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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALP014	A. BUILDING: ____ B. WING ____	10/16/2013

NAME OF PROVIDER OR SUPPLIER: SPRING WIND ASSISTED LIVING COMMUNITY

STREET ADDRESS, CITY, STATE, ZIP CODE: 1072 NORTH 22ND STREET, LARAMIE, WY 82072

(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	SALF		

WYOMING DEPARTMENT OF HEALTH
AGING DIVISION RULES
FOR PROGRAM ADMINISTRATION OF ASSISTED LIVING FACILITIES
CHAPTER 12
Section 7. Assisted Living Facility (ALF) Core Services.

The following common abbreviations are used throughout this document:

RN: Registered Nurse
DON: Director of Nursing
ADLs: Activities of daily living

Less commonly used abbreviations will be annotated in each deficiency where used.

(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:
(I) Medically defined conditions and prior medical history;
(II) Physical status;
(III) Sensory and physical impairments;
(IV) Nutritional status and requirements;
(V) Special treatments and/or procedures;

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]

TITLE: EXECUTIVE DIRECTOR

(X6) DATE: 11/7/2013

STATE FORM 6899 QUTB11

POC accepted. Call to Darrot Thiel, E.D. on 11/8/13 @ 1:00pm. Janice Cont..., ONLC

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SALF	Continued From page 1 (VI) Mental and psychosocial status; (VII) Discharge potential; (VIII) Dental condition; (IX) Activities potential; (X) Rehabilitation potential; and (XI) Medication regimen. (1.) Documentation of resident's ability to self-medicate. (iv) Frequency of assessment. An assessment must be conducted: (A) No earlier than one (1) week prior to admission; (B) Immediately upon any significant change in the resident's mental or physical condition; or (C) No less than once every twelve (12) months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the RN assessment included all required areas and was completed on an annual basis or when a significant change in status was determined for 6 of 6 sample residents (#1, #2, #3, #4, #5, #6). The findings were: 1. Review of the medical record for resident #1 showed s/he was admitted to the assisted living on 5/5/12 was moved to the dementia unit on 2/1/13, was discharged for rehabilitation on 2/15/13 and had a re-admission on 3/11/13 to the dementia unit. The RN assessment in the medical record showed it was dated 5/3/12. The assessment was done using a form titled "Nursing Screening Tool" the assessment failed to covered the required areas including discharge potential, activities potential, and dental condition. Interview with the DON on 10/16/13 at 2:45 PM verified this tool was the admission assessment.	SALF	12/01/13 The facility will ensure RN assessments will include all required areas and will be completed on an annual basis or when a significant change is determined. This will be accomplished by: A) A new RN assessment was completed on resident #2 on 10/18/13. The new assessment included discharge potential, activities potential, and dental condition. A new RN assessment was done on resident #3 on 11/01/13. The new assessment included discharge potential, activities potential, and dental condition. A new RN assessment was done on resident	

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SALF	Continued From page 2 She verified this was completed along with the ALF 102 form for each resident upon admission. The DON then stated she was unaware of the requirement to perform an annual assessment other than the ALF 102 form. She also verified this resident did not have an RN assessment completed when his/her status changed to requiring memory care services in 2/1/13, nor had a new admission assessment been done since returning to the facility in March 2013. 2. Review of the medical record for resident #2 showed s/he was admitted to the dementia unit on 12/7/12. The RN assessment was done 12/21/12 using the "Nursing Screening Tool" which failed to include the required areas of discharge potential, activities potential, and dental condition. 3. Review of the medical record for resident #3 showed s/he was admitted to the assisted living facility on 9/2/13. The RN assessment was done 9/3/13 using the "Nursing Screening Tool" which failed to include the required areas of discharge potential, activities potential, and dental condition. 4. Review of the medical record for resident #4 showed s/he was admitted to the assisted living facility on 9/12/09. Review of the medical record showed the most current RN assessment was dated in 2011. Interview with the DON on 10/15/13 at 2:45 PM revealed there was not a more current RN assessment and she was unaware of the requirement to perform an annual assessment other than the ALF 102 form. 5. Review of the medical record for resident #5 showed s/he was admitted on 5/7/13. The RN assessment was done on 5/7/13 using the "Nursing Screening Tool" which failed to include	SALF	#4 on 11/01/13. The new assessment included discharge potential, activities potential, and dental condition. Resident #1 no longer resides at this facility. Resident #6 no longer resides at this facility. B) A 100% audit of all ALF 102's will be accomplished. To ensure compliance, all resident files will be corrected to include required information such as discharge potential, activities potential, and dental condition. Additionally, every resident that needs an annual assessment or change of condition assessment will receive an updated assessment. C) A new nursing assessment that includes all required assessment criteria will be implemented facility-wide and will be used with new ALF 102's annually or with a change of condition. New assessments will also be accomplished when a resident is being moved to the memory care unit. A tickler file will be established and monitored by the DON and chart audits will be accomplished to ensure existing ALF 102's and nursing assessments are current and relevant to each resident's condition D) The DON will conduct a weekly review of the tickler file that identifies	

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SALF	Continued From page 3 the required areas of discharge potential, activities potential, and dental condition. 6. Review of the medical record for resident #6 showed s/he was admitted on 8/31/10. Review of the medical record showed the most current RN assessment was dated 9/1/10. Interview with the DON on 10/15/13 at 2:45 PM revealed there was not a more current RN assessment and she was unaware of the requirement to perform an annual assessment other than the ALF 102 form. (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, staff interview, review of investigation information, and policy and procedure review, the facility failed to ensure 3 of 3 reviewed incidents were reported to the state licensing agency as required. The findings were: 1. Review of a facility investigation dated 10/4/13 showed it was an allegation of abuse between a	SALF	residents who are due for new ALI/102's and nursing assessments. All new admissions and readmissions from the hospital will be assessed and/or reassessed with the proper forms within the required timeframes. The DON will provide evidence that she is effectively utilizing the tickler file system at quarterly quality improvement meetings. Random resident files will be evaluated by quality improvement team members as needed to ensure compliance and effectiveness of assessment tracking. 12/12/13 The facility will ensure incidents affecting the health, welfare or safety of a resident are reported to the state licensing agency as required (within one business day). This will be accomplished by:	

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SALF	Continued From page 4 contracted employee and resident (#7). The facility had informed law enforcement, department of family services, and the ombudsman. The investigation was completed and the allegation of verbal and physical abuse was found to be unsubstantiated. Upon review, there was no evidence this allegation of abuse was reported to the state licensing agency. Interview with the executive director on 10/15/13 at 12:10 PM verified the allegation was not reported to the state agency because he was not aware of this requirement for reporting. 2. Review of a emergency transfer dated 11/23/12 showed a resident to resident altercation which resulted in "several injuries" to one of the residents (#71). There was an investigation done; however, the incident was not reported to the state licensing agency. 3. Review of the medical record for resident #5 showed a nursing note dated 8/24/13 at 7 PM which documented the resident had an unwitnessed fall in his/her room. The resident could not recall how s/he fell or what caused the fall. The resident was transferred to the emergency room due to "bleeding from both nostrils and a lrg [large] hematoma above the bridge of his/her nose..." Interview with the executive director on 10/15/13 at 12:10 PM revealed he was unaware of the requirement to report significant injuries to the state licensing agency. 4. Review of the 4/2012 facility policy and procedure related to abuse prevention, intervention, reporting and investigation showed the executive director was responsible for reporting. "The Executive Director notifies the following of a suspected abuse incident: a. State	SALF	A) The abuse allegation involving resident #7 was reported on 10/16/2013. This action was taken during the survey and happened as soon as the Executive Director was made aware of the reporting requirement. Resident #71 no longer lives in the facility. Resident #5 has healed from the injury she received resulting from the unwitnessed fall on 8/24/13. Fall precautions are in place. B) Effective immediately, all resident incident reports will be reviewed by the executive director within 24 hours of occurrence to determine if resident health, welfare or safety has been compromised. Any incident meeting those criteria will be reported to the state licensing agency, the ombudsman and appropriate agencies within the proper timeframe. Any lapses in reporting by staff will be addressed by on the spot in-service and corrective action will be taken immediately. On 11/1/13 all staff members were in-serviced on the proper identification and reporting of resident abuse and neglect, including resident-to-resident issues. C) Additional training on abuse and neglect will be provided to the entire staff during the next facility all-staff scheduled for December 13, 2013 and	

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SALF	Continued From page 5 licensing/certification agency..." Section 10. Dementia Units (II) Assistance Plans for residents of secure units must, at a minimum, address the following: (A) Memory; (B) Judgment; (C) Self-care ability; (D) Ability to solve problems; (E) Mood and character changes; (F) Behavioral patterns; (G) Wandering; and (H) Dietary needs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure all required areas were identified on the assistance plans for 3 of 3 sample residents (#1, #2, #5) who resided on the dementia unit. The findings were: 1. Review of the 10/11/13 assistance/care plans for resident #1 who resided on the dementia unit showed the plan failed to include the following areas: memory, judgement, self-care ability, ability to solve problems, mood and character changes, and wandering. 2. Review of the 10/11/13 assistance/care plans for resident #2 who resided on the dementia unit showed the plan failed to include the following areas: memory, judgement, self-care ability, ability to solve problems, mood and character changes, and wandering. 3. Review of the 5/7/13 assistance/care plans for	SALF	on a quarterly recurring basis thereafter. D) A monthly quality assurance review of all incident reports will be conducted by the executive director and DON to ensure comprehensive and accurate incident reporting has occurred. A section dedicated to abuse and neglect issues will be added to the quarterly quality improvement program. The quality improvement team will implement strategies to enhance awareness of abuse and neglect issues among staff members. Appropriate follow up actions will be initiated by the quality improvement team on an on-going basis. The facility will ensure all required areas are identified on assistance plans. This will be accomplished by: A) A new assistance plan will be completed for resident #2. The new plan will include assessments of memory, judgment, self-care ability, ability to solve problems, mood and character changes, and wandering. A new assistance plan will be completed for resident #5. The new plan will	12/12/13

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SALF	Continued From page 6 resident #5 who resided on the dementia unit showed the plan failed to include the following areas: memory, judgement, self-care ability, ability to solve problems, mood and character changes, and wandering. 4. Interview with the DON on 10/15/13 at 2:45 PM verified these resident's care plans failed to address all the required areas. She stated she was unaware of the additional care areas that needed to be included for residents on the dementia unit.	SALF	include memory, judgment, self-care ability, ability to solve problems, mood and character changes, and wandering. Resident #1 no longer resides at this facility. B) Every resident on the memory care unit will have a new care plan completed that includes assessments of memory, judgment, self-care ability, ability to solve problems, mood and character changes, and wandering. C) Effective immediately, care plans that include all required areas will be completed for all new residents admitted to the memory care unit. The insufficient care plan form that was previously used has been replaced by a document that includes all required areas per section 10 rules. D) Chart audits will be completed every quarter to ensure that care plans are in full compliance with section 10 assistance plan requirements. The DON will provide evidence that quarterly audits are being accomplished at quarterly quality improvement meetings. Random resident files will be evaluated by quality improvement team members as needed to ensure compliance.	