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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
	ALF026	A. BUILDING _____ B. WING _____	C 11/26/2014

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
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 The following common abbreviations are used throughout this document: CNA - Certified Nurse Aide Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5023	Ch 12 Sec 7 (b)(iv)(A-C) Assisted Living Facility (ALF) Core Services (b) Resident Assessment and Services. The staff/contract Registered Nurse (RN) shall conduct initial and, at a minimum annually, an accurate, standardized, reproducible assessment of each resident's functional capacity, physical assessment and medication review. (iv) Frequency of assessment. An assessment must be conducted: (A) No earlier than one (1) week prior to admission; (B) Immediately upon any significant change in the resident's mental or physical condition; or (C) No less than once every twelve (12) months.	S5023		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 13 Feb 2015

2/19/15 This POC accepted between Jeff Smith Administrator and Tony Madden, Surveyor with a POC of 2/16/15.

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S5023	Continued From page 1 This State Rule and Regulation is not met as evidenced by: Based on observation, medical record review, and staff and family interview, the facility failed to ensure the nursing assessments were accurate and/or conducted in a timely manner for 11 of 17 sample residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11). The findings were: 1. Review of the ALF-102 screening dated 4/10/14 showed resident #1 was independent for mobility including transfers, was continent of bowel and bladder, was independent for feeding self, and independent for dressing and grooming. Review of the 5/13/14 nursing assessment showed it was consistent with the level of independence shown on the ALF-102. The resident resided on the memory care unit and observation on 11/25/14 at 3:40 PM showed the resident was seated in a recliner in his/her room and the resident appeared very thin. The resident was hard of hearing and was confused. The resident's son was visiting and was interviewed at that time. The following concerns were identified: a. Interview with the son on 11/25/14 at 3:40 PM revealed his parent had declined in the past two weeks. The son verified the resident could no longer transfer without assistance of two staff, and could not eat without assistance due to complications of a recently diagnosed esophageal tumor. The son verified the resident was not receiving any additional outside services. Further, the wellness director had talked to him earlier in the day regarding hospice services, and they were planning to pursue these additional services. b. Interview with CNAs #1 and #2 on 11/25/14 at 3:25 PM verified the resident required two people to physically transfer due to weakness and decline. The aides verified the resident had	S5023	**Plan of Correction** 1. Resident #1 passed away 11/28/2014. A review of all residents ensuring their level of care is appropriate for assisted living or memory care, including a review of ALF 102s, was completed 2/2/2015. Each resident will be reviewed for appropriateness by the Wellness Director and Administrator at quarterly Quality Assurance meetings and any time the resident shows a change in condition. When it is determined reassessment is needed, the Wellness Director will use the ALF 102 and/or community assessment. With Resident #1s passing, no further corrective action will be taken. The implementation of the resident care review is in effect and will be used at all QA meetings starting February 1, 2015.	2/2/2015

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S5023	Continued From page 2 required this level of assistance with transfer for about the last two weeks, and the assistance needed for eating was due to a medical condition, and had been ongoing for about 1 month. c. Interview with the wellness director on 11/26/14 at 1 PM verified a change of condition assessment had not been started and the hospice was contacted on 11/25/14. 2. Review of the ALF-102 functional screening dated 5/27/14 showed resident #2 was marked as "c. completely dependant, frequent transfers, frequent positioning..." This category required incorporation of services provided by outside sources. The resident was also shown to fall into this category for the areas of bathing and continence. Review of the 8/20/14 nursing assessment showed the resident required "regular" assistance in managing bowel and bladder care consisting of "toileting every 2 hours." Additionally, the nursing assessment showed the resident required 1 person for transferring. The following concerns were identified: a. Interview with CNA #1 and #2 on 11/25/14 at 3:05 PM verified they provided total assistance for toileting, bathing for the resident, and s/he was a two person transfer at all times. b. Review of the medical record showed there was no documentation of outside services being provided for the resident. c. Interview with the wellness director on 11/26/14 at 1 PM verified the ALF-102 and nursing assessment were not consistent. She further stated there were no outside services being provided for this resident. 3. Review of the ALF-102 functional screening dated 9/28/14 showed resident #3 had occasional incontinence and required occasional help to	S5023	2. Resident 2's reassessment was complete 12/11/2014. A review of all residents ensuring their level of care is appropriate for assisted living or memory care, including a review of ALF 102s, was completed 2/2/2015. Each resident will be reviewed for appropriateness by the Wellness Director and Administrator at quarterly Quality Assurance meetings and any time the resident shows a change in condition. When it is determined reassessment is needed, the Wellness Director will use the ALF 102 and/or community assessment. The implementation of the resident care review is in effect and will be used at all QA meetings starting February 1, 2015. 3. Resident #3's reassessment was complete 12/14/2014.	2/2/2015 2/2/2015

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S5023	Continued From page 3 clean self. Review of the 10/8/14 nursing assessment and negotiated services plan showed the resident required "reminders for bathroom or protective garment usage." Observation on 11/25/14 at 4:23 PM showed CNA #2 assisted the resident to the bathroom. At that time, the CNA stated the resident was not aware when s/he was incontinent and staff had to change the brief and to provide total perineal care each time the resident was toileted. 4. Review of the 11/11/14 ALF-102 functional screening for resident #4 showed s/he was coded under continence as continent of bowel and bladder. The assessment also showed under behavior/motivation the resident was intermittently confused and/or agitated; required occasional reminders as to person, place, or time. The area for excessive wandering was left blank. The following concerns were identified: Regarding wandering: a. Interview with employee #4 on 11/25/14 at 3:05 PM revealed the resident was always confused, wandered often, and had eloped from the facility on several occasions. Observation at that time confirmed an alarm was on the resident's front door even though this resident resided in the level I area of the facility. b. Review of the admission resident assessment revealed the resident, "Requires regular prompting due to confusion and disorientation...Wanders intrusively, but easily directed." c. Review of the admission service agreement revealed the resident "Wanders intrusively, but easily directed...Wandering r/t [related to] resident's constant movement. AEB [as evidenced by]: Resident walking around and wanting to fix pipes at home..."	S5023	A review of all residents ensuring their level of care is appropriate for assisted living or memory care, including a review of ALF 102s, was completed 2/2/2015. Each resident will be reviewed for appropriateness by the Wellness Director and Administrator at quarterly Quality Assurance meetings and any time the resident shows a change in condition. When it is determined reassessment is needed, the Wellness Director will use the ALF 102 and/or community assessment. The implementation of the resident care review is in effect and will be used at all QA meetings starting February 1, 2015. 4. Resident #4 was discharged due to higher care needs on 11/29/2014. A review of all residents ensuring their level of care is appropriate for assisted living or memory care, including a review of ALF 102s, was completed 2/2/2015. Each resident will be reviewed for appropriateness by the Wellness Director and Administrator at quarterly Quality Assurance meetings and any time the resident shows a change in condition. When it is determined reassessment is needed, the Wellness Director will use the ALF 102 and/or community assessment. The implementation of the resident care review is in effect and will be used at all QA meetings starting February 1, 2015.	2/2/2015

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S5023	Continued From page 4	S5023		

d. Review of the facility CNA communication book [not part of the medical record] revealed the following, "11/15/14 [day of admission] Got out...Very confused: Wants to get out...still confused." "11/16/14 Babysitting [the resident] all night...needs to be re-directed to bedroom." "11/18/14 Wandered in people's rooms...up half the night." "11/19/14 [The resident] went into people's rooms, wandered everywhere-including [the resident] tried to exit the exit doors." Review of Progress Notes in the CNA communication book revealed the following, "11/16/14 [The resident] left the building, was sitting in someone else's car...[The resident] wandered around and went into other resident's rooms..." "11/18/14 [The resident] Wandered into a couple of residents rooms. Redirected [the resident]." "11/20/14 [The resident]...Tried wandering into peoples rooms..."

e. Review of the memory care nurse communication book [not part of the medical record] revealed the following, "11/22/14 Went into [another resident's] room..." "11/18/14 [The resident] Confusion. High risk elopement." "11/17/14 [The resident]...elopement risk. Confused agitation...kept opening doors-court yard/hall." "11/17/14 days [The resident] Keep getting out of Building, confusion, agitation." "[Not dated] [The resident] out of building." "11/16/14 [The resident] Flight risk did get out-confused." "11/15-16/14 Wants to go home, door alarm."

f. Interview with the wellness director and administrator on 11/26/14 at 1:05 PM revealed when the resident was admitted they realized they were "in over their heads" and were actively seeking to transfer the resident to a higher level of care.

Regarding Incontinence:

a. Observation on 11/25/14 at 3:05 PM showed the resident in his/her room without pants

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S5023	Continued From page 5 on and incontinent. Interview with employee #4 at that time confirmed staff were required to routinely provide incontinence care for the resident, and did so at that time. b. Review of the facility CNA communication book [not part of the medical record] revealed the following, "11/16/14 [The resident]- babysitting [him/her] all night." c. Review of the memory care nurse communication book [not part of the medical record] revealed the following, "[not dated] [The resident] incontinent, refused to change..." "[not dated] [The resident]... Wet [the resident's] pants, refused help." d. Interview with the wellness director and administrator on 11/26/14 at 1:05 PM revealed when the resident was admitted they realized they were "in over their heads" and were actively seeking to transfer the resident to a higher level of care. 5. Review of the 10/31/14 ALF-102 functional screening showed resident #5 was marked under behavior/motivation for "Intermittently confused and/or agitated; requires occasional reminders as to person, place, or time." The area was left blank for safety concerns which included danger to self or others with continuous surveillance required. The following concerns were identified: a. Observation on 11/25/14 at 3:15 PM showed the resident had barricaded the front door to his/her apartment with a table, and an electronic alarm was noted on the resident's front door even though the resident resided in the level I area of the facility. Interview with employee #4 at that time revealed the resident barricading the front door to his/her apartment was an ongoing issue. b. Review of the facility CNA communication book [not part of the medical record] revealed the	S5023	5. Resident #5's reassessment was complete 12/15/2014. Resident transferred from assisted living to memory care on 12/1/2014. A review of all residents ensuring their level of care is appropriate for assisted living or memory care, including a review of ALF 102s, was completed 2/2/2015. Each resident will be reviewed for appropriateness by the Wellness Director and Administrator at quarterly Quality Assurance meetings and any time the resident shows a change in condition. When it is determined reassessment is needed, the Wellness Director will use the ALF 102 and/or community assessment.	2/2/2015

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S5023	Continued From page 6 resident barricaded his/her front door on 11/4/14, 11/5/14, and 11/20/14; the resident eloped from the building twice on 11/12/14, and wandered into other resident's rooms on 11/10/14 and 11/12/14. c. Review of the memory care nurse communication book [not part of the medical record] revealed the resident barricaded his/her front door on 11/4/14, 11/5/14, 11/6/14, 11/9/14 and 11/10/14. d. Interview with the wellness director on 11/26/14 at 1:05 PM revealed she was unaware the resident had safety risks concerning barricading, and felt the resident was easily manageable. 6. Review of the 10/15/14 ALF-102 functional screening for resident #6 showed the assessment was marked under behavior/motivation the resident had, "Appropriate behavior, well-motivated to, and capable of, performing ADL's." The area for intermittent confusion and/or agitation, and other more serious areas, were left blank. The following concerns were identified: a. Review of the 10/16/14 admission resident assessment showed for behaviors the resident, "Is very paranoid. Believes [the resident] is in prison. Sees things that are not there." b. Review of a 11/8/14 physician consultation showed the resident would not or could not answer questions, had been recently discharged from a geropsychiatric facility, and would state non-sensical words. c. Review of nursing notes showed the resident called the local police 4 times on 10/25/14 due to psychotic behavior, and wanted to call local police on 10/28/14 due to the feeling of being held against his/her will. d. Interview with the wellness director on 11/26/14 at 1:05 PM revealed she did not consider a resident's history when assessing and	S5023	The implementation of the resident care review is in effect and will be used at all QA meetings starting February 1, 2015. 6. Resident #6's reassessment was complete on 11/26/2014. A review of all residents ensuring their level of care is appropriate for assisted living or memory care, including a review of ALF 102s, was completed 2/2/2015. Each resident will be reviewed for appropriateness by the Wellness Director and Administrator at quarterly Quality Assurance meetings and any time the resident shows a change in condition. When it is determined reassessment is needed, the Wellness Director will use the ALF 102 and/or community assessment. The implementation of the resident care review is in effect and will be used at all QA meetings starting February 1, 2015.	2/2/2015

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S6023	Continued From page 7 admitting residents. She further revealed she was not aware of the details of the information in the - 11/8/14 physician consultation. 7. Review of the 9/3/14 admission assessment for resident #7 showed that the resident did not wander. The following concerns were identified: a. Review of a 8/19/14 psychiatric assessment from a geropsychiatric admission in another state showed the following on the risk assessment, "[The resident] is a risk for suicidal ideation...[The resident] is at risk for elopement potential. [The resident] has a history of going AMA [against medical advice] and being displeased with lock down units in the past." b. Review of the 9/3/14 assessment at the facility showed the resident required regular prompting due to confusion and disorientation, and was admitted from a geropsychiatric unit from another state. c. Review of a 9/9/14 nursing note revealed the provider stated the resident was an extreme elopement risk, and stated staff needed to monitor closely. d. Interview with the wellness director on 11/26/14 at 1:05 PM revealed she did not consider a resident's history when assessing and admitting residents. She further revealed the resident stayed in the memory care unit in the daytime. 8. Review of the 8/6/14 ALF-102 functional screening for resident #8 showed under behavior/motivation the following, "Intermittently confused and/or agitated; requires occasional reminders as to person, place, or time." The area for safety concerns was left blank. The following issues were identified: a. Interview with the resident on 11/25/14 at 4:17 PM in the day room revealed s/he planned to	S6023	7. Resident #7's reassessment was complete 1/26/2015. A review of all residents ensuring their level of care is appropriate for assisted living or memory care, including a review of ALF 102s, was completed 2/2/2015. Each resident will be reviewed for appropriateness by the Wellness Director and Administrator at quarterly Quality Assurance meetings and any time the resident shows a change in condition. When it is determined reassessment is needed, the Wellness Director will use the ALF 102 and/or community assessment. The implementation of the resident care review is in effect and will be used at all QA meetings starting February 1, 2015. 8. Resident #8's reassessment was complete 12/24/2014. A review of all residents ensuring their level of care is appropriate for assisted living or memory care, including a review of ALF 102s, was completed 2/2/2015.	2/2/2015 2/2/2015

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S5023	Continued From page 8 elope from the facility as soon as s/he formulated a plan. The resident had alarms to the front and back doors at that time even though the resident resided in the level I area of the facility. b. Review of the admission resident assessment showed the resident wandered intrusively, but could be easily redirected. c. Review of the 11/7/14 resident negotiated service plan showed, "Has occasional confusion and some difficulty recalling details. Needs occasional prompting or orientation... Risk for wandering r/t resident's need to get out. AEB [as evidenced by]: Resident verbalizes .... wants to run away." e. Interview with the wellness director on 11/25/14 at 5:20 PM revealed she was aware the resident stated s/he wanted to elope. The wellness director further stated she was not concerned, and the resident said this every day. 9. Review of the 8/26/13 ALF-102 functional screening showed under medical care requirements that resident #9 was medically stable. The area that stated, "Requires skilled nursing care for chronic conditions" was left blank. The following issues were identified: a. Review of the medical record showed a 9/26/14 faxed communication to the physician which stated, "Resident has 2 sores on Buttocks. One on the upper right side measuring 2.1 cm by 2.7 cm..." b. Review of a 9/30/14 faxed communication to the physician showed, "Resident has three open areas on inner buttocks." c. Review of an 11/5/13 letter from the home health agency (HHA) to the facility revealed the HHA provided care, but failed to mention wound care. d. Review of nursing notes showed the following wound documentation, "Original note at	S5023	Each resident will be reviewed for appropriateness by the Wellness Director and Administrator at quarterly Quality Assurance meetings and any time the resident shows a change in condition. When it is determined reassessment is needed, the Wellness Director will use the ALF 102 and/or community assessment. The implementation of the resident care review is in effect and will be used at all QA meetings starting February 1, 2015. 9. Resident #9's reassessment was complete 1/3/2015. A review of all residents ensuring their level of care is appropriate for assisted living or memory care, including a review of ALF 102s, was completed 2/2/2015. Each resident will be reviewed for appropriateness by the Wellness Director and Administrator at quarterly Quality Assurance meetings and any time the resident shows a change in condition. When it is determined reassessment is needed, the Wellness Director will use the ALF 102 and/or community assessment. The implementation of the resident care review is in effect and will be used at all QA meetings starting February 1, 2015.	2/2/2015

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S5023	Continued From page 9 2014-09-25 18:22 [6:22 PM] Resident has sore on left buttcheek. Measuring 1.4 by 1.3...Sore on right side measuring 2.1 by 2.7 non-blanchable..." e. Interview with the wellness director on 11/26/14 at 1:05 PM revealed she expected the HHA to care for the resident's wounds. 10. Review of the 10/30/14 assessment showed resident #10 had intermittent episodes of incontinence. The following concerns were identified: a. Interview on 11/25/14 at 4 PM with employee #4 confirmed staff were required to provide incontinence care routinely. b. Review of nursing notes revealed the following: "Original note at 2014-09-13 3:31 [3:31 AM] ...Required full assistance when toileting and going to bed..." c. Review of the facility CNA communication book [not part of the medical record] revealed the resident was incontinent on 11/4/14, 11/18/14 twice, and 11/16/14 twice. d. Review of the memory care nurse communication book [not part of the medical record] revealed the resident was incontinent on 11/19/14, 11/18/14 on day and night shift, on 11/15/14-11/16/14, on 11/11/14 "all night", on 11/10/14, on 11/5/14-11/6/14 nights, on 11/4/14-11/5/14 Nights, on 10/30/14 "most of day", and on 10/9/14. e. Interview with the wellness director on 11/26/14 at 1:05 PM revealed she was unaware the resident could not toilet independently. 11. Review of the 11/20/14 ALF-102 functional screening showed under behavior/motivation that resident #11 was, "Intermittently confused and/or agitated; requires occasional reminders as to person, place, time." The area for safety concerns was left blank. The following concerns	S5023	10. Resident #10's reassessment was complete on 1/3/2015. A care conference was held with the family 1/7/2015. Another care conrerence is scheduled 2/17/2015 where it is anticipated 30 day notice will be given to the family. A review of all residents ensuring their level of care is appropriate for assisted living or memory care, including a review of ALF 102s, was completed 2/2/2015. Each resident will be reviewed for appropriateness by the Wellness Director and Administrator at quarterly Quality Assurance meetings and any time the resident shows a change in condition. When it is determined reassessment is needed, the Wellness Director will use the ALF 102 and/or community assessment. The implementation of the resident care review is in effect and will be used at all QA meetings starting February 1, 2015. 11. Resident #11 was discharged due to higher care needs on 12/2/2014.	2/2/2015 2/2/2015

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	ALF026	A. BUILDING _____ B. WING _____	C 11/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER TRAIL ASSISTED LIVING	2360 REAGAN AVENUE ROCK SPRINGS, WY 82901

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S5023	Continued From page 10 were identified: a. Observation on 11/26/14 revealed the resident wandering the hallways with rambling speech and unable to engage the surveyor in an interview. Interview with employee #2 at that time revealed the resident had wandered the hallways for hours at a time since admission. In addition, the resident could not engage the staff in conversation, did not appear to understand staff, and appeared to want to leave the facility. b. Review of the admission 11/20/14 ALF 102 showed the resident was, "Acutely ill, requires 24 hour RN care/supervision to ensure medical needs are addressed." c. Review of an 11/24/14 discharge summary from an acute care hospital revealed the following, "...Memory is severely impaired....It was felt the patient is appropriate to discharge to skilled nursing facility [nursing home and not assisted living] as [the resident] was 1-2 person assist with ADL's, transfers, and feeding and further discussed with family who decided to transfer to [specific nursing home]..." d. Interview with the wellness director on 11/26/14 at 1:05 PM revealed she did not consider a resident's history when assessing and admitting residents. She further revealed she was not aware of the details of the information in the 11/24/14 hospital discharge summary.	S5023	A review of all residents ensuring their level of care is appropriate for assisted living or memory care, including a review of ALF 102s, was completed 2/2/2015. Each resident will be reviewed for appropriateness by the Wellness Director and Administrator at quarterly Quality Assurance meetings and any time the resident shows a change in condition. When it is determined reassessment is needed, the Wellness Director will use the ALF 102 and/or community assessment. The implementation of the resident care review is in effect and will be used at all QA meetings starting February 1, 2015.	
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.	S5054		

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S5054	Continued From page 11 (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; (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	S5054		

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S5054	Continued From page 12	S5054		

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.

(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.

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S5054	Continued From page 13	S5054		

(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, CNA communication book review, nurse communication book review, and staff interview, the facility failed to ensure issues required to be reported and investigated to the licensing division were done so for 5 of 17 sample residents (#4, #5, #12, #13, #14). The findings were:

Interview with the wellness director and administrator on 11/26/14 at 1 PM verified they were unaware of the requirement to investigate and report resident to resident incidents and

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S5054	Continued From page 14 altercations to the licensing division. The following residents were identified with occurrences that required reporting and further investigation related to safety: 1. Review of the medical record showed resident #12 moved into the facility on 10/23/14 and had diagnoses which included Lewy Body Dementia. Review of October 2014 nursing communication notes showed the following: a. A 10/9/14 untimed note showed the resident was "found with [resident #15] having sex." There were no additional notes, no investigation or any report made to any agencies related to this interaction between the two cognitively impaired residents. 2. Review of the medical record showed resident #13 moved into the facility on 5/7/14 and now resided on the memory care unit. Interview with employee #1 on 11/26/14 at 9:05 AM revealed the resident did not like others including staff in his/her room. The employee stated the resident had punched two residents (#14 and #16), and multiple staff members. Review of nursing communication notes, and incident reports showed the following: a. A note on 11/25/14 at 4:19 PM showed the resident had "punched" resident #16 for walking into his/her room without knocking. b. A note dated "11/24-11/25" showed resident #13 and another resident were "fighting." c. An undated note from the September to November 2014 nurse communication book showed resident #13 "hit" another resident. d. A note from 11/21/14 "nights" showed the resident hit resident #16. 3. Review of the medical record showed resident #14 moved into the facility on 2/19/14 with	S5054	1. The Wellness Director is responsible for gathering information about any incidents and non-incidents from the nursing staff. She creates a report for the Administrator via our computerized internal reporting system. The Administrator then determines the need to report the incident to the state and reports as necessary. All incidents and non-incidents will be reviewed at quarterly QA meetings to ensure they are properly categorized and reported. If the incident involving Resident #12 happened today it would be reported to the state. 2. The Wellness Director is responsible for gathering information about any incidents and non-incidents from the nursing staff. She creates a report for the Administrator via our computerized internal reporting system. The Administrator then determines the need to report the incident to the state and reports as necessary. All incidents and non-incidents will be reviewed at quarterly QA meetings to ensure they are properly categorized and reported. If the incidents involving Resident #13 happened today they would be reported to the state. 3. The Wellness Director is responsible for gathering information about any incidents	2/2/2015 2/2/2015

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S5054	Continued From page 15 diagnoses that included dementia and history of stroke and hypertension. The individual resident record failed to include notes related to the resident's behaviors or involvement in resident to resident altercations. However, review of a nursing communication book showed notes about the resident's behaviors. These notes were on a page which listed all residents on the memory care unit. Some pages were dated and some were not. The information was from September, October, and November 2014. The notes were not detailed; however, showed the resident was: "violent...up with a vengeance...feisty...angry...mean." Interview with employee #2 on 11/26/14 at 9 AM revealed this resident had "hit every resident (in the unit) at some point." In addition, the employee stated the resident's aggressive behaviors which included hitting occurred on a daily basis.	S5054	and non-incidents from the nursing staff. She creates a report for the Administrator via our computerized internal reporting system. The Administrator then determines the need to report the incident to the state and reports as necessary. All incidents and non-incidents will be reviewed at quarterly QA meetings to ensure they are properly categorized and reported. If the incidents involving Resident #14 happened today they would be reported to the state.	
	4. Review of the medical record showed resident #4 was admitted to the facility on 11/15/14 from a local long-term care facility to a Level I area [not secured] with diagnoses which included Alzheimer's disease, dementia unspecified, and depression. The review showed the resident eloped and wandered frequently. The following concerns were identified: a. Review of the facility CNA communication book [not part of the medical record] revealed the resident eloped from the facility on 11/15/14 and 11/16/14. b. Review of the memory care nurse communication book [not part of the medical record] revealed the resident eloped from the facility on 11/16/14 and 11/17/14. c. Review of the facility incident log showed no mention of elopements by the resident. d. Interview with the wellness director and administrator on 11/26/14 at 1:05 PM revealed		4. The Wellness Director is responsible for gathering information about any incidents and non-incidents from the nursing staff. She creates a report for the Administrator via our computerized internal reporting system. The Administrator then determines the need to report the incident to the state and reports as necessary. All incidents and non-incidents will be reviewed at quarterly QA meetings to ensure they are properly categorized and reported. If the incident involving Resident #4 happened today it would be reported to the state.	2/2/2015

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S5054	Continued From page 16 she did not investigate or report the elopements. 5. Review of the medical record showed resident #5 was admitted to the facility on a Level I (unlocked unit) unit on 10/31/14 with diagnoses which included memory loss. The review showed the resident had elopement and behavior issues that included barricading in his/her room. The following concerns were identified: a. Observation on 11/25/14 at 3:15 PM showed the resident had barricaded the front door to his/her apartment with a table. Interview with employee #4 at that time revealed the resident had wandered out of the facility on the evening of admission. b. Review of the facility CNA communication book [not part of the medical record] revealed the resident eloped from the facility on 11/3/14 and 11/15/14. c. Review of the memory care nurse communication book [not part of the medical record] revealed the resident attempted to leave the facility on 11/2/14 and barricaded his/her front door on 11/6/14. d. Review of the facility incident log showed no mention of any barricading or elopements by the resident. e. Interview with the wellness director and administrator on 11/26/14 at 1:05 PM revealed she did not investigate or report elopements or barricading.	S5054	5. The Wellness Director is responsible for gathering information about any incidents and non-incidents from the nursing staff. She creates a report for the Administrator via our computerized internal reporting system. The Administrator then determines the need to report the incident to the state and reports as necessary. All incidents and non-incidents will be reviewed at quarterly QA meetings to ensure they are properly categorized and reported. If the incidents involving Resident #5 happened today they would be reported to the state.	2/2/2015
S5071	Ch 12 Sec 7 (i)(iii)(A-B) Assisted Living Facility (ALF) Core Services (i) Adult Protection. (iii) The facility is responsible to ensure all allegations of abuse are investigated expediently	S5071		

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S5071	Continued From page 17 and that the resident(s) are protected from further, potential abuse while the investigation is in progress. (A) Instances of abuse, neglect, or exploitation of disabled adults shall be reported to the sheriff's department, the local police department, or to the department of family services in accordance with W.S. 35-20-103. (B) The facility must ensure that, if necessary, additional authorities are contacted if there is an allegation of abuse, neglect, or exploitation. These additional authorities may include the Wyoming State Board of Nursing, Office of Healthcare Licensing and Survey, and the State Long Term Care Ombudsman. This State Rule and Regulation is not met as evidenced by: Based on medical record review, nurse communication documentation review, and staff interview, the facility failed to ensure incidents involving potential abuse were reported and investigated for residents #12, #13, and #14. The census of the unit was 13. The findings were: 1. Interview with employee #1 on 11/26/14 at 9:05 AM revealed s/he was concerned about the safety of residents who resided in the memory care unit. The employee stated residents #12, #13 and #14 had aggressive behaviors. The employee stated these residents had behaviors that included hitting, yelling, and breaking things. These behaviors were directed at staff and other residents. The employee stated s/he was "afraid someone would be hurt." The employee further stated many of the behaviors and incidents were not documented due to confusion within the facility of what was required. The employee was	S5071	1. The Wellness Director is responsible for gathering information about any incidents and non-incidents from the nursing staff. She creates a report for the Administrator via our computerized internal reporting system. The Administrator then determines the need to report the incident to the state and reports as necessary. All incidents and non-incidents will be reviewed at quarterly QA meetings to ensure they are properly categorized and reported. If the incidents involving Residents #12, #13 and #14 happened today they would be reported to the state.	2/2/2015

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S5071	Continued From page 18 sure the administration knew of these incidents/behaviors; however, other than a recent attempt to keep consistent staff working on the unit, there was no clear directions or interventions in place related to resident safety. 2. Interview with employee #2 on 11/26/14 at 9 AM verified resident #12 had behaviors that affected others including breaking things, yelling, and hitting. She stated these kinds of behaviors occurred weekly. 3. Review of the medical record showed resident #13 moved into the facility on 5/7/14 and at the time of the survey, resided on the memory care unit. Interview with employee #1 on 11/26/14 at 9:05 AM revealed the resident did not like others, including staff, in his/her room. The employee stated the resident had punched two residents (#14 and #16) and multiple staff members. The employee further revealed these incidents were reported to administration; however, there was nothing being done related to the aggressive behaviors by residents in the unit. Review of nursing communication notes, and incident reports showed the following: a. A note on 11/25/14 at 4:19 PM showed the resident had "punched" resident #16 for walking into his/her room without knocking. b. A note dated "11/24-11/25" showed resident #13 and another resident were "fighting." c. An undated note from the September to November 2014 nurse communication book showed resident #13 "hit" another resident. d. A note from 11/21/14 "nights" showed the resident hit resident #16. 4. Review of the medical record showed resident #14 moved into the facility on 2/19/14 with diagnoses that included dementia, history of	S5071	2. The Wellness Director is responsible for gathering information about any incidents and non-incidents from the nursing staff. She creates a report for the Administrator via our computerized internal reporting system. The Administrator then determines the need to report the incident to the state and reports as necessary. All incidents and non-incidents will be reviewed at quarterly QA meetings to ensure they are properly categorized and reported. If the incidents involving Resident #12 happened todaythey would be reported to the state. 3. The Wellness Director is responsible for gathering information about any incidents and non-incidents from the nursing staff. She creates a report for the Administrator via our computerized internal reporting system. The Administrator then determines the need to report the incident to the state and reports as necessary. All incidents and non-incidents will be reviewed at quarterly QA meetings to ensure they are properly categorized and reported. If the incidents involving Resident #13 happened today they would be reported to the state. 4. The Wellness Director is responsible for gathering infomation about any incidents and non-incidents from the nursing staff.	2/2/2015 2/2/2015 2/2/2015

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S5071	Continued From page 19 stroke and hypertension. The individual resident record failed to include notes related to the resident's behaviors or involvement in resident to resident altercations. However, review of a nursing communication book showed notes about the resident's behaviors. These notes were on a page which listed all residents on the memory care unit. Some pages were dated and some were not. The information was from September, October, and November 2014. The notes were not detailed; however, showed the resident was: "violent...up with a vengeance...feisty...angry...mean." Interview with employee #2 on 11/26/14 at 9 AM revealed this resident had "hit every resident [in the unit] at some point." In addition, the employee stated the resident's aggressive behaviors, which included hitting, occurred on a daily basis. 5. Interview with the wellness director and administrator on 11/26/14 at 1 PM verified they were unaware of the requirement to investigate and report resident to resident incidents and altercations to the licensing division.	S5071	She creates a report for the Administrator via our computerized internal reporting system. The Administrator then determines the need to report the incident to the state and reports as necessary. All incidents and non-incidents will be reviewed at quarterly QA meetings to ensure they are properly categorized and reported. Resident #14 passed away 1/3/2015. If the incidents involving Resident #14 happened today they would be reported to the state.	
S5095	Ch 12 Sec 8 (a)(i) Services Which Cannot Be Provided by Level I Services which cannot be provided by the Level I Assisted Living Facility staff. (a) The following services cannot be provided: (i) Continuous assistance with transfer and mobility; This State Rule and Regulation is not met as evidenced by: Based on observation, medical record review,	S5095		

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	ALF026	A. BUILDING _____ B. WING _____	C 11/26/2014

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
S5095	Continued From page 20 CNA communication book review, and staff interview, the facility failed to ensure 1 of 1 resident (#10) could transfer independently. The findings were: Review of the medical record for resident #10 showed s/he was admitted to the facility on 5/5/14 with diagnoses which included depression and osteoporosis. The following concerns were identified: a. Observation of the resident in the dining area on 11/25/14 at 4 PM showed the resident was in a wheelchair. An attempt to interview the resident at that time was unsuccessful. Interview at that time with employee #4 confirmed the resident could not transfer independently, and staff were required to transfer the resident from the bed to the wheelchair, from the wheelchair to the bed, from the wheelchair to the toilet, and from the toilet to the wheelchair. b. Review of nursing notes revealed the following: "Original note at 2014-08-28 4:01 [4:01 AM] Resident had a fall at beginning of day shift. Resident was using the restroom and just fell. [The resident] did not remember [the resident] pendent or pull cord. Dragged [self] from restroom to front room of apartment...Original note at 2014-09-13 3:31 [3:31 AM] Resident is unable to transfer self or stand without assistance. Required full assistance when toileting and going to bed. Will continue to monitor. Original note 2014-10-22 2:55 [2:55 AM] Resident was found on bathroom floor. [The resident] stated [the resident] was trying to transfer [the resident] from the toilet to the wheelchair independently. As [the resident] was pulling up [the resident's] brief [the resident] went down landing on [the resident's] bottom. Rt [resident] denies any pain or discomfort. No injuries noted..."	S5096	Resident #10's decrease in mobility was not communicated to the Wellness Director. Aides now use a computerized reporting system which is accessable by the nurses and the Wellness Director. The nurses check notes daily and the Wellness Director checks notes 2-3 times a week. Issues found in change of condition will trigger a new assessment (ALF 102 and community assessment) by the Wellness Director. Residents of concern will also be reviewed at QA meeting to ensure their any changes are noted and new needs are met. A review of mobility competency for all residents was complete 2/2/2015.	2/2/2015

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S5095	Continued From page 21 c. Review of the facility CNA communication book [not part of the medical record] revealed the following, "11/4/14 [The resident] ...the only time [the resident] got up is at 5:30 AM when I got her up for the day." d. Interview with the wellness director on 11/26/14 at 1:05 PM revealed she was unaware the resident could not transfer independently.	S5095		
S5097	Ch 12 Sec 8 (a)(iii) Services Which Cannot Be Provided By Level I Services which cannot be provided by the Level I Assisted Living Facility staff. (a) The following services cannot be provided: (iii) Total assistance with bathing and dressing; This State Rule and Regulation is not met as evidenced by: Based on observation, medical record review, CNA communication book review, nurse communication book review, and staff interview, the facility failed to ensure staff requirements did not include total assistance with bathing and dressing for 2 of 9 sample residents (#4, #11) who resided on the Level I unit. The findings were: 1. Review of the medical record showed resident #4 was admitted to the facility on 11/15/14 from a local long-term care facility with diagnoses which included Alzheimer's disease, dementia unspecified, and depression. The following concerns were identified: a. Observation on 11/25/14 at 3:05 PM showed the resident in his/her room without pants	S5097	1. Resident #4 was discharged to higher care on 11/29/2014. A review of all residents ensuring their level of care is appropriate for assisted living or memory care, including a review of ALF 102s, was completed 2/2/2015.	2/2/2015

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S5097	Continued From page 22 on, and attempting to put a shirt on in place of pants, placing his/her legs in the sleeves of the shirt. An attempt to interview the resident at that time was unsuccessful, as the resident was unaware the surveyor was in the room following repeated attempts by the surveyor to get his/her attention. Interview with employee #4 at that time confirmed staff were required to dress the resident and provide total care including bathing and frequent cleaning due to incontinence. The aide then provided incontinence care and dressed the resident. b. Review of the facility CNA communication book [not part of the medical record] revealed the following, "11/16/14 [The resident] babysitting [the resident] all night." c. Review of the memory care nurse communication book [not part of the medical record] revealed the following, "[not dated] [The resident] incontinent, refused to change, no shower 4 weeks." "[not dated] [The resident] slept in chair most of night. Wet [the resident's] pants, refused help." d. Interview with the wellness director and administrator on 11/26/14 at 1:05 PM revealed when the resident was admitted they realized they were "in over their heads" and were actively seeking to transfer the resident to a higher level of care. 2. Review of the medical record showed resident #11 was admitted to the facility on the Level I unit [unlocked unit] on 11/24/14 with diagnoses which included frontal lobe dementia of mixed etiology, Alzheimer's disease, and vascular dementia. The following concerns were identified: a. Observation on 11/26/14 revealed the resident wandering the hallways with rambling speech and unable to engage the surveyor in an interview. Interview with employee #2 at that time	S5097	Each resident will be reviewed for appropriateness by the Wellness Director and Administrator at quarterly Quality Assurance meetings and any time the resident shows a change in condition. When it is determined reassessment is needed, the Wellness Director will use the ALF 102 and the community assessment or both. With Resident #4s discharge, no further corrective action will be taken. The implementation of the resident care review is in effect and will be used at all QA meetings starting February 1, 2015. 2. Resident # 11 was discharged for higher care needs on 12/2/2014. A review of all residents ensuring their level of care is appropriate for assisted living or memory care, including a review of ALF 102s, was completed 2/2/2015. Each resident will be reviewed for appropriateness by the Wellness Director	2/2/2015

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S5097	Continued From page 23 revealed the resident required total assist with dressing and bathing. b. Review of the admission 11/20/14 ALF 102 showed the resident was, "Acutely ill, requires 24 hour RN care/supervision to ensure medical needs are addressed." c. Review of an 11/24/14 discharge summary from an acute care hospital revealed the following, "... Memory is severely impaired....It was felt the patient is appropriate to discharge to skilled nursing facility [nursing home and not assisted living] as [the resident] was 1-2 person assist with ADL's, transfers, and feeding and further discussed with family who decided to transfer to [specific nursing home]." d. Interview with the wellness director on 11/26/14 at 1:05 PM revealed she did not consider a resident's history when assessing and admitting residents. She further revealed she was not aware of the details of the information in the 11/24/14 hospital discharge summary.	S5097	and Administrator at quarterly Quality Assurance meetings and any time the resident shows a change in condition. When it is determined reassessment is needed, the Wellness Director will use the ALF 102 and/or community assessment. With Resident #11's discharge, no further corrective action will be taken. The implementation of the resident care review is in effect and will be used at all QA meetings starting February 1, 2015.	
S5100	Ch 12 Sec 8 (a)(vi) Services Which Cannot Be Provided By Level I Services which cannot be provided by the Level I Assisted Living Facility staff. (a) The following services cannot be provided: (vi) Care of resident whose wandering jeopardizes the health and safety of the resident; This State Rule and Regulation is not met as evidenced by: Based on observation, medical record review, CNA communication book review, nurse communication book review, and staff interview,	S5100		

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S5100	Continued From page 24 the facility failed to ensure staff in the Level I area of the facility did not provide services for 5 of 5 sample residents (#4, #5, #7, #8, #11) who had wandering and eloping behaviors. The findings were: 1. Review of the medical record showed resident #4 was admitted to the facility on 11/15/14 from a local long-term care facility to a Level I area [not secured] with diagnoses which included alzheimer's disease, dementia unspecified, and depression. The following concerns were identified: a. Observation on 11/25/14 at 3:05 PM showed the resident in his/her room without pants on, and attempting to put a shirt on in place of pants, placing his/her legs in the sleeves of the shirt. An attempt to interview the resident at that time was unsuccessful, as the resident was unaware the surveyor was in the room despite repeated attempts to get his/her attention. An alarm that prompts staff electronically when the door is opened was attached to the resident's door even though the resident resided in the level I area of the facility. Interview with employee #4 at that time confirmed the resident was always confused, wandered often, and had eloped from the facility on several occasions. b. Review of the admission resident assessment revealed the resident, "Requires regular prompting due to confusion and disorientation...Wanders intrusively, but easily directed." c. Review of the admission service agreement revealed the resident "Wanders intrusively, but easily directed...Wandering r/t resident's constant movement. AEB [as evidenced by]: Resident walking around and wanting to fix pipes at home. Expected outcome: For the next 30 days, resident wandering will be	S5100	1. Resident #4 was discharged due to the need for higher care on 11/29/2014. When a need is determined, a safety plan will be written by the Wellness Director and approved by the Administrator or designee. That safety plan will be contained in the resident plan of care. The Wellness Director or designee will educate the balance of the wellness staff on the new needs for that resident and the implementation of the safety plan. The need for safety plans will also be visited during QA meetings. With the discharge of Resident #4, no further corrective action will be taken.	2/2/2015

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S5100	Continued From page 25	S5100		

evaluated. Resident will be redirected by staff as needed and kept safe..."

d. Review of the facility CNA communication book [not part of the medical record] revealed the following, "11/15/14 [day of admission] Got out...Very confused: Wants to get out...still confused." "11/16/14 Babysitting [the resident] all night...needs to be re-directed to bedroom." "11/18/14 Wandered in people's rooms...up half the night." "11/19/14 [The resident] went into people's rooms, wandered everywhere-including [the resident] tried to exit the exit doors." Review of Progress Notes in the CNA communication book revealed the following, "11/16/14 [The resident] left the building, was sitting in someone else's car...[The resident] wandered around and went into other resident's rooms. A few residents were upset that they were wandering into their room." "11/18/14 [The resident] Wandered into a couple of residents rooms. Redirected [the resident]." "11/20/14 [The resident] Resident was awake all night. Tried wandering into peoples rooms. When CNA tried to redirect resident got very violent and combative. [The resident] was hitting & pushing. Meds didn't help calm patient. Eventually calmed down about 3:30 A.M."

e. Review of the memory care nurse communication book [not part of the medical record] revealed the following, "11/22/14 Went into [another resident's] room and got punched, agitated." "11/18/14 [The resident] Confusion. High risk elopement." "11/17/14 [The resident]...elopement risk. Confused agitation...kept opening doors-court yard/hall." "11/17/14 days [The resident] Keep getting out of Building, confusion, agitation." "[Not dated] [The resident] out of building." "11/16/14 [The resident] Flight risk did get out-confused.'"11/15-16/14 Wants to go home, door alarm."

f. Interview on 11/26/14 at 9:30 AM with

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S5100	Continued From page 26 resident #17 revealed s/he felt unsafe because the resident wandered into her room, and now locks the front door. Interview on 11/26/14 at 9:35 AM with resident #18 revealed the resident had been scared after the resident wandered into his/her room. g. Interview with the wellness director and administrator on 11/26/14 at 1:05 PM revealed when the resident was admitted they realized they were "in over their heads" and were actively seeking to transfer the resident to a higher level of care. However, the wellness director acknowledged the resident slept in his/her room on the Level I [unlocked unit] unit. 2. Review of the medical record showed resident #7 was admitted to the facility on a Level I [unlocked unit] on 9/3/14 with diagnoses which included dementia, depression, and anxiety Observation of the resident on 11/25/14 at 4 PM showed s/he was confused and could not state what kind of facility s/he was in. The following concerns were identified: a. Review of a 8/19/14 psychiatric assessment from a geropsychiatric admission in another state showed the following on the risk assessment, "[The resident] is a risk for suicidal ideation...[The resident] is at risk for elopement potential. [The resident] has a history of going AMA [against medical advice] and being displeased with lock down units in the past." b. Review of the 9/3/14 resident assessment showed the resident required regular prompting due to confusion and disorientation, and was admitted from a geropsychiatric unit from another state. c. Review of nursing notes revealed the following: "Original Note at 9/9/14 15:04 [3:04 PM] Res [resident] seen by provider today. Provider states [the resident] is an extreme elopement	S5100	2. When a need is determined, a safety plan will be written by the Wellness Director and approved by the Administrator or designee. That safety plan will be contained in the resident plan of care. The Wellness Director or designee will educate the balance of the wellness staff on the new needs for that resident and the implementation of the safety plan. The need for safety plans will also be discussed at QA meetings. An emopement assessment was complete upon admission and most recently on 1/22/2015. The assessment did not indicate Resident #7 is an elopement risk. The resident's primary care physician agrees with the assessment and will provide documentation of his opinion. Further assessments will be complete by the Wellness Director if there is a change in condition.	

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S5100	Continued From page 27 risk. States we need to monitor closely. Resident in MC [memory care] most of the day talking with other residents." d. Interview with the wellness director on 11/26/14 at 1:05 PM revealed she did not consider a resident's history when assessing and admitting residents. She further revealed the resident stayed in the memory care unit in the daytime; however, the resident stays in the Level I [unsecured unit] unit in his/her own apartment at night. 3. Review of the medical record showed resident #5 was admitted to the facility on a Level I [unlocked unit] unit on 10/31/14 with diagnoses which included memory loss. The following concerns were identified: a. Observation on 11/25/14 at 3:15 PM showed the resident had barricaded the front door to his/her apartment with a table. Employee #4 at that time came to the resident's room and was able to push the door with table aside and enter. Interview with the resident at that time revealed s/he was confused and did not know where s/he was. The door had an electronic device that alerted staff via electronic messaging if the door was opened even though the resident resided in the level I area of the facility. Interview with employee #4 at that time revealed the resident had wandered out of the building on the evening of admission. b. Review of the facility CNA communication book [not part of the medical record] revealed the following," "11/15/14 [The resident] wandered outside emergency exit." "11/20/14 [The resident] wandered all day...tried going outside." "11/6/14 [The resident] wandered." Review of the separate CNA communication form in the CNA communication book revealed the following, "11/3 [Resident] room #[resident's room] got out of the	S5100	3. Resident #5 was transferred to memory care on 11/29/2014. When a need is determined, a safety plan will be written by the Wellness Director and approved by the Administrator or designee. That safety plan will be contained in the resident plan of care. The Wellness Director or designee will educate the balance of the wellness staff on the new needs for that resident and the implementation of the safety plan. The need for safety plans will also be visited during QA meetings. With the transfer of Resident #5 to memory care, no further corrective action will be taken.	2/2/2015

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S5100	Continued From page 28 exit by room #113. No alarm went off. Reported it to [wellness director]." "11/5/14 [The resident] has wandered into [3 other resident rooms] and the beauty shop. Residents are getting upset. Tried to take [the resident] away from people doors. [The resident] gets upset-Talked to [another CNA] about it. [The resident] also tried to exit through emergency door by the beauty shop. I redirected [the resident] back to the bistro living room..." "[The resident] was wandering down the hallways going into everyone's room. CNA's tried to re-direct [the resident] from pounding on other resident's doors. [The resident] grabbed other CNA's and started to hit them and was yelling. Resident also ran outside towards cars trying to leave * 2 [twice]." "11/12/14 [The resident] wandering, very combative, trying to elope." c. Review of the memory care nurse communication book [not part of the medical record] revealed the following, "11/6/14 [The resident] wandering, door alarm coming. Keep an eye on. Barricades door with coffee table." "11/2/14 [The resident] confused....trying to leave." d. Interview with the wellness director on 11/26/14 at 1:05 PM revealed the resident stayed in the memory care unit in the daytime; however, the resident stayed in the Level I [unsecured unit] unit in his/her own apartment at night. 4. Review of the medical record showed resident #11 was admitted to the facility on a Level I unit [unlocked unit] on 11/24/14 with diagnoses which included frontal lobe dementia of mixed etiology, Alzheimer's disease, and vascular dementia. The following concerns were identified: a. Observation on 11/26/14 revealed the resident wandering the hallways with rambling speech and unable to engage the surveyor in an interview. Interview with employee #2 at that time	S5100	4. 1. Resident #11 was discharged due to the need for higher care on 12/2/2014. When a need is determined, a safety plan will be written by the Wellness Director and approved by the Administrator or designee. That safety plan will be contained in the resident plan of care. The Wellness Director or designee will educate the balance of the wellness staff on the new	2/2/2015

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S5100	Continued From page 29 revealed the resident had wandered the hallways for hours at a time since admission, could not engage the staff in conversation and did not appear to understand staff, and appeared to want to leave the facility. b. Review of an 11/24/14 discharge summary from an acute care hospital revealed the following, "This is a [stated age and gender] voluntarily admitted via DPOA [DPOA's name] from [a different ALF] secondary to increased irritability, restlessness, wandering behaviors, agitation with sundowning features. The patient was previously discharged for Geriatric Psychiatric Unit 2 weeks earlier after 17 day hospital stay, but was readmitted for above mentioned reasons and facility felt they were unable to effectively care for this patient. Upon admission, the patient appeared to be close to baseline to demonstrate significant echolalia [involuntary repetition of words] and echopraxia [meaningless imitation of motions made by others]. Cognitively had severe impairments, would not respond to questions in consistent manner. Frequently ramble and babble. No notable depression, anxiety, crying episodes. The patient did not appear to be responding to internal stimuli. ...Attention and concentration are poor. Interest and motivation are poor. Memory is severely impaired....It was felt the patient is appropriate to discharge to skilled nursing facility [nursing home and not assisted living] as [the resident] was 1-2 person assist with ADL's, transfers, and feeding and further discussed with family who decided to transfer to [specific nursing home]." c. Interview with the wellness director on 11/26/14 at 1:05 PM revealed she did not consider a resident's history when assessing and admitting residents. She further revealed she was not aware of the details of the information in the	S5100	needs for that resident and the implementation of the safety plan. The need for safety plans will also be visited during QA meetings. With the discharge of Resident #11, no further corrective action will be taken	

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S5100	Continued From page 30 11/24/14 discarge summary. 5. Review of the medical record showed resident #8 was admitted to the facility on a Level I unit [unlocked unit] on 8/22/14. Interview on 11/25/14 at 4:17 PM revealed the resident planned to elope from the facility as soon as s/he formulated a plan. The resident had an alarm to his/her front and back doors that alerted staff if the front door was opened even though the resident resided in the level I area of the facility. The following concerns were identified: a. Observations on 11/26/14 revealed the resident spent time mostly outside of his/her room in the day room. Those random observations showed staff were not always present in the day room area. b. Review of the admission resident assessment showed the resident wandered intrusively, but could be easily redirected. c. Review of the 11/7/14 resident negotiated service plan showed, "Has occasional confusion and some difficulty recalling details. Needs occasional prompting or orientation... Risk for wandering r/t [related/to] resident's need to get out. AEB [as evidenced by]: Resident verbalizes [s/he] wants to run away. Expected outcome: For the next 6 months, staff will assess resident's status of wandering. Currently, resident is able to come and go as [s/he] pleases. Resident's guardian the State of Wyoming is aware." d. Interview with the wellness director on 11/25/14 at 5:20 PM showed she was aware the resident stated s/he wanted to elope. The wellness director further stated she was not concerned, and the resident said this every day.	S5100	5. Resident #8 was originally admitted to memory care on 8/22/2014. Over time it was obserbed by staff that his cognitive abilities were above what was originally determined. An ALF 102, MMSE and assessment (including emopemet sub-assessment) were completed on 11/7/2014 to determine the possibility of the resident's move to assisted living. It was determined the resident would do well in a less restrictive assisted living emvironment once the resident adjusted. This has proven to be true. When a need is determined, a safety plan will be written by the Wellness Director and approved by the Administrator or designee. That safety plan will be contained in the resident plan of care. The Wellness Director or designee will educate the balance of the wellness staff on the new needs for that resident and the implementation of the safety plan. The need for safety plans will also be visited during QA meetings.	
S5101	Ch 12 Sec 8 (a)(vii) Services Which Cannot Be Provided By Level I	S5101		

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	ALF026	A. BUILDING: _____ B. WING _____	C 11/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S5101	Continued From page 31 Services which cannot be provided by the Level I Assisted Living Facility staff. (a) The following services cannot be provided: (vii) Incontinence care by facility staff; This State Rule and Regulation is not met as evidenced by: Based on observation, medical record review, CNA communication book review, nursing communication book review, and staff interview, the facility failed to ensure staff were not required to provide incontinence care for 3 of 3 sample residents (#4, #10, #11) who resided on the Level I unit and were identified as being incontinent. The findings were: 1. Review of the medical record showed resident #4 was admitted to the facility on 11/15/14 from a local long-term care facility with diagnoses which included Alzheimer's disease, dementia unspecified, and depression. The following concerns were identified: a. Observation on 11/25/14 at 3:05 PM showed the resident in his/her room without pants on, and attempting to put a shirt on in place of pants, placing his/her legs in the sleeves of the shirt. An attempt to interview the resident at that time was unsuccessful, as the resident was unaware the surveyor was in the room despite repeated attempts to get his attention. Interview with employee #4 at that time confirmed staff were required to routinely provide incontinence care for the resident. The aide then provided incontinence care for the resident. b. Review of the memory care nurse communication book [not part of the medical record] revealed the following, "[not dated] [The	S5101	1. Resident #4 was discharged for higher care needs on 11/29/2014. The Wellness Director will determine continence appropriateness through an ALF 102 and community assessment when a change of condition is noted. An overall review of assessments for all residents to ensure their accuracy was complete on 2/2/2015. If a resident does not meet the continence standard set by the state, a 30 day notice will be given to the family, ensuring a community providing the proper level of care can be found in a timely manner. The continence of residents will be reviewed at each Quality Assurance meeting. Becaues Resident #4 was discharged, no further action will be taken with this resident.	2/2/2015

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S5101	Continued From page 32 resident] incontinent, refused to change, no shower 4 weeks." "[not dated] [The resident] slept in chair most of night. Wet [the resident's] pants, refused help." c. Interview with the wellness director and administrator on 11/26/14 at 1:05 PM revealed when the resident was admitted they realized they were "in over their heads" and were actively seeking to transfer the resident to a higher level of care. 2. Review of the medical record showed resident #11 was admitted to the facility on a Level I unit [unlocked unit] on 11/24/14 with diagnoses which included frontal lobe dementia of mixed etiology, Alzheimer's disease, and vascular dementia. The following concerns were identified: a. Observation on 11/26/14 revealed the resident wandering the hallways with rambling speech and unable to engage the surveyor in an interview. Interview with employee #2 at that time revealed the resident required total assistance with toileting. b. Review of the admission 11/20/14 ALF 102 showed the resident was, "Acutely ill, requires 24 hour RN care/supervision to ensure medical needs are addressed." c. Review of an 11/24/14 discharge summary from an acute care hospital revealed the following, "... Memory is severely impaired....It was felt the patient is appropriate to discharge to skilled nursing facility [nursing home and not assisted living] as [the resident] was 1-2 person assist with ADL's, transfers, and feeding and further discussed with family who decided to transfer to [specific nursing home]." d. Interview with the wellness director on 11/26/14 at 1:05 PM revealed she did not consider a resident's history when assessing and admitting residents. She further revealed she was	S5101	1. Resident #11 was discharged for higher care needs on 12/2/2014. The Wellness Director will determine continence appropriateness through an ALF 102 and community assessment when a change of condition is noted. An overall review of assessments for all residents to ensure their accuracy was complete on 2/2/2015. If a resident does not meet the continence standard set by the state, a 30 day notice will be given to the family, ensuring a community providing the proper level of care can be found in a timely manner. The continence of residents will be reviewed at each Quality Assurance meeting. Becaues Resident 11 was discharged, no further action will be taken with this resident.	2/2/2015

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S6101	Continued From page 33 not aware of the details of the information in the 11/24/14 hospital discarge summary. 3. Review of the medical record showed resident #10 was admitted to the facility on 5/5/14 with diagnoses which included depression and osteoporosis. The following concerns were identified: a. Observation of the resident in the dining area on 11/25/14 at 4 PM showed the resident was in a wheelchair. An attempt to interview the resident at that time was unsuccessful. Interview at that time with employee #4 confirmed staff were required to provide incontinence care routinely. b. Review of nursing notes revealed the following: "Original note at 2014-09-13 3:31 [3:31 AM] ...Required full assistance when toileting and going to bed. Will continue to monitor. c. Review of the facility CNA communication book [not part of the medical record] revealed the following, "11/16/14 [The resident] ...incontinent 2 times." "11/16/14 [The resident] ...had to change in bed *2 [2 times]." "11/4/14 [The resident] ...was incontinent so I had to change [the resident's] brief in bed." d. Review of the memory care nurse communication book [not part of the medical record] revealed the following, "11/19/14 [The resident] IC [incontinent] stool." 11/18/14 Days [The resident] mess in bed." "11/18/14 Nights [The resident] incontinent BM [bowel movement] at 0100 [1 AM]." "11/15/14-11/16/14 [The resident] not refusing toileting." "11/11/14 [The resident] incontinent all night, refused care." "11/10/14 [The resident] incontinent. Refused to assist with change." "11/6/14-11/6/14 Nights [The resident] incontinent every other time, would not get up to change brief." "11/5/14 [The resident] incontinent, refused to toilet." "11/4/14-11/5/14 [The resident]	S5101	1. Resident #10's reassessment was complete on 1/3/2015. A care conference was held with the family 1/7/2015. Another care conrerence is scheduled 2/17/2015 where it is anticipated 30 day notice will be given to the family. The Wellness Director will determine continence appropriateness through an ALF 102 and community assessment when a change of condition is noted. An overall review of assessments for all residents to ensure their accuracy was complete on 2/2/2015. If a resident does not meet the continence standard set by the state, a 30 day notice will be given to the family, ensuring a community providing the proper level of care can be found in a timely manner. The continence of residents will be reviewed at each Quality Assurance meeting.	

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S5101	Continued From page 34 Incontinent at night, refused to get up to bathroom." "10/30/14 [The resident] incontinent most of day." "10/25/14 [The resident] arguing about toileting." "10/9/14 [The resident] incontinent." e. Interview with the wellness director on 11/26/14 at 1:05 PM revealed she was unaware the resident could not toilet independently.	S5101		
S5103	Ch 12 Sec 8 (a)(ix) Services Which Cannot Be Provided By Level I Services which cannot be provided by the Level I Assisted Living Facility staff. (a) The following services cannot be provided: (ix) Stage II skin care and beyond; 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 staff were not required to provide wound care for 1 of 1 sample resident (#9) who had stage II wounds. The findings were: Review of the medical record showed resident #9 was admitted to the facility on 7/25/13. Observation on 11/26/14 at 9 AM showed the resident had 2 stage II pressure ulcers to the right buttocks, and 1 stage II pressure ulcer to the right heel. Review of the resident assessment signed on 4/30/14 by the Community Wellness/Resident Services Director (wellness director) revealed the following, "Resident utilizes Home Health: Wellness Nurse will monitor visits by home health nurse and report any concerns to the healthcare provider...HHN [home health nurse] to provide	S5103	Resident #9 receives State II would care from a Home Health Agency (HHA) for a Stage 2 would which requires a sterile dressing change. Documentation from the HHA has been received describing the care to be given to Resident #9, who will provide that care and how often the care will be administered. This documentation is contained in the resident's chart. In the overall review and reassessment of current residents, the issue of would care is addressed. An overall review of assessments to ensure their accuracy as it pertains to skin care was complete 2/2/2015.	2/28/2015

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S5103	Continued From page 35 decub care per physician orders. Under the category "Acute Illness Needs" the following was identified, "Lesion: Resident has a stage II decub on [the resident's] left middle buttock. Wellness Nurse will make contact with [name of home health agency] so care can be given..." The following concerns were identified: a. Review of the medical record showed a 9/26/14 faxed communication to the physician which stated, "Resident has 2 sores on Buttocks. One on the upper right side measuring 2.1 cm by 2.7 cm. Applied antibacterial cream and covered with a tegaderm. One on the left side measuring 1.4 cm by 1.3 cm. Applied antibacterial cream." b. Review of a 9/30/14 faxed communication to the physician revealed, "Resident has three open areas on inner buttocks. May we have an order for Home Health to come and tx. Currently we are dressing with cream and simple dressing. Continues to [lessen] in condition in part due to scratching." c. Review of an 11/5/13 letter from the home health agency (HHA) to the facility revealed, "[HHA] is providing skilled nursing care and home health aide care as ordered by [primary physician]. This care is to be provided at [the resident's] residence which is your facility. The plan of care approved by [the primary physician] includes: Skilled nursing assessment once per week to include body system assessment as needed, lab draws for PT/INR every four weeks and as ordered by [the primary physician], any other labs as ordered and any other assessments as deemed necessary to maintain health." Review of the letter showed no interventions for pressure ulcers by the HHA. Review of the entire medical record failed to show other letters or agreements with the HHA, and failed to show the documentation of care from the HHA staff. d. Review of nursing notes showed the	S5103	The Wellness Director will train staff on what skin care services can be provided within the Level I community setting at an in-service meeting to be held before 2/28/2015. If a resident exceeds the care that can be provided, an HHA will be required to provide that care. The need for outside services to care for Stage 2 or beyond woulds will be adressed at each Quality Assurance meeting.	

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S5103	Continued From page 36 following wound care provided by facility staff, "Original note at 2014-07-01 18:08 [6:08 PM] [Primary physician's] office notified of [the resident's] continued swelling and weeping from legs..." "Original note at 2014-07-02 3:19 [3:19 AM] Res [resident]legs continue to weep clear fluid LLE [left lower extremity] saturated gauze dressing. Changed dressing." "Original note at 2014-09-26 18:22 [6:22 PM] Resident has sore on left buttcheek. Measuring 1.4 by 1.3. Cover in antibacterial cream. Sore on right side measuring 2.1 by 2.7 non-blanchable. Covered in antibacterial cream, foam, then tegaderm. Will continue to monitor." "Original note at 2014-09-27 18:22 [6:22 PM] Resident still has dressing in place on [the resident's] buttock." e. Interview with the wellness director on 11/26/14 at 1:05 PM revealed she was unaware facility staff had provided wound care for the resident.	S5103		
S5104	Ch 12 Sec 8 (a)(x) Services Which Cannot Be Provided By Level I Services which cannot be provided by the Level I Assisted Living Facility staff. (a) The following services cannot be provided: (x) Care of the resident with inappropriate social behavior; e.g., frequent aggressive, abusive, or disruptive behavior; and This State Rule and Regulation is not met as evidenced by: Based on observation, medical record review, CNA communication book review, nurse communication book review, and staff interview, the facility failed to ensure staff did not provide	S5104		

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S5104	Continued From page 37 care for 2 of 2 sample residents (#5, #6) with inappropriate social behavior who resided on the Level I unit [unlocked unit]. The findings were: 1. Review of the medical record showed resident #6 was admitted to the facility on the Level I unit [unlocked unit] on 10/16/14 with diagnoses which included frontal temporal lobe dementia, Alzheimer's disease, vascular disease, depression, and anxiety. Observation of the resident on 11/25/14 at 3:30 PM showed the resident was ambulatory. Interview with the resident at that time revealed facility staff assisted with his/her meals and medications. The following concerns were identified: a. Review of nursing notes showed the following, "Original note at 10/25/14 2:51 [2:51 PM] ...Res [resident] anxious, administered xanax at 2350 [11:50 PM]. Res [resident] called police *4 [four times] unable to explain why other than [the resident] was having an emergency. Nephew contacted, agreed to send [the resident] to ER if [the resident] calls police again....Res [resident] does not believe we are medical personal [SIC]. Will continue to monitor throughout the night." "Original note at 10/28/14 12:43 [12:43 PM] Resident up since 4 am. [The resident] requests to call police states someone is holding [the resident] against [the resident's] will. Brought to memory care for awhile so [the resident] would be with other staff and rts. [residents]." b. Interview with the wellness director on 11/26/14 at 1:05 PM revealed she did not consider a resident's history when assessing and admitting residents. 2. Review of the medical record showed resident #5 was admitted to the facility on the Level I [unlocked unit] unit on 10/31/14 with diagnoses which included memory loss and dementia. The	S5104	1. When a resident displays behaviors beyond what is acceptable for a Level I setting, the family will be consulted and a resolution will be sought. If a change in behavior is not anticipated, the Administrator will issue a 30 day or 72 hour discharge notice to the family, depending upon the severity of the non-compliance as determined by the Wellness Director and the Administrator. Resident behaviors will be reviewed at each Quality Assurance meeting and with any change in condition and adressed as needed. In the case of Resident #6 medication management was needed. Changes have been made by the physician which have been effective. Also, Resident #6 transferred to memory care 1/27/2015. 2. When a resident displays behaviors beyond what is acceptable for a Level I setting, the family will be consulted and a	2/2/2015

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S5104	Continued From page 38 following concerns were identified: a. Observation on 11/25/14 at 3:15 PM showed the resident had barricaded the front door to his/her apartment with a table. Employee #4 at that time came to the resident's room and was able to push the door with table aside and enter. Interview with the resident at that time showed s/he was confused and did not know where s/he was. Even though the resident resided in the level I area of the facility the door had an electronic device that prompted the staff if the door was opened. Interview with employee #4 at that time revealed concern that the resident barricading the front door to his/her apartment was an ongoing issue. b. Review of the facility CNA communication book [not part of the medical record] revealed the following, "11/4/14 [The resident] confused, kept barricading [the resident's] door with side table so CNA couldn't get in." "11/5/14 [The resident] has [the resident's] door blocked off with a coffee table." "11/10/14 [The resident] wanders a lot-refused to change clothes. Argues a lot, opening doors all morning." "11/20/14 [The resident] ...confused, barricaded door." Review of Progress Notes in the CNA communication book revealed the following, "11/4/14 [The resident] is very confused, [the resident] keeps putting [the resident's] side table in front of the door so CNA can't get into [the resident's] room." "11/12/14 [The resident] was wandering down the hallways going into everyone's room. CNA's tried to re-direct [the resident] from pounding on other resident's doors. [The resident] grabbed CNA's and started to hit them and was yelling. Resident also ran outside towards cars trying to leave *2 [two times]." c. Review of the memory care nurse communication book [not part of the medical record] revealed the following, "[no date on note]	S5104	resolution will be sought. If a change in behavior is not anticipated, the Administrator will issue a 30 day or 72 hour discharge notice to the family, depending upon the severity of the non-compliance as determined by the Wellness Director and the Administrator. Resident behaviors will be reviewed at each Quality Assurance meeting and with any change in condition and adressed as needed. Resident #5 transferred to memory care 11/29/2015 and has not displayed any behavior issues, including barricading or elopement.	

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S5104	Continued From page 39 [The resident] barricades door." "11/20/14 [The resident] new order haldol (anti-psychotic medication)." "11/9/14-11/10/14 [The resident] has table with lamp in front of door." "11/9/14 [The resident] door alarm." "11/6/14 [The resident] blocks door with coffee table, blocks the door at night." "11/5/14-11/6/14 [The resident] Wandering, door alarm coming. Keep an eye on. Barricades the door with coffee table." "11/5/14 [The resident] pushed coffee table in front of door, alarm for her door." "11/4/14-11/5/14 [The resident]...barricades the door at night." "11/2/14 [The resident] confused, check and toilet Q2h [every 2 hours]." "10/30/14 [The resident] respite-wanderer, check and toilet."	S5104		
S5107	Ch 12 Sec 9 (a)(i-v) Contractual Svcs Provided Outside ALF Auth Contractual Services Provided Outside Assisted Living Facility Authority. Residents in an assisted living facility may receive services from an outside entity for care beyond that provided for or specified in the Assisted Living Program Administration Rules. These services must be arranged by the appropriate professional and be incorporated into the resident's assistance plan. The resident's choice of providers must be honored. (a) Components of the outside service(s) contract: (i) Who will provide service(s); (ii) What service(s) will be provided; (iii) When the service(s) will be provided;	S5107		

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S5107	Continued From page 40 (iv) Where the service(s) will be provided; (v) How the service(s) will be provided, and 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 outside contractual services were specified to provide wound care for 1 of 1 sample resident (#9) who had stage II wounds. The findings were: Review of the medical record showed resident #9 was admitted to the facility on 7/25/13. Observation on 11/26/14 at 9 AM showed the resident had 2 stage II pressure ulcers to the right buttocks, and 1 stage II pressure ulcer to the right heel. Review of the resident assessment signed 4/30/14 by the wellness director revealed the following, "Resident utilizes Home Health: Wellness Nurse will monitor visits by home health nurse and report any concerns to the healthcare provider...HHN [home health nurse] to provide decub care per physician orders. Under the category "Acute Illness Needs" the following was identified, "Lesion: Resident has a stage II decub on [the resident's] left middle buttock. Wellness Nurse will make contact with [name of home health agency] so care can be given..." The following concerns were identified: a. Review of the medical record showed a 9/26/14 faxed communication to the physician which stated, "Resident has 2 sores on Buttocks. One on the upper right side measuring 2.1 cm by 2.7 cm...One on the left side measuring 1.4 cm by 1.3 cm..." b. Review of a 9/30/14 faxed communication to the physician showed, "Resident has three open areas on inner buttocks. May we have an	S5107	Resident #9 receives State 2 wound care from a Home Health Agency (HHA). A detailed letter describing services by the HHA is now in the resident's chart. The Wellness Director will monitor the needs of each resident receiving services from an HHA weekly and will determine who will meet those needs as well as how and when they will be met. A record of services provided by the HHA will be recorded on a form in the resident's room for each occurrence of services provided. The HHA provider will be required to document their visit on this form, which will allow the community wellness staff to know when services are provided. The form will be available in the room of each resident who receives HHA services by 1/26/2015. Residents who receive outside services will be reviewed at each Qualiy Assurance meeting.	2/2/2015

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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
	ALF026	A. BUILDING: _____ B. WING _____	C 11/26/2014

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
S5107	Continued From page 41 order for Home Health to come and tx..." c. Review of an 11/5/13 letter from the HHA to the facility revealed, "[HHA] is providing skilled nursing care and home health aide care as ordered by [primary physician]. This care is to be provided at [the resident's] residence which is your facility. The plan of care approved by [the primary physician] includes: Skilled nursing assessment once per week to include body system assessment as needed, lab draws for PT/INR every four weeks and as ordered by [the primary physician], any other labs as ordered and any other assessments as deemed necessary to maintain health." Review of the letter showed no interventions for pressure ulcers by the HHA. Review of the entire medical record failed to show other letters or agreements with the HHA, and failed to show the documentation of care from the HHA staff. d. Interview with the wellness director on 11/26/14 at 1:05 PM revealed she was unaware the facility failed to obtain, and place on the medical record, a contractual agreement in writing with the HHA concerning stage II pressure ulcer care, and failed to ensure the services provided by the HHA was documented in the medical record.	S5107		
S5136	Ch 12 Sec 10 (f)(ii) Secure Dementia Units Secure Dementia Units. Level 2 assisted living facilities require adherence to all Level I requirements with the following additional criteria for a Level 2 Assisted Living Facility License. (f) Level 2 Discharge Requirements. In addition to Level 1 discharge criteria residents of Level 2 facilities must be discharged when one or more of the following situations exist:	S5136		

2/19/15

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	ALF026	A. BUILDING: _____ B. WING _____	C 11/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER TRAIL ASSISTED LIVING	2360 REAGAN AVENUE ROCK SPRINGS, WY 82901

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S5136	Continued From page 42 (II) When it has been determined that intermittent nursing care has become ongoing; or This State Rule and Regulation is not met as evidenced by: Based on medical record review, observation, and staff and family interview, the facility failed to ensure 2 of 8 sample residents (#1, #2) were appropriate for ALF level 2 (secure dementia unit) additional care services. The findings were: 1. Review of the ALF-102 functional screening assessment dated 5/27/14 showed resident #2 was marked as "c. completely dependent, frequent transfers, frequent positioning..." This category on the screening assessment required incorporation of services provided by outside sources. The resident was also shown to fall into this category of requiring outside service for the areas of bathing, and continence. Review of the 8/20/14 nursing assessment showed the resident required "regular" assistance in managing bowel and bladder care consisting of "toileting every 2 hours." Additionally, the nursing assessment showed the resident required 1 person for transferring. The following concerns were identified: a. Interview with CNA #1 and #2 on 11/25/14 at 3:05 PM verified for this resident they provided total assistance for toileting and bathing, and s/he was a two person transfer at all times. They stated the resident no longer ambulated, s/he used a wheelchair for mobility. b. There was no documentation to show outside services were being provided for the resident. c. Interview with the wellness director on 11/26/14 at 1 PM verified there was not a clear understanding of what level of services could be	S5136	1. Resident #2 continues to receive outside services including physical therapy and occupational therapy which started 12/29/2015 in an effort to help the resident return to a more independent state of mobility. The Wellness Director will monitor the progress of Resident #2 and assess the resident with the ALF 102 and community assessment to ensure the resident continues to be appropriate for the community. When resients are found to fall outside the bounds of state regulations, the Administrator will issue a 30 day or 72 hour discharge notice to the family, depending upon the severity of the non-compliance as determined by the Wellness Director and the Administrator. Resident behaviors will be reviewed at each Quality Assurance meeting and with any change in condition and adressed as needed.	2/28/2015

2/19/15

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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 11/26/2014

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
S5136	Continued From page 43 provided. She further stated there were no outside services being provided for this resident. 2. Review of the medical record showed resident #1 moved into the facility on 4/11/14 and resided on the memory care unit. Review of the ALF-102 screening dated 4/10/14 showed the resident was independent for mobility including transfers, was continent of bowel and bladder, was independent for feeding self, and independent for dressing and grooming. Review of the 5/13/14 nursing assessment showed it was consistent with the level of independence shown on the ALF-102. The following concerns were identified: a. Observation on 11/25/14 at 3:40 PM showed the resident was seated in a recliner in his/her room and the resident appeared very thin. The resident was hard of hearing and was confused. The resident's son was visiting and was interviewed at that time. Interview with the son revealed his parent had declined in the past two weeks. The son verified the resident could no longer transfer without assistance of two staff and could not eat without assistance due to complications of a recently diagnosed esophageal tumor. The son verified the resident was not receiving any additional outside services. Further, the wellness director had talked to him earlier in the day regarding hospice services, and they were planning to pursue these additional services. b. Interview with CNAs #1 and #2 on 11/25/14 at 3:25 PM verified the resident required two people to physically transfer due to weakness and decline. The aides verified the resident had required this level of assistance with transfer for about the last two weeks, and the assistance needed for eating was due to a medical condition and had been ongoing for about 1 month. c. Interview with the wellness director on	S5136	2. Resident #1 passed away 11/28/2014. When resients are found to fall outside the bounds of state regulations, the Administrator will issue a 30 day or 72 hour discharge notice to the family, depending upon the severity of the non-compliance as determined by the Wellness Director and the Administrator. Resident behaviors will be reviewed at each Quality Assurance meeting and with any change in condition and adressed as needed. With Resident #1's passing no further corrective action will be taken with this resident.	2/2/2015

2/17/15

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	ALF026	A. BUILDING: _____ B. WING _____	C 11/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER TRAIL ASSISTED LIVING	2360 REAGAN AVENUE ROCK SPRINGS, WY 82901

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S5136	Continued From page 44 11/26/14 at 1 PM verified a change of condition assessment had not been completed and was not in process. Further, the facility had not issued any notice to the family regarding the increased level of care that was required above what could be provided by the facility staff. As of 11/26/14 the resident's information was sent to a local hospice service and acceptance was yet to be determined.	S5136		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
ALF026	A. Building B. Wing	3/26/2015

Name of Facility	Street Address, City, State, Zip Code
DEER TRAIL ASSISTED LIVING	2360 REAGAN AVENUE ROCK SPRINGS, WY 82901

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix S5023 Reg. # Ch 12 Sec 7 (b)(iv)(A-C) LSC	Correction Completed 02/02/2015	ID Prefix S5054 Reg. # Ch 12 Sec 7 (e)(i)(A-K) LSC	Correction Completed 02/02/2015	ID Prefix S5071 Reg. # Ch 12 Sec 7 (i)(iii)(A-B) LSC	Correction Completed 02/02/2015
ID Prefix S5097 Reg. # Ch 12 Sec 8 (a)(iii) LSC	Correction Completed 02/02/2015	ID Prefix S5100 Reg. # Ch 12 Sec 8 (a)(vi) LSC	Correction Completed 02/02/2015	ID Prefix S5103 Reg. # Ch 12 Sec 8 (a)(ix) LSC	Correction Completed 02/28/2015
ID Prefix S5107 Reg. # Ch 12 Sec 9 (a)(i-v) LSC	Correction Completed 02/02/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By TS 7/24/15	Date:	Signature of Surveyor: Janelle Conlin /TS	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
11/26/2014	YES NO