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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
	ALF003	A. BUILDING _____ B. WING _____	C 01/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW WIND ASSISTED LIVING COMMUNI1	3955 EAST 12TH STREET CASPER, WY 82609

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SALF	LIC REGS FOR ASSISTED LIVING FACILITIES WYOMING DEPARTMENT OF HEALTH AGING DIVISION RULES FOR PROGRAM ADMINISTRATION OF ASSISTED LIVING FACILITIES Chapter 12 Section 7. Assisted Living Facility (ALF) Core Services. (lv) Frequency of assessment. An assessment must be conducted: (B) Immediately upon any significant change in the resident's condition. This REQUIREMENT was not met as evidenced by: Based on observation, medical record review, and resident, and staff interview, the facility failed to accurately and timely assess significant declines in function for 3 of 8 sample residents (#6, #7, #8). The findings were: 1. Medical record review for resident #7 showed s/he was admitted to the facility on 11/20/09 with diagnoses which included anxiety. Review of the resident's 11/1/11 ALF 102 assessment showed s/he was independent with mobility, but was intermittently confused and/or agitated, and staff was required to give the resident occasional reminders as to person, place, and time. The following concerns were noted: a. Review of the resident's nurses' notes dated 12/23/11, 1/8/12, and 1/10/12 revealed concerns with elopement. The review showed the	SALF	**Resident #7** was assessed on 1/9 and had been found to be inappropriate for assisted living. The family had been notified and the resident was placed on 15 minute safety checks. She was later placed on 24 hour 1 on 1 care until discharged on 1/23/12 **Resident#8** was determined to be inappropriate for assisted living. The facility had previously spoken with a higher level of care facility but no documentation was recorded on this issue. The facility will document all contact with other facilities in the future. She will be discharged on 2/17/2012. **Resident # 6** was determined to be inappropriate for assisted living due to incontinence issues. The family was notified and they are seeking placement in a higher level of care. In regards to assessments, these are to be done at a minimum annually or upon any significant change. The administrator, DON, and charge nurses will monitor the resident charts to ensure these state requirements are being met. A monitoring tool will be implemented in the form of a spreadsheet which shows the history of assessments that have been given and will record the dates these are updated due to significant change. This will be addressed quarterly by the quality assurance team	2/27/12

2/27/12

This POC accepted with a good to date insertion changes on 2/14/12 between Robert Ford Tammy Jarrard and Tony Madden

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SALF	Continued From page 1 resident eloped from the facility on 12/23/11 at 11 AM and was confused at that time. Further review showed the resident attempted to elope from the facility on 1/8/12 at 11:30 AM. Continued review showed the resident eloped from the facility on 1/10/12 at 4 PM and was confused. b. During an interview with the resident on 1/12/12 at 3:25 PM, the resident stated s/he did not know the place, date, day, time, or what type of facility s/he was in. c. Review of the resident's elopement risk evaluation dated 1/9/12 (17 days after the first elopement) showed the resident was at risk for elopement. Review of the record showed the facility failed to reassess the resident for increased confusion. d. During an interview with the administrator and DON on 1/13/12 at 10:20 AM, the DON confirmed the facility had not reassessed the resident, with the exception of a urinalysis on 12/23/11 after the first elopement, for increased elopement risk until 1/9/12 (17 days after the first elopement), and had not reassessed the resident for increased confusion since the 11/1/11 ALF 102. 2. Medical record review showed resident #8 had diagnoses which included dementia. Review of the resident's 11/23/11 ALF 102 assessment showed potential for substance abuse, but was not coded for behavioral safety concerns. The following concerns were noted: a. Review of the resident's nurses' notes dated 5/27/11, 11/1/11, 11/6/11, 11/7/11, 11/9/11, 11/26/11, and 11/27/11, and physician fax requests dated 7/7/11, 7/20/11, 11/9/11, and 11/10/11 revealed aggressive behavior from resident #8 toward other residents and/or staff. b. During a confidential interview with a resident on 1/12/12 at 3:30 PM, the resident	SALF		

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SALF	Continued From page 2	SALF		

stated that s/he was afraid of resident #8 because of his/her aggressive behavior. The resident stated that resident #8 tried to punch him/her once, but missed. S/he stated that the resident usually appeared to be angry. The resident also stated that resident #8 would sometimes attempt to hit staff and other residents for no apparent reason.

c. During an interview with the administrator and DON on 1/13/12 at 10:20 AM, the DON confirmed that, with the exception of the resident's 11/23/11 ALF 102 which showed no behavioral concerns, the facility failed to reassess the resident for behaviors. Instead, the administrator stated that the facility had hoped to place the resident in the level II area of the facility once it was available.

3. Medical record review for resident #6 showed s/he had diagnoses which included dementia. Review of the resident's 1/10/12 ALF 102 assessment showed s/he was occasionally incontinent and needed occasional help to clean himself/herself. The assessment also showed the resident had appropriate behavior and was well motivated to performed activities of daily living. The following concerns were noted:

a. Review of facility CNA notes revealed the aides were required to assist the resident with incontinence care twice daily on 12/24/11, 12/25/11, 12/26/11, 12/28/11, 12/29/11, 12/30/11, 1/1/12 , 1/3/12, 1/5/12, 1/6/12, 1/7/12 , and 1/12/12.

b. During an interview with the resident on 1/12/12 at 3 PM, s/he was unable answer where s/he was, the date, day, or time. Instead, the resident looked around the room and spoke random words that made no sense. The room smelled strongly of stale urine at that time, and the resident was unable to answer whether or not

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SALF	Continued From page 3 s/he might need to go to the restroom. c. On 1/12/12 at 3:10 PM, just after the interview, CNA #1 was brought to the resident's room. During an observation at that time, the aide took the resident back into the bathroom and assisted him/her with an incontinence brief and perineal care. d. On 1/12/11 at 3:20 PM, just after the observation, the aide confirmed the resident often required assistance of staff due to unawareness of incontinence, and confusion. e. During an interview with the administrator and DON on 1/13/12 at 10:20 AM, they confirmed the 1/10/12 ALF 102 did not accurately assess the resident's cognition and incontinence issues. Section 8. Services Which Cannot Be Provided By The Level I Assisted Living Facility Staff. (a) The following services cannot be provided: (vi) Care of the resident 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, medical record review, and resident, and staff interview the facility failed to ensure 3 of 8 sample residents (#6, #7, #8) who required a higher level of care had been accurately assessed for appropriate placement. The findings were: 1. Medical record review for resident #7 showed s/he was admitted to the facility on 11/20/09 with diagnoses which included anxiety. Review of the	SALF	**Resident#7** was found to be inappropriate for assisted living. Resident #7 was accepted to a higher level of care and was immediately put on 15 minute checks. Later, the residents risk elevated and she was put on 24 hour 1 on 1 care until she was discharged on 1/23/12 The charge nurse or DON will immediately assess (ALF 102) and evaluate any resident who attempts an elopement. The chance of another elopement (elopement risk will be determined immediately and family will be contacted with documentation to support this.	2/27/12

2/14/12

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SALF	Continued From page 4 resident's 11/1/11 ALF 102 assessment showed s/he was independent with mobility, but was intermittently confused and/or agitated, and staff was required to give the resident occasional reminders as to person, place, and time. Review of the resident's 7/11/11 comprehensive assessment/service plan showed the resident had not attempted to elope from the facility at any time. The following concerns were noted: a. Review of the resident's nurses' notes dated 12/23/11, 1/8/12, and 1/10/12 revealed concerns with elopement. The notes showed the resident had eloped from the facility on 12/23/11 at 11 AM and was confused at that time. Further review revealed the resident attempted to elope from the facility on 1/8/12 at 11:30 AM. The notes documented that on 1/8/12 at 5:25 PM the resident was still agitated after the attempted elopement and was redirected multiple times. Continued review showed the resident eloped from the facility on 1/10/12 at 4 PM and was confused. The notes did not specify how long the resident may have been outside of the facility during either of the two elopements, when staff found the resident wandering. b. Review of the resident's elopement risk evaluation dated 1/9/12 (17 days after the first elopement) showed the resident was an elopement risk. Review of the record showed no change to the resident's treatment plan at that time, or assessment for placement to a higher level of care. c. During an interview with resident #7 on 1/12/12 at 3:25 PM, the resident stated that s/he did not know the place, date, day, time, or what type of facility s/he was in. d. During an interview with the administrator and DON on 1/13/12 at 10:20 AM, the administrator said he had spoken via phone with the resident's daughter on 1/10/12 concerning the	SALF	An in-service will be given by the DON and administrator to all nursing staff in regards to the proper protocol to follow upon any elopement attempt. A monitoring protocol will be implemented to ensure proper handling of all elopement situations to properly address the risk a resident poses to jeopardizing their own health and safety. This protocol will consist of taking all recorded documentation of an elopement and organizing it into separate months. All elopements will be reviewed quarterly by the quality assurance team for compliance of the elopement protocol.	2/27/12

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SALF	Continued From page 5 need for a higher level of care. He further stated that a local long term care facility had agreed to admit the resident when a room became available. The administrator stated there was no documentation concerning that conversation with the resident's daughter or with the long term care facility. He stated the facility intended to send a 30-day notice to the resident's daughter that day (1/13/12). The DON confirmed the facility had not reassessed the resident, with the exception of a urinalysis obtained after the 12/23/11 elopement, for increased elopement risk until 1/9/12 (17 days after the first elopement). e. A return phone call message from the resident's daughter on 1/13/12 at 4:38 PM revealed she was unaware the resident had been considered for a higher level of care by the facility, or that a long term care facility had been contacted regarding the resident. f. Review of 1/13/12 faxed information from the facility administrator revealed a copy of a 30 -day notice (dated 1/10/12) to the resident's daughter stating the resident required a higher level of care. The letter did not mention any prior contact with the resident's daughter concerning this issue. 2. Medical record review for resident #8 showed s/he had diagnoses which included dementia. Review of the resident's 11/23/11 ALF 102 assessment showed potential for substance abuse, but was not coded for behavioral safety concerns. Review of the resident's care plan last updated on 1/6/12 showed the resident was verbally abusive and threatened others, but did not indicate the resident was physically threatening. The following concerns were noted: a. Review of the resident's nurses' notes dated 5/27/11, 11/1/11, 11/6/11, 11/7/11, 11/9/11, 11/26/11, and 11/27/11, and physician fax	SALF	**Resident #8** was assessed for aggressive behaviors and determined to be inappropriate for assisted living. Family was contacted in regards to this issue, a 30 day discharge letter was sent, and family in conjunction with our facility has found placement at a higher level of care. The resident will be discharged on 2/17/2012. The charge nurse and DON will monitor all residents for aggressive behaviors and any instance of an aggressive behavior will be immediately documented to determine the proper level of care. Continual documentation and compliance will determine the frequency of behaviors and therefore determine the appropriateness of the resident as well.	2/17/12

2/14/12

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SALF	Continued From page 6 requests dated 7/7/11, 7/20/11, 11/9/11, and 11/10/11 revealed aggressive behavior from resident #8 toward other residents and/or staff. The documentation showed the resident hit or attempted to hit other residents and staff on numerous occasions. However, no residents or staff members were injured. With the exception of the resident's 11/23/11 ALF 102 which showed no behavioral concerns, the resident was not reassessed for behaviors. b. The record showed no attempts by the resident to elope. However, a 1/6/12 elopement risk evaluation scored the resident at a 20, with 10 or higher being at risk for elopement. c. During a confidential interview with a resident on 1/12/12 at 3:30 PM, the resident stated that s/he was afraid of resident #8 because of his/her aggressive behavior. The resident stated that resident #8 tried to punch him/her once, but missed. S/he stated that the resident usually appeared to be angry. The resident also stated that resident #8 would sometimes attempt to hit staff and other residents for no apparent reason. d. During an interview with the administrator and DON on 1/13/12 at 10:20 AM, both confirmed that the resident had not been considered for placement to a higher level of care outside of the facility. Instead, the administrator stated that the facility had hoped to place the resident in the level II area of the facility once it was available. 3. Medical record review for resident #6 showed s/he had diagnoses which included dementia. Review of the resident's 1/10/12 ALF 102 assessment showed s/he was occasionally incontinent and needed occasional help to clean himself/herself. The assessment also showed the resident had appropriate behavior and was well motivated to performed activities of daily living.	SALF	The DON will give an in-service on all paperwork, documentation, communication, and any techniques for resident care that need to take place in such instance. Each aggressive behavior will be reviewed by the DON and administrator to determine if we are caring for a resident with inappropriate social behavior, e.g. frequent aggressive, abusive, or disruptive behavior. (Section 8 (X)) All aggressive behaviors will be organized by month and reviewed quarterly as well as immediately to uncover trends.	2/27/12

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SALF	Continued From page 7 Review of the resident's 8/18/11 comprehensive assessment/service plan showed the resident was oriented to time and place and behaved appropriately to the situation. The plan also showed staff were required to remind the resident on wearing a poise pad during the day and a brief with poise pad inside (for incontinence). The following concerns were noted: a. Review of facility CNA notes revealed the aides were required to assist the resident with incontinence care twice on 12/24/11, 12/25/11, 12/26/11, 12/28/11, 12/29/11, 12/30/11, 1/1/12 , 1/3/12, 1/5/12, 1/6/12, 1/7/12, and 1/12/12. b. During an interview with the resident on 1/12/12 at 3 PM, s/he was unable answer where s/he was, the date, day, or time. Instead, s/he looked around the room and spoke random words that made no sense. The room smelled strongly of stale urine at that time, and the resident was unable to answer whether or not s/he might need to go to the restroom. c. On 1/12/12 at 3:10 PM, just after the interview, CNA #1 was brought to the resident's room. The aide confirmed the room smelled of stale urine. During an observation at that time, the aide attempted to get the resident to go to the toilet, and was required to take the resident's arm and direct him/her. The resident was saturated with urine in his/her brief and additional incontinence pad. The aide set-up the clean brief and pad and left them with the resident. The resident then came out of the bathroom without a brief on and was holding the brief in his/her hand with a confused look on her face. At that time, the aide took the resident back into the bathroom and assisted him/her with the brief and perineal care. d. On 1/12/11 at 3:20 PM, just after the observation, the aide confirmed that the resident often required assistance of staff due to unawareness of incontinence, and confusion.	SALF	**Resident # 6** was re evaluated for incontinence and determined to be inappropriate for assisted living. Family has been contacted and they are seeking a higher level of care. Resident # 6 is currently on two hour toileting reminders and will remain on this until she is discharged. Other residents will be identified by having nurse's aides and nurses monitoring residents for incontinence patterns to determine if they are managing this process. This information will be documented to determine patterns. An in-service will be given to all nursing aides and nurses on proper incontinence care in regard to assisted living in the state of Wyoming. All issues in regards to incontinence will be reviewed upon significant change, quarterly by the quality assurance team, and on the comprehensive service plan completed bi-annually.	2/27/12

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SALF	Continued From page 8 e. During an interview with the administrator and DON on 1/13/12 at 10:20 AM, they stated the facility had tried different techniques to assist the resident to care for his/her incontinence, but had been unsuccessful. They stated the resident had been considered for placement to a higher level of care, but no plan had been put in place.	SALF		

2/10/12