PRINTED 07/20/2015
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF026	A. BUILDING _____ B. WING _____	C 07/08/2015

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 A complaint survey, in addition to a licensure survey, was conducted by Healthcare Licensing and Surveys on 7/7/15 through 7/8/15. The survey was prompted by complaint intakes LIC-15-035, LIC-15-036, and LIC-15-040	S 000		
S5008	Ch 12 Sec 6 (d)(I)(A-F) Personnel and Staffing Requirements (d) Infection Control. Written policies shall be in effect to ensure that newly hired and current employees do not spread a communicable disease that could be transmitted through usual job duties. These shall not be limited to (ii) Tuberculin Testing (A) Tuberculin testing must be accomplished for each employee prior to employment and annually thereafter (B) Employees having known positive skin tests shall provide a certificate of noninfectiousness, recommendations, if any, for treatment, and evidence they have complied with such recommendations (C) Individuals provide documentation of negative skin test administered within the last twelve (12) months do not require a follow-up	S5008		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 17 Aug 2015

STATE FORM GHTF11 — If continuation sheet 1 of 6

POC accepted. Case to Jeff Smith, Administrator on 8/17/15 @ 4:14 p.m.

PRINTED: 07/20/2015
FORM APPROVED
Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF026	A. BUILDING _____ B. WING _____	C 07/08/2015

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
S5008	Continued From page 1 (D) Individuals who have not had a skin test or who do not have written proof of skin test results, shall have an intradermal Mantoux using 5TU PPD. This shall be accomplished via the two (2) step procedure. If the first test is negative and the employee is asymptomatic, the employee may engage in resident contact prior to the results of the second skin test (I) A negative reaction requires no follow-up (II) A positive reaction (10mm in duration suing 5TU PPD) requires a referral to a physician for x-ray and certification of noninfectiousness and appropriate treatment if needed. Follow up shall comply with the recommendations of the attending physician (E) If symptoms occur, a new certificate of noninfectiousness is required. (F) No person with an airborne, contagious or infectious disease shall be employed until a work release is obtained. (I) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents and their food, if direct contact will transmit a disease. (II) The facility shall require staff to follow universal precautions when performing direct resident care This State Rule and Regulation is not met as evidenced by: Based on review of personnel files and staff	S5008		

Healthcare Licensing and Surveys

PRINTED: 07/20/2015
FORM APPROVED

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 07/08/2015

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
S5008	Continued From page 2 Interview, the facility failed to provide evidence of tuberculin testing for 1 of 3 newly hired employees (CNA #1) reviewed. The findings were: Review of the personnel file revealed certified nurse aide (CNA) #1 was hired 2/16/15. Further review of the file showed no evidence of tuberculin testing. On 7/7/15 at 1:50 PM the administrator stated the wellness director said she did the tuberculin testing on the employee but was unable to find the documentation.	S5008	A review of all staff charts will be complete by the Administrative Assistant to ensure all required documentation is in place, including TB testing. The Administrative Assistant will regularly review employee files to ensure all required documentation is present. This item will also be monitored at each Quality Assurance meeting. CNA #1 now has TB documentation in he/r employee file.	8/10/2015
S5053	Ch 12 Sec 7 (d)(v)(A) Assisted Living Facility (ALF) Core Services (d) Medications (v) Medication Administration (A) An RN shall be responsible for the supervision and management of all medication administration as required by the Wyoming Nurse Practice Act, and the Wyoming Board of Nursing Rules and Regulations This State Rule and Regulation is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure medications were administered in accordance with physician's orders for 1 of 8 sample residents (#2). The findings were: According to the Wyoming Nurse Practice Act, nursing must function under the direction of a physician. The following concerns were identified related to failure to follow physician's orders for resident #2:	S5053		

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 07/08/2015

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
S5053	Continued From page 3 a. Review of the May 2015 medication administration record (MAR) showed the metoprolol succinate ER 50 milligrams (mg) once per day was not given on 5/8/15, 5/9/15, 5/10/15, and 5/11/15. There lacked documentation why the medication was not given. b. Review of physician's orders showed on 5/14/15 the physician ordered albuterol sulfate 0.083% three times per day. Review of the May 2015 MAR showed the albuterol was not administered until 5/15/15 at 5 PM, there lacked documentation why the 8 AM and 1 PM doses were not administered. On 5/15/15 the physician then ordered the albuterol to be given every 4 to 6 hours. Review of the MAR showed the albuterol was not given every 4 to 6 hours as ordered, instead, it was given three times per day, until 5/19/15 when the order was changed. There lacked documentation why it was not given as ordered. c. Review of the June 2015 MAR showed the donepezil HCL (Aricept) 5 mg every day was not given on 6/20/15 through 6/26/15. A nursing note on 6/22/15 stated the Aricept was not given that day because the medication was not available. A nursing note on 6/29/15 showed the family was upset because the resident did not receive the donepezil for one week. The note stated the refill had been called in weeks before and the family had been notified to pick up the refill. However, there lacked documentation to show the family had been notified of the need to pick up a refill. d. During an interview on 7/8/15 at 2 PM the wellness director confirmed the medications were not given in accordance with physician's orders. She stated there had been some issues with having the family supply the medications. However, she acknowledged there lacked documentation to show the family had been notified to pick up refills.	S5053	a.-d. Communication with families regarding medications is now being noted by the nurse in the nurse charting notes. All communication with families, including when prescriptions were called in as well as when family was notified to pick up the prescription, will be documented in the resident's chart. Also, reasons a medication was not administered will be documented in the resident's chart. The Wellness Director will ensure compliance with this charting when conducting regular chart audits. This item will be reviewed at each Quality Assurance meeting.	8/10/2015

PRINTED: 07/20/2015
FORM APPROVED
Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF026	A. BUILDING _____ B. WING _____	C 07/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER TRAIL ASSISTED LIVING	2380 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
S5131	Ch 12 Sec 10 (d)(iii) 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 (d) Level 2 additional core services. In addition to the previously listed Core Services increased assistance may be required with activities of daily living depending upon assessed resident functional and cognitive ability (iii) Services necessary to maintain the highest continence level and skin integrity, and This State Rule and Regulation is not met as evidenced by Based on observation, record review, and staff interview, the facility failed to provide toileting assistance as needed to maintain the highest continence level for 2 of 6 sample residents (#2, #5) residing in the level 2 secure unit. The findings were 1. On 7/7/15 at 2:45 PM certified nurse aide (CNA) #2 showed the surveyor the toileting schedule for resident #2. The toileting schedule was 2 AM, 6 AM, 11 AM, 2 PM, 5 PM, and 9 PM, in addition to as needed (PRN) times. The CNA stated the resident had been toileted at around 1:30 PM that day. Observation of the resident on 7/7/15 starting at 2 PM showed the resident was not toileted until 5:50 PM (50 minutes past the 5 PM scheduled time). Interview with CNA #3 at that time revealed the resident was incontinent of bladder and bowel. The CNA stated they usually toileted the resident after dinner. During an interview on 7/8/15 at 2 PM the wellness director stated the toileting schedule for the resident was	S5131	1. In an effort to avoid conflict with mealtimes, the Wellness Director will change the toileting schedule from specific times to a schedule of toileting upon rising in the morning, before and after meals and before retiring at night. This will allow some flexibility around meals while still providing the services needed by the resident. The Wellness Director will conduct random observations to ensure compliance with the toileting schedule. Additionally, this item will be reviewed at each Quality Assurance meeting.	8/10/2015

PRINTED: 07/20/2015
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF026	A. BUILDING _____ B. WING _____	C 07/08/2015

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
S5131	Continued From page 5 established per the request of the family and should be followed. 2. Review of the 3/26/15 and 6/29/15 service plans for resident #5 revealed the resident was incontinent and that "nursing will assess usual" toileting patterns." There lacked a specific plan for toileting. Observation on 7/7/15 starting at 2 PM showed the resident was not toileted until 6:45 PM (4 hours 45 minutes since start of observation), the observation further revealed the resident was incontinent of bladder. During an interview on 7/8/15 at 2 PM the wellness director stated the resident's toileting plan was every 3 to 4 hours.	S5131	2. Resident #5 was discharged on 7/30/2015 8/10/2015 for higher care needs. When making future toileting schedules the Wellness Director will use a schedule of toileting upon rising in the morning, before and after meals and before retiring at night. This will allow some flexibility around meals while still providing the services needed by the resident.The Wellness Director will conduct random observations to ensure compliance with the toileting schedule. Additionally, this item will be reviewed at each Quality Assurance meeting.	