PRINTED: 11/30/2015
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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 11/13/2015

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 survey was conducted by Healthcare Licensing and Surveys on 11/12/15 through 11/13/15. The survey was prompted by complaint intake LIC-16-005.	S 000		
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 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	S5071		

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

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

STATE FORM 6899 PTWX11 If continuation sheet 1 of 10

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WY Dept of Health
DEC 17 2015
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POC accepted. Spoke to Jeff Snider, Administrator on 12/18/15 @ 10:20 a.m. DOC - 12/10/15

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S5071	Continued From page 1 evidenced by: Based on medical record review, staff interview, and review of policies, the facility failed to ensure an allegation of staff to resident abuse was reported and investigated for 1 of 1 allegations reviewed. The findings were: 1. Review of the nurse charting in the closed medical record for resident #5 revealed the following entries: a. An entry written by RN #1 on 1/23/15 at 12:17 PM: "Resident getting other residents agitated as well as [herself\himself]...began to toss dice, cards, and puzzles around. Resident taken to room to calm down...no bruising or injury noted. When coming out to lunch, resident points to swollen wrist. Wrist appears to be bruised and has a large bump on it.." b. An entry written by CNA #7 on 1/23/15 at 9:43 PM: "resident keeps telling other residents that the nurse hurt [his/her] wrist." c. An entry written by RN #2 on 1/24/15 at 02:48 AM: "right wrist edema and eccymosis noted." d. An entry written by LPN #1 on 1/24/15 at 2:10 PM: "resident has been telling anyone who will listen that nursing injured [his/her] wrist." e. An entry written by CNA #7 on 1/24/15 at 10:58 PM: "resident keeps blaming wrist injury on nursing staff." 2. During an interview on 11/13/15 at 9:25 AM certified nurse aide (CNA) #2 and CNA #3 stated they observed the RN #1 verbally and physically abuse resident #5. They couldn't recall the exact dates, but stated it was almost a year ago. They stated there should be documentation in the chart about the resident's injured wrist. The CNAs stated they told the DON she needed to report it, or they would. They further stated they reported it	S5071	1.-5. The community has an approved policy in place to respond to allegations of abuse. As noted, the policy states in part that, "the Administrator will conduct an investigation of any alleged abuse/neglect"; "that any employee alleged to be involved in an instance of abuse and/or neglect will be suspended immediately"; and that the Administrator, Wellness Director and nurse on duty will intervene and report situations of abuse, neglect, and injuries of unknown origin. In the incident noted in the finding, the Administrator was not notified of a complaint of abuse. No formal or informal notification was given to initiate an investigation. The on duty nurse attended to the injuries sustained by the resident immediately. The Wellness Director reported the injuries to the State of Wyoming Department of Health Division of Aging as required. The Wellness Director, nurse on duty and Administrator followed the protocol for an injury of an unknown origin. The injury was not deemed abuse or neglect nor was any report of such made at that time.	12/10/15

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S5071	Continued From page 2 to the Administrator a few days later. They stated nothing had been done, and so they mentioned it to the Administrator again about a month ago. 3. During interview on 11/13/15 at 10:50 AM CNA #3 described the event she had witnessed. CNA #3 stated she and CNA #2 saw RN #1 grab the resident by [his/her] wrist and yank the resident up out of a chair and take the resident to [his/her] room. Once in the room, RN #1 "threw the resident onto the bed." During this, the resident said "you are hurting me." The CNA also stated the RN #1 told the resident to "act your age" and "if you are going to act like a kid, I'll treat you like a kid." 4. On 11/13/15 at 10:15 AM the Administrator stated there had been no allegations of staff to resident abuse in the last two years. The administrator further stated he was not aware of any allegations involving resident #5. Later, at 12:40 PM, the Administrator stated he did remember two CNAs bringing something up about a month previous regarding the RN #1 bruising someone's arm, but he stated the CNAs were "emotional", and he never got the details. The Administrator confirmed the allegation should have been reported and investigated. 5. Review of the facility's policy "Abuse and Neglect" policy (#22, rev 1/20/14) revealed "...The Administrator will conduct an investigation of any alleged abuse/neglect...any employee alleged to be involved in an instance of abuse and/or neglect will be suspended immediately...will report such allegations to the state..."	S5071	Once advised by the state surveyor on 11/13/2015 that there abuse was suspected by two employees the policy was implemented. The Department of Family Services (DFS) was notified, the Administrator gathered written statements from all parties involved, the family of the resident was notified, the state Department of Nursing was notified of the allegations, and the employee alleged to have committed the abuse was suspended. DFS concluded its investigation with no findings. After reviewing statements from the involved parties as well as the family, the Administrator also concluded there was no basis for the allegations of abuse. The employee was reinstated and the Department of Nursing was notified. When allegations of abuse are made the Administrator will strictly follow the policy as outlined. While no changes to the policy will be made, it will be implemented immediately when any allegations are made. To ensure allegations are not missed or delayed the Wellness Director will review nursing documentation and the Administrator will address the subject at each staff meeting.	
S5100	Ch 12 Sec 8 (a)(vi) Services Which Cannot Be Provided By Level I	S5100	A review of all residents in the community and the possibility of abuse or neglect is and will continue to be reviewed at each Quality Assurance meeting.	

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S5100	Continued From page 3 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 medical record review, staff interview, and review of incident logs, the facility failed to ensure a resident did not exhibit wandering behaviors which could jeopardize the safety of the resident for 1 of 3 sample residents (#2) residing in the Level I Assisted Living Facility (ALF). The findings were: 1. During an interview on 11/13/15 at 9:01 AM, certified nurse aide (CNA) #1 and CNA#2 stated resident #2 was more confused lately. Review of the facility's incident log showed on 10/18/15 the resident had an "elopement without injury but had unwitnessed fall." Review of physician visit forms showed on 9/29/15 it was documented "[resident] has increased confusion...also tried to elope from the facility and was getting out the door." Another physician visit form dated 10/14/15 documented "...wandering out of facility to find husband who passed away years ago." Review of nurse charting showed the following entries: a. 9/29/15- "...later was up and was trying to exit out the door by room 140."	S5100	1. The community adhers to the state policy outlined in Chapter 12. When a resident's wandering jeopardizes the health and safety of the resident, the community can no longer care for them. In the case of Resident #2, the Wellness Director suspected an infection caused the increased confusion and was advised by the resident's medical caregiver that was the case. The caregiver also advised the confusion should be a temporary condition which he could treat. A care conference was held with the family informing them that if the condition did not improve a lease termination notice would be issued. After the 10/18/15 incident instructions were given to more closely monitor Resident #2 and he/r whereabouts during the recovery process. Agitation decreased and there has not been another similar wandering incident to 10/18/15. When a resident's wandering jeopardizes the health and safety of the resident the Wellness Director will investigate the cause of that confusion. If it is determined by a medical professional to be correctable the Wellness Director and Administrator will decide if the improvement will be quick enough to	12/10/15

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S5100	Continued From page 4 b. 10/2/15- "...left the facility without assist." c. 10/9/15- "...increased confusion, agitation and talking about "leaving this place."" d. 10/18/15- "resident was found outside today laying on the grass, walker in front of [him/her]." e. 10/28/15- "resident confused, states we have changed [his/her] room again...has been in same room since moved in." f. 11/10/15- "resident up off and on throughout night...in hallways yelling."	S5100	retain the resident within the community during recovery. If the behaviors are too severe or if recovery is determined to be too long the resident will be refered to a community which can care for the resident during that recovery period. Any time a resident's wandering behavior become a risk to their well being the Wellness Director and Administrator will take the above outlined actions based upon information from a medical professional and in consultation with the family.	
S5101	Ch 12 Sec 8 (a)(vii) 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: (vii) Incontinence care by facility staff; 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 providing incontinence care to 2 of 3 sample residents (#1, #2) residing in the Level I Assisted Living Facility (ALF). The findings were: 1. During an interview on 11/13/15 at 9 AM, certified nurse aide (CNA) #1 and CNA #2 stated residents #1 and #2 required assistance to manage their incontinence, including providing pericare. 2. Observation on 11/13/15 at 9:01 AM revealed CNAs #1 and #2 provided care to resident #1. During the observation, the resident required staff	S5101	The Wellness Director will look for wandering behaviors when conducting reviews of nursing documentation and in briefings with CNA staff. Wandering is and will continue to be a topic during Quality Assurance meetings. 1.-4. The community adheres to the state regulation outlined in Chapter 12 regarding incontinence care in Level I. When a resident is found to be unable to care for their incontinence independently the Wellness Director will determine if there is a cause for the change in condition.	12/10/15

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S5101	Continued From page 5 assistance to manage incontinence, including removing the wet brief, performing pericare, and putting on a new brief. Review of nurse charting in the medical record showed the following entries: a. 11/5/15- "assisted resident with going to the bathroom." b. 11/5/15- "resident was incontinent of urine, total pericare was done." c. 11/3/15- "assisted resident to toilet, pericare was done." d. 11/3/15- "resident was changed and pericare was done." e. 10/31/15- "assisted resident out of bed...incontinent of urine...was all wet. I wiped [him/her] down with a warm washcloth." f. 10/26/15- "resident incontinent of BM. Resident was a total pericare and changing." g. 10/26/15- "total pericare was done." h. 10/17/15- "resident soaked with urine." Review of the activities of daily living (ADLs) tracking form for November 2015 showed the resident was coded as requiring limited or extensive assistance for toilet use. 3. Review of nurse charting in the medical record for resident #2 showed the following entries: a. 11/5/15- "resident was incontinent...had total pericare." b. 11/3/15- "resident incontinent of BM...total assistance with pericare and changing." c. 10/30/15- "assisted resident with cleaning BM from bathroom floor, also from [his/her] body." d. 10/28/15- "pericare was done." e. 10/26/15- "incontinent of urine...total pericare done." f. 10/21/15- "incontinent of BM...had it all over	S5101	If a medical professional determines there is a cause which is temporary and expresses confidence he/she can treat that condition, then the Wellness Director and Administrator will determine if the resident's needs can be met at the community or if the resident will need to recover from the condition elsewhere. If the condition is determined to be not reversible, the community will issue a lease termination notice as outlined in Chapter 12. In the case of Resident #1, CNAs #1 and #2 disregarded instructions to allow Resident #1 to manage he/r own incontinence. The Wellness Director has observed and assessed Resident #1 13 times since the week of 11/16/15 and has found the resident to be unable to manage he/r own incontinence 0 times. CNAs are instructed once again to allow Resident #1 to care for he/rself even though it may be time consuming. Resident #2 was determined to have difficulty managing he/r incontinence during the infection/recovery period. Since recovery Resident #2 is able to manage any incontinence issues independently.	

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S5101	Continued From page 6 [himself/herself]." 4. During the exit conference on 11/13/15 at 12:40 PM, the director of nursing (DON) stated she thought that incontinence care would be considered "limited nursing care" and allowed in the regulations.	S5101	Any time a resident is unable to care for their incontinence the Wellness Director and Administrator will take the above outlined actions based upon information from a medical professional and in consultation with the family.	
S5134	Ch 12 Sec 10 (e)(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. (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: (ii) Assistance Plans for residents of secure units must, at a minimum, address the following: (A) Memory; (B) Judgement; (C) Self-care ability; (D) Ability to solve problems; (E) Mood and character changes; (F) Behavioral patterns; (G) Wandering; and	S5134	To ensure compliance with this level of care, the Wellness Director will look for instances of incontinence when reviewing nursing and CNA documentstion. The topic will also be addressed at each Quality Assurance meeting.	

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S5134	Continued From page 7 (H) Dietary needs. This State Rule and Regulation is not met as evidenced by: Based on observation, medical record review, staff interview, the facility failed to ensure the resident assistance plan addressed all needed areas for 1 of 5 sample residents (#4) residing in the Memory Care unit (Level II). The findings were: 1. During interviews on 11/13/15 at 9:01 AM and 9:20 AM, certified nurse aide (CNA) #2 and CNA #3 stated resident #4 was incontinent of urine and frequently refused to allow staff to assist him/her to the bathroom or to change his/her clothes. They stated the resident could get aggressive. Observation on 11/13/15 at 9:45 AM revealed the resident was seated at a dining room table. The resident's pants were visibly wet and there was a strong odor of urine. CNA #3 and CNA #6 both tried to get the resident to go to his/her room to change his/her clothing, but the resident refused. Review of the assistance plan (printed 11/13/15) showed it documented the resident was "continent of bowel and bladder," and did not address the resident's refusals to allow staff to assist with incontinence. Review of the typed CNA instructions showed only "needs encouragement to change clothes when dirty. If [s/he] becomes upset please just let [him/her] keep the clothing on..." The plan did not address how to deal with the incontinence to ensure skin integrity and promote a sanitary environment for other residents.	S5134	1. Residents are reassessed any time there is a change in condition or annually at the longest. In the case of Resident #4, the Wellness Director was aware of the change in condition and had completed a new assessment which, at the time of the survey, was awaiting finalization by the Administrator. The current care plan was approved and implemented 11/19/2015 after Administrator approval. Administrator will ensure that assessments awaiting approval are viewed at least weekly to ensure timely implementation of the needed changes. The Wellness Director will advise the Administrator of any assessments which are overdue. The status of resident assessments will be addressed at each Quality Assurance meeting.	11/19/15

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S5137	Ch 12 Sec 10 (f)(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. (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: (iii) When the resident requires more than limited assistance to evacuate the building. This State Rule and Regulation is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the resident did not require more than limited assistance to evacuate the building for 1 of 5 sample residents (#3) residing in the Memory Care unit (Level II). The findings were: 1. Observation on 11/12/15 at 5:20 PM revealed certified nurse aide (CNA) #4 and CNA #5 assisted resident #3 from the wheelchair to the toilet in the bathroom. The resident required the assistance of two persons to transfer. During interview on 11/13/15 at 9:20 AM, CNA #3 stated the resident required two people to transfer. Review of nurse charting showed the following entries: a. 11/8/15- "requires one to two assist with cares and transfers." b. 11/3/15- "requiring max 2 person assist." c. 11/2/15- "2 person assist to bathroom	S5137	1. Residents are assessed any time there is a change in condition. When the Wellness Director is made aware of a change in condition the resident will be reassessed. After that reassessment the Wellness Director and Administrator will determine if the resident's needs can continue to be met by the community. If they cannot, the resident will be issued a lease termination notice. In the case of Resident #3, a care conference was held with the family and the resident's family was issued a lease termination notice on 12/7/2015 in compliance with the state regulation requiring a resident to evacuate the building with limited assistance. The Wellness Director will look for mobility issues when reviewing nursing and CNA documentation and discuss the status of resident's mobility with the wellness staff on a regular basis. Mobility is and will continue to be a topic of discussion at each Quality Assurance meeting.	12/7/15

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S5137	Continued From page 9 before dinner." d. 11/1/15- "2-person transfer." e. 10/25/15- "2 person assist for all transfers."	S5137		