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WY Dept of Health
DEC 19 2014
Healthcare Licensing and Surveys

PRINTED: 12/10/2014
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
	ALF006	A. BUILDING: ~~Healthcare Licensing~~ and Surveys B. WING	C 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN WIND ASSISTED LIVING COMMUNITY	4010 NORTH COLLEGE DRIVE CHEYENNE, WY 82001

(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
S5049	Ch 12 Sec 7 (d)(i)(A-K) Assisted Living Facility (ALF) Core Services (d) Medications. (i) An individual record shall be kept for each resident, recording any prescription drugs administered by the facility. This record shall include: (A) Name of resident; (B) Name and telephone number of primary physician; (C) Name and telephone number of the primary pharmacy; (D) Name and description of the medication, including prescribed dosage; (E) Dosage administered; (F) Quantity; (G) Times and dates administered; (H) Method of administration; (I) Any adverse reactions to the medication; (J) Signature of licensed staff administering medication; and (K) RN review date and signature. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a complete	S5049	A. Each individual medication record will be cross checked by nursing staff with all MD orders in chart to assure proper transfer has taken place to be completed by January 30 2015. including ROD #42, #54 B. Starting today and going forward all MD orders that come in will be double checked by two separate nurses and noted off that transfer into medication record is correct. C. All medication records will be thoroughly checked by two nurses every month. D. A very detailed in-service will be conducted with all nursing staff by the CSD to include medication administration of oral, topical, gtts, patches, inhalants, immediately and quarterly thereafter. E. Each nurse will be evaluated by means of CSD using corporate competency form by December 31, 2014. F. Each nurse will be audited during a med pass weekly until competency is proven then quarterly times two then annually.	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 12/19/2014

STATE FORM 6899 — 280Z11 — If continuation sheet 1 of 14

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Changes made per phone conversation with Jessie Mc. Hicks, E.D., on 4/13/15 @ 3:30pm. POC accepted. POC - 2/1/15. Janice Collins RN BSN

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S6049	Continued From page 1 medical record was maintained for 2 of 9 sample residents (#42 and #54) selected for review of medications. The findings were: 1. Medical record review revealed resident #42 had diagnoses that included dementia with behaviors. Review of the hospital's "Prior to Admission medications" list dated 10/29/14 showed a physician order for an Exelon patch 9.5 mg/24 hour to be applied once a day. Review of the hospital history and physical dated 10/29/14 showed the resident was admitted to the hospital with diagnoses that included syncope (loss of consciousness). Review of the Emergency Department nurse's note dated 10/29/14 showed the resident was found "to have 3 exelon patches in place." Interview on 11/25/14 at 9:45 AM with LPN #1 revealed the facility was informed about the medication error on 10/29/14 by the physician. Review of facility memo dated 10/30/14 revealed the facility provided education to the nurses about the medication error in the form of a printed website from Novartis that explained the symptoms of a drug overdose. These symptoms included bradycardia, hypotension and seizures. Further review revealed "Mistakes in using Exelon patch have resulted in serious side effects; some cases have required hospitalization...Most mistakes have involved not removing the old patch when putting on a new one and the use of multiple patches at one time. Only one Exelon Patch should be worn at a time." The following concerns were noted: a. Review of the November 2014 MAR revealed documentation was lacking for removal of the patches on 11/8, 11/9, 11/10, and 11/11.	S6049	G. The CSD will check the medication record for proper sign off and documentation three times a week for one month then weekly times eight weeks then twice a month times two months then monthly thereafter. Monitored through facility's QA process.	2/1/15

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S5049	Continued From page 2 b. Review of the hospital discharge summary dated 11/7/14 revealed the resident was admitted to the hospital on 11/4/14 with diagnoses that included syncope (loss of consciousness), and "The cause of syncope was likely secondary to medications. The patient was found to have multiple Exelon patches on..." c. Review of the Emergency Department nursing notes dated 11/6/14 at 5:25 AM showed "it was noted that Pt [patient] had on 2 Exelon patches. One patch was dated for 10/31/14 and the other patch was dated for 11/4/14...spoke with [pharmacist]...[whom] stated that a side effect of the Exelon patch [overdose] is syncopal episodes or fainting." d. Interview on 11/25/14 at 9:30 AM with the DON revealed that after the facility was informed of the second medication error, education was again provided to the nurses and a new system for a double sign off was implemented. 2. Medical record review revealed resident #54 had diagnoses that included dementia and had a physician order dated 11/12/12 for an Exelon patch 4.6 mg/24 hour to be applied once a day. Review of the November 2014 MAR revealed documentation was lacking for a double sign off for the removal of the patch on 11/12, 11/13, 11/15, 11/16, 11/18, 11/20, 11/21, and 11/22. Interview on 11/25/14 at 2:10 PM with the DON confirmed the above documentation was lacking in the medical record.	S5049		
S5052	Ch 12 Sec 7 (d)(iv)(A) Assisted Living Facility (ALF) Core Services (d) Medications.	S5052		

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S5052	Continued From page 3 (iv) Medication assistance. (A) The staff shall be responsible for providing necessary assistance to residents deemed capable of self-medicating, but are unable to do so because of a functional disability, in taking oral medications. Non-licensed staff can only assist with oral medications. Medication assistance may include: (I) Reminding resident to take medications; (II) Removing medication containers from storage; (III) Assisting with removal of cap; (IV) Assisting with the removal of a medication from a container for residents with a disability which prevents independence in this act; (V) Observing the resident take the medication; and (VI) Documentation of observation. This State Rule and Regulation is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the nurse supervised the administration of medications for 4 of 9 sample residents (#11, #18, #21, and #26) observed during a medication pass. The findings were: 1. Observation on 11/25/14 at 11:55 AM showed LPN #1 administered glucosamine chondroitin one tablet and Combivent Respimat (an inhaler)	S5052	A. In-service with all nurses on medication safety to include, nurses will watch all residents while taking all medications unless they are deemed safe by self-administration assessment and a doctors order. including Res #11, #18, #21, #26 B. In-service will also include keeping residents safe by locking med carts and rooms that store medication to be done by January 15, 2015 2/11/15 Monitored through facility's QA process.	

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to resident #26. During the observation the LPN left the medications with the resident and did not observe the medications being taken. Review of the medical record revealed the resident was not assessed for safe self-administration of medication.

2. Observation on 11/25/14 at 12 PM showed LPN #1 administered Centrum Silver one tablet, Tylenol 500 mg, Calcium/Vitamin D 600 mg/400 mg, and oxycodone 5 mg to resident #21. During the observation the LPN left the medications with the resident and did not observe the medications being taken. Review of the medical record revealed the resident was not assessed for safe self-administration of medication.

3. Observation on 11/25/14 at 12:05 PM showed LPN #1 administered Tylenol 650 mg to resident #11. During the observation the LPN left the medication with the resident and did not observe the medication being taken. Review of the medical record revealed the resident was not assessed for safe self-administration of medication.

4. Observation on 11/25/14 at 12:10 PM showed LPN #1 administered Tylenol 500 mg to resident #18. During the observation the LPN left the medications with the resident and did not observe the medications being taken. Review of the medical record revealed the resident was not assessed for safe self-administration of

5. Interview with LPN #1 on 11/25/14 at 11:56 AM revealed the nurse routinely left medications with the residents, and did not ensure the medications were swallowed.

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S5052	Continued From page 5 6. Observation on 11/25/14 from 11:55 AM to 12:15 PM also revealed the nurse did not lock the cart between resident medication administration, at times her back was to the unlocked cart, and residents were wandering in the main dining room. 7. Interview with the DON on 11/25/14 at 12:15 PM revealed the facility expectation was for the nurse to stay by the resident until the medication is taken. Interview with the DON on 11/25/14 at 4:30 PM revealed the facility expectation was for the nurse to lock the medication cart between residents. 8. Wyoming State Board of Nursing Advisory Opinion "LPN and RN Scope of Practice" dated July 2014 "In participating in the nursing process and implementing client care across the lifespan, a LPN shall...4. Implement aspects of a client's care consistent with the LPN scope of practice in a timely and accurate manner including...e. promote a safe client environment."	S5052		
S5053	Ch 12 Sec 7 (d)(v)(A) Assisted Living Facility (ALF) Core Services (d) Medications. (v) Medication Administration (A) An RN shall be responsible for the supervision and management of all medication administration as required by the Wyoming Nurse Practice Act, and the Wyoming Board of Nursing Rules and Regulations. This State Rule and Regulation is not met as evidenced by:	S5053	A. Each individual medication record will be cross checked by nursing staff with all MD orders in chart to assure proper transfer has taken place to be completed by January 30 2015. including #42, and #47 B. Starting today and going forward all MD orders that come in will be double checked by two separate nurses and noted off that transfer into medication record is correct.	

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S5053	Continued From page 6 Based on observation, medical record review, and staff interview the facility failed to ensure medications were administered correctly for 2 of 9 sample residents (#44 and #47) during observations of a medication pass. Two medication errors out of 20 opportunities were observed, with an error rate of 10%. The findings were: 1. Observation on 11/25/14 at 8:15 AM showed RN #1 administered medication Dulera 120 (an inhaler) two puffs in quick succession to resident #44. The nurse did not wait one minute between puffs. Interview on 11/25/14 at 1:15 PM with RN #1 showed she was unaware of the requirement to wait one minute between puffs of an inhaler medication. Clinical Nursing Skills, Smith, Duell and Martin, 7th Edition, page 596 "Instruct client to wait one or two minutes between inhalations and to shake canister before each puff. Rationale: Waiting between doses helps prevent paroxysmal bronchospasm." 2. Observation on 11/25/14 at 11:57 AM showed LPN #1 administered Combivent Respimat 20 mcg/100 mcg (an inhaler) one puff to resident #47. Review of the medical record showed a physician order dated 10/16/14 for the resident to be given Combivent Respimat 18 mcg/103 mcg two puffs into the lungs every 6 hours as needed. Review of the MAR for the month of November 2014 showed the medication was to be administered as one puff. Interview on 11/25/14 at 3:40 PM with the DON showed there was confusion and she was seeking clarification for the physician order. Documentation provided to the State Survey Agency on 11/26/14 at 10 AM showed the	S5053	C. All medication records will be thoroughly checked by two nurses every month. D. A very detailed in-service will be conducted with all nursing staff by the CSD to include medication administration of oral, topical, gtts, patches, inhalants, immediately and quarterly thereafter. E. Each nurse will be evaluated by means of CSD using corporate competency form by December 31, 2014. F. Each nurse will be audited during a med pass weekly until competency is proven then quarterly times two then annually. G. The CSD will check the medication record for proper sign off and documentation three times a week for one month then weekly times eight weeks then twice a month times two months then monthly thereafter. monitored through facility's QA process.	2/1/15

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resident was to be given two puffs of the medication.

Based on medical record review and staff interview the facility failed to prevent two significant medication errors for 1 of 10 sample residents (#42) reviewed for medication errors. The findings were:

1. Review of the medical record showed resident #42 was admitted to the facility on 9/18/13 with diagnoses that included dementia, depression, lymphoma, and anxiety. Review of the hospital cardiology consult note dated 10/29/14 showed the resident had a heart attack on 10/17/14, and was admitted to the hospital on 10/29/14 with diagnoses that included syncope (loss of consciousness). Review of the hospital "Prior to Admission Medications list" showed a physician order for Exelon patch 9.5 mg/24 hour; place one patch onto the skin daily. The following concerns were noted:

a. Review of the Emergency department nursing note dated 10/29/14 timed 5:45 PM showed the resident was "noted to have 3 exelon patches in place, one on L [left] abdomen which was removed d/t [due to] past date for removal, one on L [left] shoulder with date of today, and one on L [left] shoulder with an old date, so this one was also removed."

b. Interview on 11/25/14 at 9:45 AM with LPN #1 revealed the facility was informed about the medication error on 10/29/14 by the physician.

2. Review of Nursing Physical Assessment dated 11/1/14 showed resident #42 was re-admitted to the facility from the hospital with 2 Exelon patches dated 10/29/14 and 10/30/14. Interview on 11/25/14 at 9:45 AM with LPN #1

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revealed she removed the old Exelon patches and placed a patch dated 11/1/14, during a head-to-toe assessment, and no other patches were seen at this time.

3. Review of the hospital discharge summary dated 11/7/14 revealed the resident was admitted to the hospital on 11/4/14 with diagnoses that included unresponsiveness and syncope. Review of the Emergency department nursing note dated 11/5/14 timed 5:25 AM revealed "Pt [patient] had on 2 Exelon patches. One patch was dated for 10/31/14 and the other patch was dated for 11/4/14. The patch dated 10/31/14 was removed. When this pt [patient] was admitted in October with a syncopal episode, admitting RN stated that [patient] had more than one Exelon patch on at that time as well. Spoke with... [pharmacist]...[whom] stated that a side effect of the Exelon patch [overdose] is syncopal episodes or fainting."

4. Review of the physician discharge summary dated 11/10/14 timed 12:10 AM revealed the resident "came in with complaint of unresponsiveness/syncope...The cause of syncope was likely secondary to medications. The patient was found to have multiple Exelon patches on.

Interview on 11/25/14 at 9:30 AM with the DON revealed after the facility was informed of the second medication error, education was provided to the nurses and the Exelon patches were being saved on all the resident's MAR's when the patches were removed from the resident, and required a sign-off by a second nurse.

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S5054	Continued From page 9	S5054		
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	S5054	A. All staff in-service done on reporting any staff vs staff, staff vs resident, resident vs resident altercation immediately to your supervisor. Supervisors will review state and corporate regulations on reporting with the administrator. This will be done by January 1st and quarterly thereafter times one year the annually and upon new hire. 2/1/15 Incidents Reviewed and monitored through facility's QA process.	

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insurance identifying data;

(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

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S5054	Continued From page 11 generally accepted accounting principles of each resident's personal funds entrusted to the facility. (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 medical record review, staff interview and State Survey Agency record review, the facility failed to report incidents involving the	S5054		

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health, welfare or safety of a resident to the Licensing Division in a timely manner for 2 of 21 sample residents (#42, #72) selected for review of incidents. The findings were:

1. Review of the medical record revealed resident #72 was admitted to the facility 8/25/12 with diagnoses that included dementia. The following concerns were noted:

a. Review of the nursing notes dated 10/25/14 revealed the resident was involved in a physical altercation with another resident, that resulted in visible injuries to both residents.

b. Review of physician notification fax dated 10/25/14 revealed resident #72 had a right swollen cheek over his/her cheekbone, and resident #65 had 3 skin tears on his/her right forearm, and the residents were separated until further notice.

c. Review of Licensing Division records revealed the facility did not report the incident until 11/25/14.

2. Review of the medical record showed resident #42 was admitted to the facility on 9/18/13 with diagnoses that included dementia, depression, lymphoma, and anxiety. Review of the hospital cardiology consult note dated 10/29/14 showed the resident was diagnosed with a heart attack on 10/17/14, and was admitted to the hospital with diagnoses that included syncope (loss of consciousness). Review of the hospital "Prior to Admission medications" list showed a physician order for Exelon patch 9.5 mg/24 hour; place one patch onto the skin daily. The following concerns were noted:

a. Review of the Emergency Department nurse's note dated 10/29/14 showed the resident was "noted to have 3 exelon patches 'n place."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF006	A. BUILDING: _____ B. WING _____	C 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN WIND ASSISTED LIVING COMMUNITY	4010 NORTH COLLEGE DRIVE CHEYENNE, WY 82001

(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	Continued From page 13 b. Interview on 11/25/14 at 9:45 AM with LPN #1 revealed the facility was informed about the medication error on 10/29/14 by the physician. c. Review of Nursing Physical Assessment dated 11/1/14 showed the resident was re-admitted to the facility from the hospital with 2 Exelon patches dated 10/29/14 and 10/30/14. d. Review of the hospital physician discharge summary dated 11/7/14 revealed the resident was admitted to the hospital on 11/4/14 and "came in with complaint of unresponsiveness/syncope...The cause of syncope was likely secondary to medications. The patient was found to have multiple Exelon patches on..." e. Review of the Emergency Department nursing notes dated 11/5/14 at 5:25 AM showed "it was noted that Pt [patient] had on 2 Exelon patches. One patch was dated for 10/31/14 and the other patch was dated for 11/4/14...spoke with [pharmacist]...[whom] stated that a side effect of the Exelon patch [overdose] is syncopal episodes or fainting." f. Review of Licensing Division records revealed the facility did not report the two medications errors that affected the health of the resident. Interview on 11/25/14 at 4:30 PM with the administrator confirmed the above incidents had not been reported to the Licensing Division.	S5054		