86 3/5/13

PRINTED: 02/07/2013
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 _____	R-C 01/17/2013

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 WYOMING DEPARTMENT OF HEALTH AGING DIVISION RULES FOR PROGRAM ADMINISTRATION OF ASSISTED LIVING FACILITIES CHAPTER 12 The following common abbreviations are used throughout this document: RD Registered Dietitian CDM Certified Dietary Manager Less commonly used abbreviations will be annotated in each deficiency. Section 7. Assisted Living Facility (ALF) Core Services. (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 observation, staff interview, medical record review, and review of the menu, the facility	{SALF}	Other abbreviations used throughout this document: DTAL Deer Trail Assisted Living WPD Wellness Program Director. The WPD is an RN QI quality improvement QA quality assessment **DTAL will ensure that the contracted RD will:** **Approve written menus to include portion sizes** **Approve dietary modifications** **Approve special diet needs** **Plan individual diets** **Provide guidance and education to dietary staff in areas of preparation, service, and monitoring** The RD will visit DTAL at least monthly to review resident dietary orders and ensure that the above stated dietary compliance is met and dietary staff is educated	~~12/5/12~~

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

Administrator
TITLE

2/13/2013
(X6) DATE

Accepted w/ No changes on 3/5/13 by Admin Tina Godby-Ware notified Sandra Re DOC all tags = 3/17/13

3/15/13

PRINTED: 02/07/2013
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 _____	R-C 01/17/2013

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}	Continued From page 1 failed to ensure the physician diet orders were followed for 2 of 2 residents (#13, #14) with therapeutic diets. In addition, the facility failed to ensure the menus were planned to include portions to be nutritionally adequate. The findings were: 1. Interview with the RD and CDM on 1/15/13 at 2:45 PM revealed the therapeutic diets were not being followed. The RD who was responsible to make the dietary modifications and instruct the staff said she was unable due to time and illness to complete the needed menu modifications and education to the dietary staff. Review of the documentation kept in the kitchen for therapeutic diets showed three residents had therapeutic diets; however, when medical records were reviewed, the following residents had therapeutic diets ordered: a. Resident #14 showed the undated diet order was for "no concentrated sweets." b. Resident #13 had a 10/9/12 diet order for a "low sodium diet." c. Resident #4 had a "no added sodium, limited concentrated sweets" diet ordered upon admission. d. Resident #5 had a "low sodium/low fat" diet ordered on 11/28/12. 2. Review of the 5 week cycle facility menu showed there were no portion sizes on the menu. In addition, there were no instructions to show any modifications needed to follow various diets (no concentrated sweets, low sodium). Observation on 1/15/13 at 5:05 PM showed the menu for the evening meal was a grilled ham and cheese sandwich and soup. Cook #1 was serving resident meals and when she was asked what the portion size was for the soup, she stated it was 2	{SALF}	The RD and CDM have created a QI monitoring tool to ensure the above is accomplished. This QI tool will be implemented and completed monthly by the CDM and reported quarterly at the QA committee meeting. Appropriate follow-up actions will be initiated by the QA committee.	3/17/2013

8A 3/15/13

PRINTED: 02/07/2013
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 _____	R-C 01/17/2013

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}	Continued From page 2 ounces. Observation showed this was the portion served. The cook stated all of the residents were served small portions and 2 ounces of soup was served to all the residents. Interview with the CDM on 1/15/13 at 5:20 PM verified there were no planned portion sizes. She further revealed a diet manual was available (Becky Dorner & Associates, Inc. Diet manual 2011) and when reviewed, it showed a small portion for soup was 4-6 ounces. At that time the CDM verified standard portion sizes needed to be used and she needed the RD to help in setting up the menu to include these as well as modifications for therapeutic diets. Section 7. Assisted Living Facility (ALF) Core Services. (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 1 of 9 sample residents (#2). The findings were: 1. Review of the medical record for resident #2 showed s/he had a diagnoses of Alzheimer's dementia. Review of the 1/9/13 nurse charting timed at 4:14 PM revealed the resident had a coughing/choking spell in which s/he became cyanotic and was gasping for air. Further review showed the paramedics were called at which time the resident's respirations and color returned to normal. The nursing notes indicated staff would "continue to monitor" the resident, however,	{SALF}	**DTAL will ensure that an assessment is conducted immediately upon any significant change in a resident's mental or physical condition.** The WPD will interview nursing staff daily and educate them to keep current on any immediate resident changes. An assessment will be completed by the WPD if needed. A change of condition assessment was completed on resident #2 by the WPD. Nursing staff was educated on resident needs. A change of condition QI monitoring tool has been created and implemented by the WPD to ensure immediate change of condition assessments are completed and signed. This tool will be completed monthly and reported at the quarterly QA committee meeting. Appropriate follow-up actions will be initiated by the QA committee.	3/17/2013

8E 3/5/13

PRINTED: 02/14/2013
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 _____	R 01/17/2013

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}	Continued From page 3 review of the entire medical record showed no evidence any further assessment or monitoring of the resident's condition post incident was performed. Interview with the DON on 1/16/13 at 11:50 AM revealed a follow-up assessment and monitoring should have been performed for a period of time after the incident. (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 review of the medical record, and staff interview, the facility failed to ensure service plans included all required elements and were updated to reflect the current needs and services provided to 6 of 9 sample residents (#2, #4, #5, #8, #9, #16). The findings were: 1. Review of the 12/10/12 service plan for resident #9 revealed it failed to include all the required elements to show what, when, where, by whom, and how the assessed resident needs would be provided for. The needs included the areas of activities, falls, and medication monitoring related to Coumadin therapy. 2. Review of the 11/12/12 service plan for resident #8 revealed it failed to include all the required elements to show what, when, where, by whom, and how the assessed resident needs would be provided for. The identified needs included the areas of activities and current catheter care being provided by a home health contract. 3. Review of the 12/10/12 service plan for resident #16 revealed it failed to include all the	{SALF}	**DTAL will ensure that the WPD will develop a current service plan of care for each resident that includes the who, what, when, where and how the assessed resident needs will be provided for. The WPD will educate appropriate staff on the plans of care for the residents.** Current service plans of care that includes the who, what, when, where and how have been created and implemented by the WPD for residents # 8, #9, #16, #2, #5, and #4. Education on the plans of care to the appropriate DTAL staff has been done. The WPD has created and implemented a QI monitoring tool that will be completed monthly and reported quarterly at the QA meeting. Appropriate follow-up actions will be initiated by the QA committee.	3/17/2013

3/5/13

PRINTED: 02/07/2013
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 _____	R-C 01/17/2013

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}	Continued From page 4 required elements to show what, when, where, by whom, and how the assessed resident needs would be provided for. The needs included the areas of adjustment and grief, wandering, depression, altered sleep cycle, hallucinations/delusions, activities, falls, and medication monitoring related to psychotropic medications. 4. Review of the 8/8/12 service plan for resident #2 revealed it failed to include all the required elements to show what, when, where, by whom, and how the assessed resident needs would be provided. The needs included the areas of elopement, wandering, communication, and activities. 5. Review of the 11/15/12 service plan for resident #5 revealed it failed to include all the required elements to show what, when, where, by whom, and how the assessed resident needs would be provided. The needs included the areas of confusion, wandering, inappropriate behaviors, dressing and grooming, bathing, toileting assistance, and medication monitoring. 6. Review of the 10/18/12 service plan for resident #4 revealed it failed to include all the required elements to show what, when, where, by whom, and how the assessed resident needs would be provided. The needs included the areas of wandering, behaviors, communication, dressing and grooming, bathing, toileting, sensory assistive devices, and mobility. 7. Interview with the DON on 1/16/13 at 10:55 AM verified the service plans did not provide the required elements and needed to include more information. She further stated the computer program populated fields from the assessments;	{SALF}		

2/6/13

PRINTED: 02/07/2013
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 _____	R-C 01/17/2013

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}	Continued From page 5 however, then the approaches needed to be developed and typed into the service plan. (e) (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 incidents were investigated and reported to the State Licensing and Survey agency for 2 of 2 incidents involving resident #2. The findings were: Review of the 1/2/13 nursing notes timed at 7:39 PM for resident #2 showed two bruises were noted on the right hip. Further review of the notes revealed the resident did not know how the bruises were obtained. Review of all the subsequent nursing notes showed there was no additional or follow up information in regard to the bruises. Review of the incident log for January 2013 showed no evidence the two bruises were reported or investigated. In addition, review of the	{SALF}	**DTAL shall ensure that each resident file shall include all accidents, injuries, incidents, illnesses, and allegations of abuse, neglect or exploitation. These shall be reported to the family or responsible party and be documented in the individual resident records. Reports of all incidents affecting the health, welfare or safety of a resident shall be provided to the Licensing Division within one business day. 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 be present in the resident records.** DTAL staff has been educated on the DTAL incident policy and will fill out incident forms that are faxed to the Licensing Division and are then given to the WPD and the Administrator so that the Administrator can enter these into the QI incident monitoring log and an internal investigation done. Reporting to the Licensing Division will be done as required above. An incident form has be completed, an internal investigation done, log entry made for bruising and choking incidents on resident #2.	

3/5/13

PRINTED: 02/14/2013
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 _____	R 01/17/2013

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}	Continued From page 6 1/9/13 nursing notes timed at 4:14 PM for the same resident showed s/he had a coughing/choking episode severe enough staff called the paramedics. However, there was no evidence this incident was reported or investigated either. Interview with the DON on 1/16/13 at 11:50 AM revealed she was not aware of the two bruises noted on 1/2/13. She said she was aware of the coughing/choking incident and verified that neither incident was investigated or reported as required. Section 9. Contractual Services Provided Outside Assisted Living Facility Authority. "Residents in an assisted living facility may receive services from an outside entity for care beyond that provided for or specified in the Assisted Living Program Administration Rules. These services must be arranged by the appropriate professional and be incorporated into the resident's assistance plan. The resident's choice of providers must be honored. (a) Components of the outside service(s) contract: (i) Who will provide service(s); (ii) What service(s) will be provided; (iii) When the service(s) will be provided; (iv) Where the service(s) will be provided; (v) How the service(s) will be provided; and ..." This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the contracted services were included in the resident service plans for 2 of 2 sample residents (#8, #9) who were receiving contracted services. The findings were:	{SALF}	Incidents from the QI monitoring tool will be presented at the QA quarterly committee meeting. Appropriate follow-up will be done by the QA committee. **DTAL has a "Contractural Services" policy in place.** The WPD has completed service plans of care that include who, what, when, where, and how the contractural services will be provided for residents #8, and #9. Orders for these services are in the resident files. DTAL staff has been educated on the policy and service plans of care. A QI monitoring tool has been created and implemented by the WPD to be completed monthly and presented at the quarterly QA committee meeting. Appropriate follow-up actions will be initiated by the QA committee.	3/17/2013 3/17/2013

3/5/13

PRINTED: 02/14/2013
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 _____	R 01/17/2013

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}	Continued From page 7 Interview with the wellness program coordinator on 1/16/13 at 11:35 AM revealed residents #8 and #9 were receiving contracted services from home health agencies. Review of these residents' medical records revealed the service plans failed to include the details of the services being provided by these contracted home health agencies. In addition, there were no notes, orders, or communications in the records related to these services which were provided. Continued interview with the DON stated she would call these agencies and have the orders faxed. Review of the faxed documentation showed resident #9 had home health certification and a plan of care dated 12/28/12. Review of the orders for resident #8 showed a home health certification and plan of care dated 12/21/12. Interview with the administrator on 1/16/13 at 12:15 PM verified there was not any facility policy and procedure related to contracted services and responsibilities.	{SALF}		

HEALTHCARE LICENSING AND SURVEYS

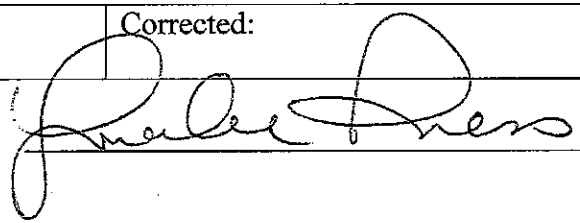
Revisit Report for State Deficiencies Corrected
"B" Form

Facility Name: Deer Trail Assisted Living City: Rock Springs
Springs

Date of Follow-up Visit: 1/17/13 Follow-up to Survey Date of: 10/11/12

Tag #: Sect 7 Core Services: Incontinence/Catheter Independance Date Corrected: 12/10/12	Tag #: Core Services: Nursing medication review Date Corrected: 12/10/12	Tag #: Core Service: lack of admission orders and H&P Date Corrected: 12/10/12	Tag #: Core Services: Lack of immunization status/screening Date Corrected: 12/10/12
Tag #: Core Services: Medication management assessment Date orrected: 12/10/12	Tag #: Core Services: Medication administration Date Corrected: 12/10/12	Tag #: Core Services: Grievance Procedure Date Corrected: 12/10/12	Tag #: Core Services: Qualified Dietary Manager Date Corrected: 12/10/12
Tag #: Core Services: Quality Imporvement Date Corrected: 12/10/12	Tag #: Sect 10: Secure Dementia Unit- required staff education Date Corrected: 12/10/12	Tag #: Date Corrected:	Tag #: Date Corrected:
Tag #: Date	Tag #: Date	Tag #: Date	Tag #: Date

Corrected:	Corrected:	Corrected:	Corrected:

Signature of Surveyor:  Date: 4/18/13

(Rev. 12/08/06)