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 06/05/2014

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
S5054	Ch 12 Sec 7 (e)(I)(A-K) Assisted Living Facility (ALF) Core Services (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 Licensing Division, or designated representative upon request. (I) Each folder shall include the following: (A) Information from the referring agent, if applicable; (B) History and physical performed by a physician or physician extender; (C) Individual admission form. The form shall, at a minimum, contain the following information: (I) Full name of resident and former address; (II) Date of admission; (III) Sex, race, date of birth, social security number, and former occupation; (IV) Name, home address, and telephone number of relative, friend, Power of Attorney, or guardian; (V) Name, address, and telephone number of resident's personal physician, dentist, ophthalmologist or optometrist; (VI) Medicare number of other medical insurance identifying data;	S5054		

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S5054	Continued From page 1	S5054		

(VII) A written inventory of all personal possessions; however, this inventory need not include personal clothing.

(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;

(E) An accounting of all personal funds deposited with and disbursed by the facility;

(I) Upon written authorization of a client, the facility must hold, safeguard, manage and account for the personal funds of the client.

(1.) The facility must deposit any personal funds in excess of $100 in an interest bearing account.

(2.) The facility must establish and maintain a system that assures a full and complete and separate accounting according to generally accepted accounting principles of each resident's personal funds entrusted to the facility.

6/23/14 - The POC was accepted between Jeff Smith, Manager and Tony Madden, Surveyor. The POC is 6/14/14

6/23/14

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S5054	Continued From page 2	S5054		

(3.) Upon the death of a resident with a personal fund deposited with the facility, the facility must convey, within 30 days, the resident ' s funds a final accounting of those funds, to the individual or probate jurisdiction administering the resident ' s estate.

(4.) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare except for applicable deductible and coinsurance amounts.

(F) A signed copy of the resident's rights;

(G) The resident's assessment and individualized assistance plan;

(H) Copies of all applicable resident assistance contracts, signed by both parties;

(I) Written acknowledgment of the receipt and explanation of all facility policies including admission/discharge policies;

(J) Copy of all ALF 102's; and

(K) Copy of outside contractual responsibilities, if applicable.

This State Rule and Regulation is not met as evidenced by:
Based on observation, medical record review and staff interview the facility failed to report incidents involving resident health, welfare or safety to the Licensing Division in a timely manner for 2 of 2 sample residents with observable injuries (#26,

6/23/14

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S5054	Continued From page 3 #27). The findings were: 1. Observation on 6/4/14 at 1 PM showed resident #26 had dark bruising to the left side of his/her face, and a line of sutures on the left ear. Nurse charting dated 6/1/14, timed 4:09 PM, revealed the resident had fallen that morning, and had a laceration to the left ear that required treatment at the emergency room. Review of Licensing Division records revealed the facility did not report the incident until 6/4/14. 2. Observation on 6/4/14 at 3:14 PM showed resident #27 had a scabbed area and hematoma over his/her left eye, and bruising that extended below the left eye. Nurse charting dated 5/31/14, timed 4:52 AM, revealed the resident claimed to have fallen out of bed and sustained a contusion to the left forehead, with an "abrasion to center area of lump." Review of Licensing Division records revealed the facility did not report the incident until 6/4/14. 3. Interview with the facility administrator on 6/5/14 at 1:05 PM confirmed the incidents had not been reported to the Licensing Division until 6/4/14, and should have been reported within one business day.	S5054	**Plan of Correction** Documentation of incidents for residents #26 and #27 are complete and were submitted to the state. The submission to the state came past the time prescribed in Chapter 12 but before the finding of the surveyors. A review of previous incidents from January 2014 to present reveals all other resident incidents were reported properly. A procedure is in place for the reporting of incidents to the Administrator and for the Administrator to report appropriately to the state. In this case the Administrator failed to follow the procedure resulting in the late reporting. To ensure the process is followed the Wellness Director will follow up after incidents are reported to the Administrator to make sure necessary incidents are reported to the state. These corrective actions are currently in place and took effect June 4th 2014. This process will also be reviewed in monthly QA meeting for Corrective Action Responsibility	6/4/2014

20 June 2014
Jeffrey Smith - Administrator

6/18/14