PRINTED: 10/23/2012
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Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF026	A. BUILDING _____ B. WING _____	C 10/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER TRAIL ASSISTED LIVING	2360 REAGAN AVENUE ROCK SPRINGS, WY 82901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
SALF	LIC REGS FOR ASSISTED LIVING FACILITIES The following common abbreviations are used throughout this document: CNA Certified Nurse Aide MAR Medication Administration Record TAR Treatment Administration Record LPN Licensed Practical Nurse ADL Activities of Daily Living RN Registered Nurse Less commonly used abbreviations will be annotated in each deficiency. WYOMING DEPARTMENT OF HEALTH AGING DIVISION RULES FOR PROGRAM ADMINISTRATION OF ASSISTED LIVING FACILITIES CHAPTER 12 Section 7. Assisted Living Facility (ALF) Core Services. (a) (viii) (G) Care of the resident who can independently manage his own catheter or ostomy, e.g, resident who can change his own catheter bags, able to clean and care for his ostomy; This REQUIREMENT is not met as evidenced by: Based on medical record review and staff and resident interview, the facility failed to ensure 1 of 10 sample residents (#4) was appropriate for the assisted living level of care. The findings were: Review of the medical record for resident #4 showed s/he moved into the facility on 9/23/12.	SALF	Deer Trail Assisted Living will be abbreviated as DTAL Resident Assistance Plans are referred to as care plans The DTAL Wellness Program Director is the RN referred to in Chapter 12 regulations Resident file is also referred to as resident chart Quality Assurance is referred to as QA **DTAL will comply with Chapter 12 Core Care Services referring to catheter care** Resident #4 was re-evaluated related to ability to perform independent catheter care. The resident was found to be capable to perform independent care of the catheter, and a contract is in place with a hospice service to change out the foley catheter as ordered. The resident's care plan was updated. Education in-service was provided to DTAL direct care staff related to the resident's updated care plan.	

Dina Godby-Ware Administrator
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

12/5/2012
(X6) DATE

Accepted on 12/5/12 by

gf 10/5/12

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SALF	Continued From page 1 Review of the resident assessment dated 9/27/12 showed the resident had an indwelling catheter. Further review showed the catheter bag needed to be changed 3 times per day, and "at least once at night." Review of the resident service plan dated 9/27/12 showed the care of the indwelling catheter would be performed by a "care partner." Interview with the administrator on 10/10/12 at 9:20 AM verified a care partner was a staff CNA. The service plan indicated the CNA would empty, change and clean the catheter bag for the resident. Interview with the resident on 10/10/12 at 9:30 AM verified s/he was unable to independently care for the catheter stating, "I can't take care of it myself." Further interview with the administrator on 10/10/12 at 12:30 PM revealed the level of care being provided to the resident was viewed as assistance. Lack of nursing medication review: (a) The assisted living facility core services include the following: (ix)(A) Registered Nurse medication review every two (2) months or sixty-two (62) days or whenever new medication is prescribed or the resident's medication is changed; This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure a review of medications was performed every sixty two days or when medications were changed or added for 8 of 10 sample residents (#1, #2, #8, #9, #10, #12, #13, #14). The findings were: Review of the medical records for residents #1, #2, #8, #9, #10, #12, #13, and #14 showed no evidence their medication regimens were evaluated every two months or when medications	SALF	Other resident's having catheters will be reviewed to determine appropriate level of care. Any new residents admitted will be evaluated for appropriate level of care related to caring for catheters. An audit will be developed and conducted by Wellness Program Director RN to evaluate all resident's with catheters, and their ability to independently care for their catheters or have appropriate out-side services in place. The results of these audits will be presented to the Quality Assurance (QA) committee at monthly meetings for the next 3 months to ensure compliance. **<u>Medication Review will be done when medications are changed and/or every two months.</u>** Medications for residents #1, #2, #8, #9, #10, #12, #13, #14 have been reviewed by an RN. All residents will have a medication review completed by an RN every 60 days as required. The nursing staff have been educated to this requirement. An audit was developed and will be used to ensure all resident's medications are reviewed. This will be completed on	12/10/2012

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SALF	Continued From page 2 were changed or added. Interview with the administrator on 10/9/12 at 3:30 PM verified no medication reviews had been performed for any residents since their admission. Interview with LPN #1 on 10/10/12 at 2:40 PM also verified no medication reviews were performed for any residents since admission. Lack of admission orders and/or history and physical: (b) Resident Assessment and Services. (ii) Admission orders. A resident shall be admitted only if accompanied by a history and physical completed by a physician or physician extender within ninety (90) days prior to admission. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policies and procedures, the facility failed to ensure there were physician admission orders prior to admission for 6 of 10 sample residents (#2, #4, #8, #12, #13, and #14). In addition, the facility failed to ensure a history and physical (H&P) was performed prior to admission for 10 of 10 sample residents (#1, #2, #3, #4, #8, #9, #10 #12, #13, #14). The findings were: 1. Review of the medical record for resident #4 showed s/he moved into the facility on 9/23/12; however, there were no physician orders until 10/4/12. Review of the 10/4/12 physician admission orders showed the resident was receiving hospice care, was on a "no concentrated sweets" diet, and included unclear orders related to physical therapy and occupational therapy. In addition, there were no medications listed. The admission orders referred to a hospice list for the medications; however, the	SALF	the 10th day of resident charts every month to ensure the review is completed. Results of these audits will be reported to the QA committee for review of progress. 12/10/2012 **Admission orders and history and physicals will be obtained and filed in resident charts prior to move-in** Physician admission orders and history and physicals are filed for residents #1,#2,#3,#4,#8,#9,#10,#12,#13,#14. All other residents have admission orders and history and physicals. An admission packet was developed to ensure that new residents will all have current physician admission orders and history and physicals. All staff was educated on the above requirements. A chart audit is in place. The results of the chart audit will be presented to the QA committee at monthly meetings to ensure compliance. 12/10/2012	

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SALF	Continued From page 3 referred to medication list was not included in the medical record. In addition, there was not any H&P included in the medical record for the resident as of 10/10/12. 2. Review of the medical record for resident #12 showed s/he moved into the facility on 2/16/12 and moved out on 8/24/12. Review of the physician admission orders showed they were dated 4/12/12, almost two months after the date the resident moved into the facility. In addition, there was no H&P available for this resident. 3. Review of the medical record for resident #14 showed s/he moved into the facility on 2/20/12 and moved out on 9/21/12. Review of the closed resident file failed to show any physician admission orders or any H&P. 4. Review of the medical record for resident #8 showed s/he moved into the facility on 3/6/12. Review of the entire resident record showed no evidence the facility obtained admission physician orders and there was no H&P available. 5. Review of the medical record for resident #13 showed s/he moved into the facility on 2/18/12. Review of the physician admission orders showed they were dated 4/12/12, nearly two months after the resident was admitted to the facility. In addition, there was no H&P performed for this resident. 6. Review of the medical record for resident #2 showed s/he moved into the facility on 2/23/12. Review of the admission physician orders, however, showed they were not written until 7/11/12, almost five months after the resident was admitted to the facility. In addition, there was no H&P available in the file for this resident.	SALF		

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SALF	Continued From page 4	SALF		

7. Review of the medical record for resident #10 showed s/he moved into the facility on 3/19/12; however, there was no H&P in the record until 4/6/12.

8. Review of the medical record for resident #1 revealed s/he was admitted to the facility on 6/8/12 but had no H&P available in the record.

9. Review of the medical record for resident #3 showed s/he was admitted to the facility on 9/14/12 but had no H&P available.

10. Review of the medical record for resident #9 showed s/he was admitted to the facility on 6/26/12 but had no H&P performed.

11. Interview with the administrator on 10/10/12 at 12:30 PM verified admission orders were not always obtained prior to admission, and that H&P's were lacking. Further she verified unclear orders needed to be clarified with the physician.

12. Review of the facility policy on admission and discharge criteria, dated 10/10/11, showed "Residents will only be admitted based upon a physician's or physician's assistant order...Admissions to the community are accepted after...physician's orders, physician's history and physical (completed within 90 days prior to admission), and nursing....assessments have been met. Medication regimen and special treatment orders will be verified at time of admission."

Lacking immunization status/screening:

(b) (ii) (A) Admission orders shall include an order for TB screening, influenza and pneumococcal

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SALF	Continued From page 5 immunization status and orders for immunization if required, unless contraindicated. The facility must develop and implement policies and procedures to ensure the following: Residents, or their legal representative, are educated regarding the risks and benefits of these immunizations. The immunizations are offered unless medically contraindicated or the resident is currently immunized. If the resident is not vaccinated, the medical record must reflect the reason, such as medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of facility policies and procedures, the facility failed to ensure physician admission orders included tuberculosis (TB) screening, and influenza and pneumococcal immunization status for 10 of 10 sample residents (#1, #2, #3, #4, #8, #9, #10, #12, #13, #14). The findings were: Review of the medical records for residents #1, #2, #3, #4, #8, #9, #10, #12, #13, and #14 showed no evidence of immunization status for influenza, pneumonia, or TB screening. Further review of the medical records showed no education of the risks and benefits of immunization were provided to the residents or families, no influenza or pneumococcal vaccine was offered to the residents, and no TB testing was provided. Interview with the administrator on 10/11/12 at 11:10 AM verified the immunization status of these residents was not obtained, nor was education provided to residents or families, and no testing or immunizations were offered. Lack of assessing mental and physical change:	SALF	**DTAL will develop and implement policies and procedure to ensure: residents, or their legal representative, are educated regarding the risks and benefits of TB screening, influenza and pneumococcal immunization. Resident will be currently immunized unless contraindicated by physician. Documentation will be in resident chart:** Policies are in place reflecting the above. Nursing staff was educated on the Policy. Residents #1,#2,#3,#4,#8,#9,#10, #12, #13, #14 immunizations are complete, noted, and filed in their respective charts. All other resident's immunizations are complete as well. Education on immunizations was provided to all residents and their families. A physician immunization order form is in the "admission packet" to ensure compliance. An audit is in place and will be presented to the QA committee at the monthly meeting.	12/10/2012 12/10/2012

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SALF	Continued From page 6 (b) (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 is not met as evidenced by: Based on medical record review, staff interview, and review of policies and procedures, the facility failed to ensure medical and/or physical issues were assessed in a timely manner for 4 of 10 sample residents (#2, #3, #9, #13). The findings were: 1. Review of the medical record for resident #13 showed s/he was admitted to the facility on 2/18/12. Further record review showed s/he had diagnoses including congestive heart failure, apical hypertrophic cardiomyopathy, and chronic obstructive pulmonary disease. The following concerns with a change in condition and new or additional physician orders were identified: a. Review of the physician's admission orders showed an order for a low salt diet, less than 1200 milligrams per day. However, review of the 3/23/12 assessment showed s/he was provided a regular diet. Interview with the administrator on 10/11/12 at 11:10 AM verified there were no dietitian notes to address this resident's special diet. She also verified the resident did receive a regular diet while in the facility. b. The physician ordered daily weights on 4/11/12 due to exacerbation of the resident's congestive heart failure. However, review of the medical record showed no evidence weights were taken daily. c. Review of the medical record showed s/he had diagnoses including anxiety. Review of the admission physician orders showed an order for	SALF	**Resident assessments will be conducted one week prior to admission and upon any significant change in resident's mental or physical condition.** Assessments were completed for resident's #2, #3, #9, #13. All other resident charts were reviewed for required assessments and have been completed. Use of "change in condition" form was implemented for nursing staff to use to ensure compliance. All nursing staff were educated on this assessment compliance process. A chart audit will be done by Wellness Program Director. Information will be presented to the QA committee at its monthly meeting.	12/10/2012

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SALF	Continued From page 7 Xanax (antianxiety) 0.25 mg twice daily as needed. Review of the April 2012 MAR showed the resident was administered Xanax 19 times. Further review showed no evidence the resident's level of anxiety was re-assessed after the Xanax was administered to determine the effectiveness of the medication 14 out of the 19 times it was administered. Interview with the administrator on 10/11/12 at 9:20 AM verified no re-assessments were performed but should have been. 2. Review of the medical record for resident #9 showed a physician's order dated 10/9/12 for daily weights. Review of the entire medical record showed no evidence the resident's weight was obtained on 10/10/12 or 10/11/12. Interview with LPN #1 on 10/11/12 at 10 AM revealed the order was new and had not yet been implemented. In addition, review of the 6/21/12 physician's orders for this resident showed an order to check his/her temperature every week. Review of the October 2012 MAR showed no evidence the resident's temperature was checked as scheduled on 10/9/12. Interview with LPN #1 on 10/10/12 at 2:40 PM revealed both the facility thermometers were broken on that day and as of 10/11/12, the thermometers had not been repaired or replaced. 3. Review of the nursing communication notes for resident #2 showed s/he complained of chest pain on 6/27/12. Review showed his/her vital signs were obtained and were within normal limits, however, there was no evidence the resident was monitored or assessed again until two days later on 6/29/12. Interview with the administrator on 10/11/12 at 9:20 AM revealed staff should not have waited two days to follow-up on the resident's complaints of chest pain. 4. Review of the admission physician's orders for	SALF		

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SALF	Continued From page 8 resident #3 showed s/he had diagnoses including diabetes, hypertension, hypothyroidism, and Alzheimer's disease. Further review showed orders for weekly weights, and daily blood pressure (B/P), temperature and pulse readings. Review of the MAR/TAR for September 2012 and October 2012 showed these orders were not followed as written. The deficiencies were as follows: a. The resident's pulse was not obtained on 9/19/12 and 9/25/12 according to the vital sign flow sheet for September 2012. In addition, the pulse was not obtained on 10/1/12, 10/2/12, 10/4/12, 10/5/12, 10/6/12, 10/8/12, or 10/10/12 according to the MAR/TAR for October 2012. b. The resident's temperature was taken only on 10/3/12, not daily as ordered. c. The resident's weight was not obtained the first two weeks of admission. d. The resident's B/P was not obtained on seven days; from admission on 9/14/12 through 10/8/12 Interview with LPN #1 on 10//11/12 at 10 AM verified the physician's orders were not followed as written. 5. Review of the facility policy and procedure on admission and discharge criteria, dated 10/10/11 showed "11. The nursing staff implements the care plan:...g. re-assessment to be initiated immediately upon any significant change in the resident's mental or physical condition." According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, nursing must function under the direction of a licensed physician. Lack of medication management assessments:	SALF		

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SALF	Continued From page 9 (b)(iii) The Registered Nurse shall make an initial assessment of the resident's needs, which describes the resident's capability to perform ADLs and notes all significant impairments in functional capability. (A) Initial assessment. A current assessment shall be maintained in each resident's file. (B) The assessment shall include at least the following information: (XI) Medication regimen. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure medication management was adequately assessed for 2 of 10 sample residents (#9, #10). The findings were: 1. Review of the medical record for resident #10 showed s/he moved into the facility on 3/19/12. The physician admission orders dated 3/19/12 showed the resident had 10 medications which included an antipsychotic medication olanzapine. Review of the orders failed to show any recommendation or order related to how medications should be managed for this resident. Review of the "in progress" resident assessment signed by the licensed nurse on 3/16/12 showed the resident reported s/he was independently taking medications while living alone; however, the family had concerns "wondering if medication administration has been adhered to properly." The assessment also showed the resident would require "employee partners assist/administer medications up to 3 [times] per day with 4 or fewer medications per pass." Further review of the medical record failed to show any final assessment or a resident service plan. The following concerns were identified related to medication management for this resident:	SALF	**Medication Management assessments will be completed and maintained in each resident chart:** A medication form for assessing resident ability to take own medications has been used to evaluate resident's #9, #10. All other residents that are self-administering medications were evaluated as well by the RN. Staff was educated on compliance for medication management assessments. A medication management audit is in place. This information will be presented to the QA committee at the monthly meeting.	12/10/2012

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SALF	Continued From page 10 a. Review of the 4/26/12 nurse's note showed the resident would be allowed to self-administer medications under nurse supervision. However, there was no evidence of any evaluation or assessment to show this was a safe method for medication management. b. Review of an 8/5/12 late entry nurse's note for 8/3/12, showed the resident experienced a medication error. The note showed the resident received PM medications in the AM and the AM meds in the PM. c. Interview with LPN #1 on 10/11/12 at 9:15 AM verified the resident's medications were kept by nursing. During medication passes, they would deliver the medications to the resident who then opened the bottles and self-administered while nursing staff observed. The LPN also verified there was nothing documented related to this resident's medication management plan. In addition, she was unaware of any investigation done in relation to the medication error in August. 2. Observation of a medication pass on 10/9/12 at 5:30 PM revealed LPN #1 placed a medication cup with three medications including Metoprolol (antihypertensive), Claritin (for allergies) and Allopurinal (for gout) on the table for resident #9 and then walked away. Interview with the LPN at 5:40 PM on that same day revealed she always left medications at the table for the resident because s/he was particular about taking them whenever s/he wanted. The LPN said she usually went back periodically to check to make sure the resident took the medications. Review of the undated service assistance plan showed the resident required employee partners to administer medications. Lack of resident assistance plans:	SALF		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF026	A. BUILDING _____ B. WING _____	C 10/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER TRAIL ASSISTED LIVING	2360 REAGAN AVENUE ROCK SPRINGS, WY 82901

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SALF	Continued From page 11 (b) (vi) Resident assistance plan. (A) An RN shall develop an assistance plan for each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to use the results of the nurse assessment to develop an individualized resident service/assistance plan for 2 of 10 sample residents (#10, #13). The findings were: 1. Review of the medical record for resident #10 showed s/he moved into the facility on 3/19/12. Review of the resident assessment showed it was dated by the RN on 3/16/12 prior to the resident moving in, and was "in progress." Interview on 10/10/12 at 12:30 PM with the administrator, who was also the RN that completed the initial assessment, verified a re-assessment was needed for this resident and a service plan was yet to be developed. The administrator/RN also acknowledged there were other residents that were in need of re-assessments and service plans. 2. Review of the medical record showed resident #13 was admitted to the facility on 2/18/12. Review of the admission physician orders showed s/he had diagnoses including atrial fibrillation, congestive heart failure, lower extremity edema, hypokalemia, generalized anxiety, and hypo magnesia. Review of the entire medical record showed no evidence a service plan was developed or implemented during his/her entire three month stay to address his/her chronic disease state or to plan for his/her care needs. Interview with the administrator on 10/11/12 at 11:10 AM verified there was no	SALF	**<u>The Wellness Program Director (RN) will develop an assistance plan for each resident:</u>** The Wellness Program Director (RN) has done care plans for resident's #10, #13. All other residents have care plans as well. Staff was educated on the use of the care plans. A care plan log was developed for use by the staff to ensure care plans are complete and updated as needed. A review of the log will be made and presented in the QA committee.	12/10/2012

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SALF	Continued From page 12 service assistance plan for this resident. 3. Review of facility policy on admission and discharge criteria, dated 10/10/11 showed "The Wellness Program Director/RN shall develop a Care Plan for each resident." Medication Administration issues: (d) Medications. (v) Medication Administration (A) An RN shall be responsible for the supervision and management of all medication administration as required by the Wyoming Nurse Practice Act, and the Wyoming Board of Nursing Rules and Regulations. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure medications were administered per physician order and according to nursing standards of practice during one of one medication pass. This failure affected sample residents #2, and #8. The findings were: 1. Observation of a medication pass on 10/9/12 showed resident #8 was administered Ocuvite (eye vitamin) 1 tablet, Metoprolol (anti-hypertensive) 50 milligrams (mg), and Zoloft (antidepressant) 50 mg at 5:20 PM. The resident also had Xalatan 0.005 % eye drops for administration. Review of all physician orders showed no order for the Xalatan eye drops, Ocuvite, Metoprolol, or Zoloft. Interview with the LPN on 10/10/12 at 2:40 PM revealed this resident's medications were originally provided by a home health agency so there were no admission orders for medications. She said they obtained a list from the home health agency when	SALF	**<u>An RN shall be responsible for the supervision and management of all medication administration as required by the Wyoming Nurse Practice Act, and the Wyoming Board of Nursing Rules and Regulations:</u>** The Wellness Program Director (RN) has reviewed the current physician medication orders and medications for resident's #2, #8 and has observed the medication pass on these residents. The same has been done for all other residents. DTAL staff has been trained on medication management. An audit tool is in place to comply with physician medication orders. This information will be shared with the QA committee at the monthly meeting. 12/10/2012	

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SALF	Continued From page 13 the facility began to administer the resident's medications. However, the LPN said the facility never called the physician to verify the list of medications from the home health agency. She acknowledged there were no actual physician orders for the Metoprolol, Zoloft, Xalaton eye drops, or Ocuvite that were administered. 2. Review of the admission physician orders dated 7/11/12 for resident #2 showed an order for an Exelon patch daily to treat memory loss. Observation during medication pass on 10/9/12 at 5 PM revealed the resident had no Exelon patch applied or in place. Interview with LPN #1 at on 10/10/12 at 2:40 PM revealed the resident was not on an Exelon patch. Review of the October 2012 MAR showed no Exelon patch was listed as a current medication. However, review of the medical record showed no physician order to discontinue the Exelon patch. Interview with the LPN on 10/10/12 at 2:40 PM verified there was no physician's order to discontinue the medication and she was unsure why it had been. In addition, review of the October 2012 MAR showed the resident received aspirin 81 mg daily. However, review of the medical record showed no physician's order for the daily aspirin. 3. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, nursing must function under the direction of a licensed physician. Lack of individual resident records: (e) Resident Records and Reports. Each resident's records shall be current, organized and maintained in individual folders which shall be made available to the resident, the	SALF	**<u>An individual chart (record) will be kept for each resident</u>** One chart each for resident's #1, #2, #3, #4, #8, #9, #10, #12, #13, #14 is kept in the nursing clinical room with all information required by Chapter 12. Each resident has an individual chart with the information required by Chapter 12. All staff has been educated that an individual resident chart is required by Chapter 12 The Wellness Director, RN has created an individual chart for each resident and reviewed for completeness. Chart audit is in place for compliance. This information will be shared with the QA committee at the monthly meeting. 12/10/2012	

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SALF	Continued From page 14 Licensing Division, or designated representative upon request. (i) Each folder shall include the following: (D) All accidents, injuries, incidents, illnesses, and allegations of abuse, neglect or exploitation shall be reported to the resident's family or responsible party and be documented in the individual resident records. All such occurrences shall also be reported to the appropriate entity for follow up and resolution. Reports of all incidents affecting the health, welfare or safety of a resident shall be provided to the Licensing Division immediately (within one business day). Reporting shall be done by telephone or fax. The facility's investigation of the incident shall be reported to the Licensing Division and the Long Term Care Ombudsman within five (5) working days. Documentation to support the facility reporting the situation and follow up must also be present in the resident records; This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure resident records were complete and contained in an individual file for 10 of 10 sample residents. In addition, 2 of 2 known resident incidents were not reported to the state licensing and survey agency. The findings were: Review of medical record information for sample residents #1, #2, #3, #4, #8, #9, #10, #12, #13, and #14 showed there were two records kept for each resident. One file per resident was maintained in the administrator's office, another in the nursing office. The resident file in the administrator's office contained the nursing assessment and the resident service plan, along with other resident information. The resident files	SALF		

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SALF	Continued From page 15 the nurses kept did not consistently include the assessment or the service plan, and there were no nursing notes in either file. Further review showed a spiral notebook labeled nursing communication. Review of this book showed there were clinical nursing notes chronologically by date for all of the residents. Interview with LPN #1 on 10/10/12 at 2:40 PM verified the clinical nursing notes were not kept in the individual resident records. Lacking documentation on Incidents: 1. During an interview with the administrator on 10/9/12 at 3PM, she revealed the facility did not maintain an incident log. However, the administrator revealed there was one case of an allegation of financial abuse involving a resident (#12). Review of email correspondence dated 8/9/12 and 8/10/12, the only documentation related to this case, showed an investigation had been started and involved the adult protective services and the state ombudsman office. There were measures put into place to protect the resident during the investigation; however, a conclusion was not evident. In addition, the required report and follow up to the state licensure agency was not done. Review of the resident's record failed to show any information related to any incident report. Interview with the administrator on 10/9/12 at 3 PM revealed she was not aware this allegation needed to be reported to the licensing and survey agency. 2. Review of the nursing communication notes for resident #1 showed on 9/24/12 a bruise of unknown origin was discovered on his/her right arm. Further review of the notes showed administration was notified. Interview with the administrator on 10/11/12 at 9:20 AM revealed	SALF	**Reports of all incidents affecting the health, welfare or safety of a resident shall be provided to the Licensing Division immediately (within one business day). Reporting shall be done by telephone or fax. DTAL's investigation of the incident shall be reported to the Licensing Division and the Long Term Care Ombudsman within five working days. Documentation to support DTAL's reporting the situation and follow up will also be present in the resident records.** Documentation of incidents on resident #1, #12 is complete. All future incidents will be documented and reported as required All staff was educated on Chapter 12 requirements for incidents. Incident log is in place to track reporting of incidents. Results will be shared with the QA committee at the monthly meeting. 12/10/2012	

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SALF	Continued From page 16 she was aware of the bruise and an investigation was performed; however, there was no documentation of the investigation and the incident was not reported to the healthcare licensing and survey office. Lack of implementation for resident grievance process: (g) Grievance procedure The written grievance procedure shall establish a system of receiving, reviewing, and alleviating concerns, complaints and allegations of resident rights violations, and poor service provided to include, but not limited to: Resident's method to express and document grievances; Documentation of the provider's response to verbal and written resident grievances; List of agencies, with address and telephone numbers for resident to contact if grievances are not addressed satisfactorily (e.g ., State Long Term Care Ombudsman and the Depart of health, Office of Licensing and Surveys): and The facility shall provide written reports of the grievances and resolutions to the Ombudsman and the Licensing Division within ten (10) days after the grievance is filed. The written grievance procedure shall be posted in a conspicuous place within the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of information provided to residents upon admission, and review of facility policies and procedures, the facility failed to ensure a process was in place for residents to voice grievances and recommend changes in polices and services. The census was 11. The findings were:	SALF	**DTAL will implement a process whereby residents can voice grievances and recommend changes in policies and services by:** DTAL has Grievance Policy with Procedure. Grievance procedure is posted at the reception desk. All residents are informed of the grievance policy/procedure during the admission/ lease process and given a copy. DTAL staff has been educated on the Grievance Policy and Procedure. The Life Enrichment Director facilitates the Resident Council meeting monthly. Minutes are taken and filed. Minutes will be shared at the QA monthly meeting to ensure all concerns and grievances are followed up on. This process for reporting grievances was reviewed with the residents at the resident council meeting	12/10/2012

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SALF	Continued From page 17 1. Observation of the notice posted in the lobby, near the reception area, showed the state licensure and survey agency name, address, and number were not included. In addition, the posting did not include the steps a resident could take in filing a written grievance. According to the facility policy and procedure, developed 10/10/11, A "Grievance" form will be kept at the reception desk at all times. However, interview with the receptionist on 10/9/12 at 2:30 PM revealed she was unaware of any forms or that there were supposed to be forms for residents to file a grievance. Review of the admission information given to residents upon admission contained the same information as the posted notice which was incomplete. 2. Review of facility documents showed a resident council meeting was established for residents to address concerns they had. These meetings were coordinated by the life enrichment director and were scheduled to meet on a monthly basis. Review of the resident council minutes showed meetings were not held in May, June, or August of 2012. Review also revealed no evidence issues brought up were addressed or resolved. For example, review of meeting minutes, undated, showed residents stated they would like to have heated plates for their meals. Continued review showed no evidence this request was followed up or acted upon. Review of these same undated minutes showed one resident had missing items from his/her apartment. Further review of minutes again revealed no evidence this issue was investigated or resolved. Interview with the administrator on 10/11/12 at 11:31 AM verified there had been months when resident council meetings were not held because of turnover in staff. The	SALF		

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SALF	Continued From page 18 administrator also verified there had not been good follow-up to resident concerns that may have been brought forward in meetings. Lack of registered dietitian involvement: (j) Food Service and Nutrition (i) Assisted Living Facilities that choose to admit residents who need therapeutic or mechanically modified diets must employ or contract with a Registered Dietitian who shall approve written menus and dietary modifications, approve special diet needs, plan individual diets, and provide guidance to dietary staff in areas of preparation, service, and monitoring. The frequency of visits is determined by the residents' needs and the competency of the dietary staff but must include at least a monthly onsite review of dietary services. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of consultant reports, and staff interview, the facility failed to ensure special physician ordered diets were provided for 3 of 3 sample residents with special diets. The findings were: 1. Review of the physician's admission orders for resident #13 showed an order for a low salt diet, less than 1200 milligrams per day. However, review of the 3/23/12 assessment showed the resident was on a regular diet. Interview with the administrator on 10/11/12 at 11:10 AM verified there were no registered dietitian (RD) notes to address this resident's special diet. She also verified the resident received a regular diet while in the facility. 2. Review of the 10/4/12 physician orders for	SALF	**DTAL will contract with a Registered Dietician who will approve written menus, dietary modifications, special diet needs, plan individual diets, and provide guidance to dietary staff in areas of preparation, service and monitoring. There will be a minimum of monthly onsite review of dietary services.** DTAL has a contract with a Registered Dietician. The RD has reviewed the physician's dietary requirements for residents #4, #13, #10 and created individual dietary cards for these residents for use by the kitchen staff. The RD has also reviewed the physician's dietary orders for all other residents and created dietary cards for each resident. DTAL staff has been educated on the Chapter 12 Registered Dietician requirements. A monthly chart audit is in place by the RD. Dietary requirements for residents will be given to the QA committee at the monthly meeting.	12/10/2012

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SALF	Continued From page 19 resident #4 showed a "no concentrated sweets" diet order. Review of the resident assistance plan showed the diet was "regular" not requiring any alteration. 3. The admission physician orders dated 3/19/12 for resident #10 showed an order for a "no concentrated sweets" diet. Review of the record showed there was not any service plan, or any further documentation related to how this resident's diet needed to be modified. 4. Review of the registered dietitian reports for April, May, August, and September 2012 (there were no June and July reports) showed the RD made comments related to cleaning and sanitation issues in the kitchen and dining rooms. However, the reports did not show any mention of specific residents or any special diet orders and needed modifications. 5. Interview with cook #1 on 10/11/12 at 11:15 AM verified they did not have any special diets, and there were not individualized diet cards. The meal service system used was for staff to ask each resident their meal preference from the options available and the portion size they would like prior to each meal. Lack of sanitary conditions: (j) Food Service and Nutrition (vi) The kitchen and dining area shall be kept clean and sanitary in accordance with standards established in the current edition of FDA Food Code. The dining area shall provide suitable furniture and adequate space to comfortably seat all residents. This REQUIREMENT is not met as evidenced by:	SALF	**The kitchen and dining area shall be kept clean and sanitary in accordance with standards established in the current edition of FDA Food Code. DTAL will comply by:** DTAL has hired a Certified Dietary Manager (CDM) as of October 29. Food in the kitchen areas are dated and labeled correctly Cleaning logs are in place to maintain sanitary conditions. Kitchen staff have been educated on Chapter 12 requirements. Information will be shared at QA monthly meetings. The RD is available to the CDM by e-mail or phone if needed between RD visits.	12/10/2012

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SALF	Continued From page 20 Based on observation and staff interview, the facility failed to ensure sanitation and food safety measures in 2 of 2 kitchens. The findings were: 1. Observation on 10/9/12 at 2 PM in the memory care kitchen and at 2:35 PM in the main kitchen showed unlabeled/dated foods being stored in refrigerator units. In the memory care kitchen refrigerator there were two bags of an unknown product labeled with a resident name but no date. There were also two bowls of what appeared to be ice cream or butter that were not covered, dated, or labeled. In the main kitchen walk-in refrigerator, there was a container of orange gelatin with fruit that was not covered or dated. In this same walk-in, there was a container with 12 hardboiled eggs that was labeled "boiled eggs 9/28/12" Interview with cook #2 on 10/9/12 at 2:40 PM verified the date indicated when the food was made, and the eggs should not be kept for more than one week. The cook then threw out the eggs which had been in the walk-in and available for consumption for 11 days. According to Food Code 2009, U.S. Public Health Service: 3-501.17 "(A) ...refrigerated, ready-to-eat, potentially hazardous food (time/temperature control for safety food) prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days." 2. Observation of the main kitchen on 10/9/12 at 2:35 PM revealed the removable hood vents located above the range/fryer unit were in need of cleaning. There was a noticeable build-up of grease and dust on the vents. Interview with the	SALF		

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SALF	Continued From page 21 dietary manager on 10/11/12 at 10:10 AM verified the hood vents were on a cleaning schedule and they were scheduled to be cleaned once per month. She was unsure of the last time they were cleaned. According to Food Code 2009, U.S. Public Health Service: 4-601.11"...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." Lack of qualifications for dietary manager: (j) Food Service and Nutrition (iii)(A) Day to day responsibilities for food production and management of the dietary services shall be assigned to a person with nutrition and food service management experience equivalent to that of a Certified Dietary Manager. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of enrollment information, the facility failed to ensure the minimum qualifications were met for the dietary manager. The findings were: Interview with the dietary manager on 10/11/12 at 10:10 AM revealed she did not meet the requirement for being a certified dietary manager. However, she verified she was enrolled in a certification program at that time. Review of the course information materials showed the manager was enrolled in the University of North Dakota course as of 5/8/12. The expected completion for the course was estimated to be twelve months. Lack of quality improvement program:	SALF		

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SALF	Continued From page 22 (l) Quality Improvement. (i) The facility shall have an active quality improvement program to ensure effective utilization and delivery of resident care services. (B) The quality improvement program shall encompass a review of all services and programs provided for all residents. The program shall have: (I) A written description; (II) Problem areas identified; (III) Monitor identification; (IV) Frequency of monitoring; The REQUIREMENT was not met as evidenced by: Based on staff interview, no quality improvement program was currently in place. The census was 11. The findings were: Interview with the administrator on 10/11/12 at 9:20 AM revealed the facility had no written quality improvement program description, no problem areas identified, no monitoring identification or frequency of monitoring established. She said the only thing the facility did currently was meet every Friday to talk about goals accomplished and set priorities for tasks to do the following week. Lack of required policies and procedures: (m) Facility Policies and Procedures. (i) Management shall develop policies and procedures that are available to residents and staff, including but not limited to: (O) Incident reports; (R) Identification and notification of change in resident's condition.	SALF	**DTAL will have an active quality improvement program:** DTAL has implemented a QA program with a written plan outlining how problem areas will be identified, how data will be collected and analyzed, how interventions will be developed and implemented, and the frequency of monitoring to sustain improvement. A QA committee was established and is responsible for the oversight of the QA program. The Committee will meet weekly until well established. Members of the QA committee include the administrator, the wellness program director, the Assistant Administrator, the certified dietary manager, the maintenance director, and the administrative assistant. The administrator will serve as the coordinator of the QA program. Minutes of the meetings will be written and maintained. All cited deficiencies will be included in the QA program for correction and sustained improvement.	12/10/2012

12/5/12

PRINTED: 10/24/2012
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF026	A. BUILDING _____ B. WING _____	C 10/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER TRAIL ASSISTED LIVING	2360 REAGAN AVENUE ROCK SPRINGS, WY 82901

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SALF	Continued From page 23 The REQUIREMENT was not met evidenced by: Based on review of policies and procedures and staff interview, the facility failed to have all of the required policies and procedures in place. The findings were: Interview with the administrator on 10/11/12 at 11:10 AM verified the facility did not have policies and procedures regarding incident reports and identification and notification of a change in a resident's condition. Section 10. Secure Dementia Units. Lack of required education/training: (c) Level 2 Direct Care Staff. In addition to meeting all other requirements for direct care staff stated in this Chapter, assisted living Level 2 direct care staff must receive additional documented training in: (i) The facility or units philosophy and approaches to providing care and supervision of persons with severe cognitive impairment; (ii) The skills necessary to care for, intervene, and direct residents who are unable to independently perform activities of daily living; (iii) Techniques for minimizing challenging behaviors: (A) Wandering; (B) Hallucinations, illusions, and delusions; and (C) Impairment of senses; (iv) Therapeutic programming to support the highest level of residents function including: (A) Large motor activity; (B) Small Motor activity; (C) Appropriate level cognitive tasks; and (D) Social/emotional stimulation;	SALF	**DTAL will have all required policies and procedures to include incident reports and identification and notification of change in resident's condition** All required policies and procedures are in place. A new-employee orientation agenda is in place. New employees #1, #2, #3, #4, #9, #11, #12 have been oriented and documentation is in their individual employee file. Employee education is part of the Quality assurance plan **DTAL will comply with need for additional documented training for Level 2 direct care staff by:** DTAL has a contract with a state recommended Alzheimers/dementia expert to provide the required training for staff. DTAL also uses inservices, DVDs and internet sites for continuing education. All nursing staff is educated on the required Alzheimer/Dementia training requirements.	12/10/2012