Received & approved 4/6/12. Called Tom McLean to let him know at 11:15 AM Linda Brown RN

PRINTED: 03/21/2012
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
	ALF001	A. BUILDING _____ B. WING _____	02/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VETERANS' HOME OF WYOMING	700 VETERANS' LANE BUFFALO, WY 82834

(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 LICENSURE REGULATIONS 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. (a) The assisted living facility core services include the following: (x) Twenty-four (24) hour monitoring of each resident. This RULE was not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure 1 of 2 sample residents (#1) who expressed suicidal ideation was adequately monitored to prevent a completed suicide. In addition, the facility failed to adequately monitor 1 of 3 current sample residents (#3) while bathing. The findings were: 1. Review of the medical record for resident #1 showed s/he was admitted to the facility on 2/6/06 and had diagnoses including chronic paranoid schizophrenia. The resident was last seen by his/her psychiatrist on 9/22/11 and by the medical physician on 11/10/11 for a routine check-up. The resident had his/her bi-annual nursing assessment completed on 8/7/11. Review of	SALF	**Plan of Correction** Chapter 12 Section 7. Assisted Living (ALF) Core Services. (a) The facility will ensure that residents who express suicidal ideations are adequately monitored to prevent a completed suicide. In addition, the facility will ensure that residents are adequately monitored while bathing. This will be accomplished by: 1a) Resident #1 is deceased. All residents including new admissions will be screened for depression and suicide risk regardless of diagnosis by the facility social worker or licensed healthcare professional. Subsequently, all residents will be screened no less than bi-annually for depression and suicide risk.	4/27/12

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Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Interim Superintendent — (X6) DATE: 3/30/2012

STATE FORM 6899 STU911 If continuation sheet 1 of 7

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SALF	Continued From page 1 progress notes written on 1/1/12 at 2:30 PM revealed the facility received a call from the National Suicide Hotline stating a resident had called indicating s/he was suicidal and had a plan. Further review of these notes showed the resident "called to [the] nursing desk, stated [s/he] was depressed this holiday season..." The resident further stated s/he had purchased some benadryl because s/he was not sleeping very well at night and was feeling "somewhat paranoid at times." Continued review showed the resident verbalized s/he had thought about suicide twice during the holiday season and said the plan was to overdose on benadryl. While review of these notes showed the resident said s/he was no longer suicidal at this time (2:30 PM on 1/1/12) and relinquished the benadryl to the nurse, the resident acknowledged continued depression. The following concerns were identified: a. The facility staff did not perform a mental health or suicide assessment to determine the seriousness of the resident's verbalized depression and call to the National Suicide Hotline. Interview on 2/29/12 at 3 PM with the nurse who worked 1/1/12 and took the National Suicide Hotline call, confirmed she did not consider a mental health emergency evaluation because she did not really think the resident would harm him/herself based on the fact that she had known him/her for a long time. b. The facility staff did not monitor the resident frequently to determine his/her safety. The next time the resident was seen by a staff member, after 2:30 PM on 1/1/12, was at medication pass at 5:30 PM (3 hours later) and at 9:30 PM (4 hours later). Nine and one-half hours later, at 7 AM on 1/2/12 the resident was checked and administered his/her morning medications. At 11:30 AM, 4 and 1/2 hours later, the resident was again checked when s/he received his/her	SALF	1b) Resident #3 has been discharged. All residents including new admissions will be assessed for bathing safety. This will continue bi-annually or more frequently if needed. c) The facility suicide prevention policy and bathing policy has been revised. d) The social worker has revised her documentation process. e) The social worker, licensed staff and certified nurse aides have been in-serviced regarding revisions to the suicide prevention policy and the bathing policy. f) Nurse Manager to audit for compliance and will report results to the Quality Improvement Committee for review and recommendations.	4/15/12 3/26/12 3/27/12 3/30/12 4/27/12

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SALF	Continued From page 2	SALF		

medications. The resident received medications at 5:30 PM and 9:30 PM that evening (1/2/12). On the morning of 1/3/12, the resident did not present to the nursing station for his/her morning medications at which time staff began a search and discovered the resident had committed suicide.

c. Review of the medical record showed the most current psychosocial assessment performed by the social worker was on 8/31/06, six years earlier, which indicated the social worker would spend time with the resident on an individual basis at least twice a week. However, review of the social service notes showed only one progress note was written per year which only included that the resident had attended the care plan conference. The most recent note was written on 8/11/11. Review of the medical record showed no evidence the social worker visited with the resident twice weekly as planned.

d. Review of the medical record showed no evidence the social worker was notified of the resident's depression and call to the National Suicide Hotline on 1/1/12. Interview on 2/29/12 at 3 PM with the nurse who worked 1/1/12 and took the National Suicide Hotline call, confirmed she did not notify the social worker.

e. Review of the 2/10/11 care plan showed altered thought processes was identified as a problem based on the resident's diagnosis of Schizophrenia. Interventions included providing safety measures as needed which, based on medical record review, facility staff failed to do. Additionally, an intervention to assess the resident's neurological/mental status on an ongoing basis was not performed when the resident verbalized depression and suicidal ideation to the staff and to the National Suicide Hotline on 1/1/12.

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SALF	Continued From page 3 2. Review of the 1/29/12 nursing notes timed at 12:15 PM for resident #3 showed s/he was found in the whirlpool tub emersed up to his/her neck in hot water. Further review showed the resident had no apparent motor control, had massive vasodilation, pinpoint pupils, and was not able to help him/herself out of the tub. The resident's body temperature was 105.1 degrees Fahrenheit, the pulse was 148 (normal is 72), and s/he appeared cyanotic. The notes documented the resident entered the bathing area at 11:30 AM (45 minutes earlier). Facility staff called 911 and the resident was transported to the emergency room. The resident was re-admitted to the facility at 4 PM that afternoon after being administered intravenous fluids. Interview with CNA #1 on 2/29/12 at 8:38 AM revealed when a resident bathes on his/her own, staff should perform a safety check after twenty minutes if the resident had not yet returned to his/her room. Section 7.. Assisted Living Facility (ALF) Core Services. (b) Resident Assessment and Services (iv) Frequency of assessment. An assessment must be conducted: (B) Immediately upon any significant change in the resident's mental or physical condition: This RULE was not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure a comprehensive assessment was performed immediately for 1 of 3 sample residents (#1) who experienced an acute change in condition. The findings were: Review of the medical record for resident #1 showed s/he was admitted to the facility on 2/6/06	SALF	Chapter 12 Section 7. (b) The facility will ensure that a comprehensive assessment is performed immediately for any resident who experiences an acute change in condition. This will be accomplished by: 1a) Resident #1 is deceased. All residents including new admissions will be screened for depression and suicide risk regardless of diagnosis by the facility social worker or licensed healthcare professional. Subsequently, all residents will be screened no less than bi-annually for depression and suicide risk.	4/27/12

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SALF	Continued From page 4 and had diagnoses including chronic paranoid schizophrenia. The resident was last seen by his/her psychiatrist on 9/22/11 and by the medical physician on 11/10/11 for a routine check-up. The resident had his/her bi-annual nursing assessment completed on 8/7/11. Review of progress notes written on 1/1/12 at 2:30 PM revealed the facility received a call from the National Suicide Hotline stating a resident had called indicating s/he was suicidal and had a plan. Further review of these notes showed the resident "called to [the] nursing desk, stated [s/he] was depressed this holiday season..." The resident further stated s/he had purchased some benadryl because s/he was not sleeping very well at night and was feeling "somewhat paranoid at times." Continued review showed the resident verbalized s/he had thought about suicide twice during the holiday season and said the plan was to overdose on benadryl. While review of these notes showed the resident said s/he was no longer suicidal at this time (2:30 PM on 1/1/12) and relinquished the benadryl to the nurse, the resident acknowledged continued depression. The following concerns were identified: a. The facility staff did not perform a mental health or suicide assessment to determine the seriousness of the resident's stated depression and call to the National Suicide Hotline. Interview on 2/29/12 at 3 PM with the nurse who worked 1/1/12 and took the National Suicide Hotline call, confirmed she did not consider a mental health emergency evaluation because she did not really think the resident would harm him/herself based on the fact that she had known him/her for a long time. b. Review of the 2/10/11 care plan showed altered thought processes was identified as a problem based on the resident's diagnosis of Schizophrenia. Interventions included providing	SALF	b) The facility suicide prevention policy has been revised. c) The social worker has revised her documentation process. d) The social worker, licensed staff and certified nurse aides have been in-serviced regarding revisions to the suicide prevention policy. e) Nurse Manager to audit for compliance and will report results to the Quality Improvement Committee for review and recommendations.	3/26/12 3/27/12 3/30/12 4/27/12

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SALF	Continued From page 5 safety measures as needed, which, based on medical record review, the facility staff failed to do. Additionally, an intervention to assess the resident's neurological/mental status on an ongoing basis was not performed when the resident verbalized depression and suicidal ideation to the staff and to the National Suicide Hotline on 1/1/12. Section 7. Assisted Living Facility (ALF) Core Services. (e)Resident Records and Reports. (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 RULE was not met as evidenced by: Based on staff interview and medical record review, the facility failed to report 1 of 1 incident of possible neglect that affected the health of the resident (#3) to the Healthcare Licensing and Survey office. The findings were: Review of the 1/29/12 nursing notes timed at	SALF	Section 7. (e) (D) The facility will ensure that incidents of possible neglect that affect the health and safety of residents are reported to the Office of Healthcare Licensing and Surveys (OHLS). This will be accomplished by: 1a) Resident #3 has been discharged. All residents including new admissions will be assessed for bathing safety bi-annually or more frequently if needed. b) The facility bathing policy has been revised in that all residents will be checked every twenty minutes to ensure safety while bathing.	4/15/12 3/26/12

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SALF	Continued From page 6 12:15 PM for resident #3 showed s/he was found in the whirlpool tub emersed up to his/her neck in hot water. Further review showed the resident had no apparent motor control, had massive vasodilation, pinpoint pupils, and was not able to help him/herself out of the tub. The resident's body temperature was 105.1 degrees Fahrenheit, the pulse was 148 (normal is 72), and s/he appeared cyanotic. The notes documented the resident entered the bathing area at 11:30 AM (45 minutes earlier). Facility staff called 911 and the resident was transported to the emergency room. The resident was re-admitted to the facility at 4 PM that afternoon after being administered intravenous fluids. Interview with CNA #1 on 2/29/12 at 8:38 AM revealed when a resident bathes on his/her own, staff should perform a safety check after twenty minutes if the resident had not yet returned to his/her room. Interview with the nurse manager on 2/29/12 at 3 PM revealed she thought this incident was a medical issue rather than a facility issue and therefore it was not reported to the Healthcare Licensure and Survey office as required.	SALF	c) Licensed staff and certified nurse aides have been in-serviced regarding the revisions to the bathing policy, and that reporting incidences of resident neglect will be reported to OHLS by management. d) Nurse Manager to audit for compliance and will report results to the Quality Improvement Committee for review and recommendations.	3/30/12 4/27/12