition, narrative charting on 6/28/09 documented the resident walked down the hall wearing only a shirt and an incontinence brief, and was incontinent of stool.

d. Observation on 6/11/09 at 1:40 PM showed the resident was toileted by caregivers #1 and #7. The resident was incontinent of urine and received perineal care.

e. Review of narrative charting dated 6/14/09 showed the resident was found in another resident's bed, and was incontinent of urine. The note further documented staff performed incontinence care for the resident. Narrative charting on 6/15/09 documented the resident was incontinent of stool, but would not allow staff to change his/her incontinence brief.

f. Interviews with caregivers #1 and #7 on 6/11/09 at 1:50 PM, #3 on 6/12/09 at 5:12 AM, #2 on 6/12/09 at 5:22 AM, #5 on 6/29/09 at 6:05 PM, and #6 on 6/29/09 at 6:20 PM revealed the resident was frequently incontinent, and staff was required to perform incontinence care. In addition, caregivers #5 and #6 stated the resident was confused and had experienced an increase in falls over the last four months.

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g. During an interview with the surveyor on 6/11/09 at 12:20 PM, the resident made statements that s/he was at his/her private residence living with the resident's deceased spouse.

h. Medical record review showed no assessment for the decline in the resident's medical status due to increased confusion, incontinence, and falls, and there was no indication the facility had considered a higher level of care for the resident.

7. According to the medical record, resident #7 was admitted on 12/13/06 with diagnoses which included organic brain syndrome. The following concerns were noted related to resident safety and staff provision of incontinence care:

a. On 6/11/09 at 1:40 PM an attempt by the surveyor to interview the resident was unsuccessful. The resident was not able to answer simple questions, and occasionally said words that did not make sense.

b. Review of the 1/29/09 needs and services plan showed the resident required prompting every two hours for toileting.

c. Review of narrative charting showed the resident was assessed as confused on the following days: 11/7/08, 2/14/09, 5/20/09, and 5/29/09. Interview with caregiver #5 on 6/29/09 at 6:05 PM revealed the resident had been confused for at least the last six months.

d. Review of narrative charting on 1/31/09, 3/13/09, 3/20/09, 3/26/09, 5/14/09, and 6/11/09, showed the resident was incontinent of urine and/or stool. The notes also documented staff was required to perform incontinence care, change the bed, and clean the wall and floor due to the resident's incontinence. In addition, narrative charting

(30)day written notice for resident #7 to transfer to higher level of care instituted. State guidelines and company policy complied with.

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documented the resident was incontinent of urine and/or stool during the following night shifts: 5/31/09, 6/1/09, 6/4/09, 6/5/09, 6/6/09, 6/7/09, 6/8/09, 6/11/09 and 6/12/09. During interviews with caregivers #1 on 6/11/09 at 9 AM, #8 and #9 on 6/11/09 at 3 PM, #2 on 6/12/09 at 5:22 AM, and #5 on 6/29/09 at 6:05 PM each stated the resident was frequently incontinent if not prompted by staff to toilet every two hours, and routinely required incontinence care. In addition, caregiver #5 revealed the resident's incontinence had increased for the last six months.

e. Medical record review showed no assessment for the decline in the resident's medical status due to increased confusion and incontinence, and there was no indication the facility had considered a higher level of care for the resident.

During an interview with the manager on 6/12/09 at 12:20 PM, he stated the facility had not assessed significant changes in functional status or considered any alternative placement for residents #1, #2, #3, #4, #5, #6, #7. The manager further stated that each of the seven residents received services that Level I facilities are not allowed to provide.

> Last paragraph replaced - see attached last paragraph. - dg

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incontinence, and there was no indication the facility had considered a higher level of care for the resident.

During an interview with the manager on 6/12/09 at 12:20 PM, he stated he did not know if the residents had been assessed for significant changes or considered for alternative placement to a higher level of care, but would check with the resident care director (RCD). The manager also said he and the RCD had discussed alternative placement to a higher level of care for some residents, but he could not identify the specific residents.

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8/5/09