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YR 6/9/15

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WY Dept of Health
JUN 0 5 2015
Healthcare Licensing and Surveys

PRINTED: 05/26/2015
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: ________ B. WING ________	R-C 05/22/2015

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
S 000	Opening Comments Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 12/12/2007 Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001 Follow up survey to Nov 2014 complaint survey	S 000		
{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;	{S5054}	A. Starting today and going forward all Resident incidents that result in injuries,illnesses, and/ or allegations of abuse, neglect or exploitation shall be reported to Resident's family or responsible Party, Physician and Reporting Agency. The Executive Director or designee will Report to the appropriate entity within one business day, follow-up and resolution within 5 business days in accordance with state guide lines. Any report affecting the health, safety and welfare of a resident will be reported to Licensing Division immediately. Anytime a resident is seen at an emergency room and receives treatment or sustains an injury requiring treatment a report will be filed.	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Executive Director

(X6) DATE 6/5/2015

STATE FORM 6899 28OZ12 If continuation sheet 1 of 6

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Accepted by [signature] on 6/9/15 ED notified called w/Monetta Donahue, DON

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{S5054}	Continued From page 1 (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; (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	{S5054}	All incidents that occur on weekends will be reported the following business day. All incidents shall be reviewed through the community QA process. B. All Residents which include, Resident #11, #7,#8, #9,#10 will be monitored through the Community QA and care plan process C. A very detailed in-service will be conducted with all nursing staff by the CSD to include at the minimum documentation on incidents which are as follows: • Focus charting guidelines • Incident report completion • Supervisor's resident incidents follow up report • Resident physician fall notification fax form • Protocol for Reporting to E.D. or CSD. In-service completed by July 5, 2015.	

RR 7/9/15

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{S5054}	Continued From page 2 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. (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	{S5054}	D. The Safety Committee will review all incident reports monthly for 3 months then quarterly for 3 quarters to review if the appropriate follow up was completed and the appropriate agencies notified. The review of these incidents will be recorded in the monthly safety meeting minutes. E. Daily at the stand-up meetings we will review any residents that have been sent to the ER and ensure that a report has been filed. This review process will be documented for 3 months. The documentation of this review (3 months) will be kept on file until the end of 2015. After the 3 month period starting October 1, 2015 this review will still be done daily and discussed but there will not be documentation of the review.	July 5th, 2015

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{S5054}	Continued From page 3 (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 ensure incidents that affected the health, welfare, or safety of a resident were reported to the Licensing Division in a timely manner for 5 of 11 sample residents. The findings were: 1. Review of the nursing note dated 2/13/15 untimed showed resident #11 had an unwitnessed fall that resulted in visible injuries, and was sent to the emergency room. Review of the 2/13/15 hospital discharge instructions showed the resident was diagnosed with a nasal fracture, head injury and abrasion. Review of the 2/14/15 nursing note timed at 6:45 AM showed the resident was re-admitted to the facility with a nasal fracture, bruising and abrasions. Interview with the administrator and the DON on 5/22/15 at 2 PM revealed the administrator was unaware the resident sustained a nasal fracture as a result of the fall, and confirmed the incident was not reported to the Licensing Division. 2. Review of the nursing notes dated 3/19/15 timed at 1:30 PM showed resident #7 was found at 7:30 AM that morning lying in bed with an injury, and was sent to the emergency room. Review of the nursing note dated 3/20/15 timed at 3 PM showed the resident was admitted to the hospital for a hip fracture. Interview with the administrator and the DON on 5/22/15 at 2 PM	{S5054}		

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	Continued From page 4 confirmed the incident was not reported to the Licensing Division. 3. Review of the nursing notes dated 3/18/15 timed at 7:45 AM showed resident #8 was found with an approximately 3 inch long laceration on his/her head, the resident stated s/he had a fall, and was sent to the emergency room. Interview with the administrator and the DON on 5/22/15 at 2 PM revealed the scalp laceration required steri-strips in the emergency room, and follow up care by facility nursing staff. Further, the administrator confirmed the incident was not reported to the Licensing Division. 4. Review of the nursing notes dated 4/6/15 timed 6:40 PM showed resident #9 had an unwittnessed fall, was unresponsive, and was sent to the emergency room. Review of the nursing note from that day timed at 9:30 PM showed the resident was diagnosed with a Urinary Tract Infection, and returned to the facility, but had additional episodes of emesis and dry heaving that evening. Interview with the administrator and the DON on 5/22/15 at 2 PM confirmed the incident was not reported to the Licensing Division. 5. Review of the nursing notes dated 4/20/15 untimed showed resident #10 had an unwitnessed fall that resulted in visible bruising. Review of the nursing note from that day timed 2 to 10 PM showed the resident was taken to the emergency room by a family member. Review of the nursing note dated 4/21/15 timed 2:30 AM showed the resident was admitted to the hospital. Interview with the administrator and the DON on 5/22/15 at 2 PM confirmed the incident was not reported to the Licensing Division.	{S5054}		

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{S5054}	Continued From page 5 6. Review of the Licensing Division reporting records showed the above incidents were not reported to the Office of Healthcare Licensing and Surveys.	{S5054}		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
ALF006	A. Building B. Wing	05/22/2015

Name of Facility	Street Address, City, State, Zip Code
ASPEN WIND ASSISTED LIVING COMMUNITY	4010 NORTH COLLEGE DRIVE CHEYENNE, WY 82001

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix S5049 Reg. # Ch 12 Sec 7 (d)(i)(A-K) LSC	02/01/2015	ID Prefix S5052 Reg. # Ch 12 Sec 7 (d)(iv)(A) LSC	02/01/2015	ID Prefix S5053 Reg. # Ch 12 Sec 7 (d)(v)(A) LSC	02/01/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	TB 5/26/15			
Reviewed By CMS RO	Reviewed By	Date: 5/26/15	Signature of Surveyor: [signature] RN	

Followup to Survey Completed on: 11/25/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO