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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
	ALF002	A. BUILDING: _____ B. WING _____	C 01/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN SQUARE OF CASPER	1950 SOUTH BEVERLY STREET CASPER, WY 82601

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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 1/4/16 through 1/6/16. The survey was prompted by complaint intake LIC-16-013. The following common abbreviations are used throughout the document: RN- Registered Nurse LPN- Licensed Practical Nurse CNA- Certified Nursing Assistant mg- milligrams Less commonly used abbreviations will be annoted in each deficiency.	S 000	S5023 Ch 12 Sec 7 (b)(iv)(A-C) Assisted Living Facility (ALF) Core Services *The corrective action(s) that will be accomplished for Resident #43 and Resident #22 who was identified to be affected by the deficient practice, will be to ensure that when an incident occurs, is a thorough investigation of the incident will take place. If it is noted that the incident requires an update to the Service Plan, a change in condition assessment will be completed as well. *The corrective action that will be taken to prevent other residents from being affected by the same deficient practice is for all relevant staff to attend an in-service provided by the RN on "Incident Report Investigations" additionally, all incident reports will be reviewed by the RN as well as the Administrator or designee to ensure completeness of the investigation. *Measures that will be put into place to ensure that the deficient practice does not recur will be to review all incident reports that have occurred since 1.1.16, and report any necessary incidents to OHLS. *The effectiveness of this practice will be evaluated monthly during the	
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;	S5023		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jill Tucker — TITLE: Administrator — (X6) DATE: 3-2-16

STATE FORM 6899 706J11 If continuation sheet 1 of 11

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Wyoming Dept of Health
MAR 11 2016
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Spoke with Jill Tucker administrator on 3/11/16 at 2:58PM. Plan is accepted

T Fulton

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S5023	Continued From page 1 (B) Immediately upon any significant change in the resident's mental or physical condition; or (C) No less than once every twelve (12) months. This State Rule and Regulation is not met as evidenced by: Based on medical record review, staff interview, and facility incident report review, the facility failed to ensure a change of condition assessment was completed for 2 of 2 sample residents (#22, #43) who had a change in condition. The findings were: 1. Medical record review showed resident #43 had an ALF 102 assessment completed on 6/13/15. The resident was determined to be able to transfer and/or ambulate with minimal or standby assistance was intermittently confused and/or agitated, and was medically stable at that time. Review of the service plan dated 3/21/15 showed the resident was continent of bowel and bladder, could toilet self, required reminders to use a walker, was high risk for falls, and would need assistance to evacuate the facility. The following concerns were identified: a. Review of facility incident reports from 11/1/15 through 12/31/15 showed the resident had 4 unwitnessed falls while attempting to ambulate or transfer without assistance. b. Review of a progress note dated 12/20/15 and timed 1:45 PM showed the resident attempted to elope 3 times "in the last 2 hours by going out the front door without accompaniment." After the third attempt, the resident was found by staff "in parking lot where [s/he] had fallen on the ice."	S5023	Quality Assurance meeting and documented in the minutes. *This corrective action will be completed by 4.1.16	

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S5023	Continued From page 2 c. Review of an Incident Report and Investigation of Incident dated 12/20/15 showed the resident stated "I want to leave this place" after the fall in the parking lot and the resident "had dementia-not understanding where [s/he] is." d. Review of a progress note dated 12/24/15 and timed 6 PM showed the resident was "found outside laying on the ground bleeding" and the facility called 911. e. Review of a progress note dated 12/29/15 and not timed showed the resident returned to the facility in a wheelchair and had a splint to the left arm due to fracture of both the ulna and radius. The resident was alert and oriented to self only. The facility placed the resident on a 2 hour toileting plan and alert charting. f. Review of a progress note date 12/31/15 at 10:30 AM showed the resident "fell onto the floor into sitting position next to bed. Reports [s/he] was trying to go to BR [bathroom]." g. Review of an Elopement Risk Assessment dated 3/21/15 showed the resident was medium risk for elopement. Further, the resident was marked as having the cognitive ability to make relevant decisions, did not have a history of elopement, did not say s/he wants to leave, did not have risky behaviors such as trying to open doors, did not have relevant factors from the resident's history, and did not have any other factors that contributed to the resident's risk for elopement. h. Interview with the Administrator on 1/6/16 at 9:30 AM revealed the resident should have had a change of condition assessment completed and confirmed that the elopement assessment was no longer accurate for the resident. 2. Medical record review showed resident #22 had an ALF 102 assessment completed on	S5023		

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S5023	Continued From page 3 10/15/15. The resident was determined to be occasionally incontinent, independently and appropriately able to transfer or ambulate without a device, intermittently confused, and medically stable. Review of the service plan dated 10/15/15 showed the resident was independent with transfers, continent of urine, occasionally incontinent of bowel, and had moderately impaired cognitive function. The following concerns were identified: a. Review of facility incident reports from 11/1/15 through 12/31/15 showed the resident had 2 falls while attempting to ambulate or transfer without assistance. b. Review of Progress note dated 11/6/15 and timed 9:05 AM showed the resident had fallen in his/her room after 1 to 2 seconds of loss of consciousness. At that time, the resident was disoriented and complained of pain in his/her neck, back, and arms. The resident was sent to the hospital for evaluation. c. Review of a progress note dated 11/9/15 and timed 2:30 PM showed the resident was to return to the facility. While hospitalized, the resident was treated for upper respiratory infection and dehydration. d. Review of a progress note dated 12/5/15 and not timed showed the resident was in the dining room yelling at staff and arguing with other residents. At that time, the resident was "very confused" and "slapped" a staff member on the arm. e. Review of the Elopement Risk Assessment dated 3/14/15 showed the resident was low risk for elopement. Further, the resident was marked as having the cognitive ability to make relevant decisions, did not have a related diagnosis, had no relative factors from the resident's history, and had no other factors that contributed to the resident's risk for elopement.	S5023	S5054 Ch 12 Sec 7 (e)(i)(A-K) Assisted Living Facility (ALF) Core Services	

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S5023	Continued From page 4 f. Interview with the Administrator on 1/6/16 at 9:30 AM revealed the resident should have had a change of condition assessment completed after the resident was hospitalized. Further, the interview confirmed the Elopement Risk Assessment was not accurate for the resident.	S5023	*The corrective action that will be accomplished for Resident # 43, who was found to have been affected by the deficient practice will be to ensure that ALL incidents regardless of the nature or severity are reported to OHLS. *The corrective action that will be taken to prevent other residents from being affected by the same deficient practice is for the Administrator or designee to review all incident reports on a daily basis to ensure that incidents involving the health, safety, or welfare of residents are reported to OHLS. *Measures that will be put into place to ensure that the deficient practice does not recur will be to review all incident reports that have occurred since 1.1.16, and report any necessary incidents to OHLS. *The effectiveness of this practice will be evaluated monthly during the Quality Assurance meeting and documented in the minutes. *This corrective action will be completed by 4.1.16	
S5054	Ch 12 Sec 7 (e)(i)(A-K) Assisted Living Facility (ALF) Core Services (e) Resident Records and Reports. Each resident's records shall be current, organized and maintained in individual folders which shall be made available to the resident, the Licensing Division, or designated representative upon request. (i) Each folder shall include the following: (A) Information from the referring agent, if applicable; (B) History and physical performed by a physician or physician extender; (C) Individual admission form. The form shall, at a minimum, contain the following information: (I) Full name of resident and former address; (II) Date of admission; (III) Sex, race, date of birth, social security number, and former occupation; (IV) Name, home address, and telephone number of relative, friend, Power of	S5054		

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S5054	Continued From page 5 Attorney, or guardian; (V) Name, address, and telephone number of resident's personal physician, dentist, ophthalmologist or optometrist; (VI) Medicare number of other medical insurance identifying data; (VII) A written inventory of all personal possessions; however, this inventory need not include personal clothing. (D) All accidents, injuries, incidents, illnesses, and allegations of abuse, neglect or exploitation shall be reported to the resident's family or responsible party and be documented in the individual resident records. All such occurrences shall also be reported to the appropriate entity for follow up and resolution. Reports of all incidents affecting the health, welfare or safety of a resident shall be provided to the Licensing Division immediately (within one business day). Reporting shall be done by telephone or fax. The facility's investigation of the incident shall be reported to the Licensing Division and the Long Term Care Ombudsman within five (5) working days. Documentation to support the facility reporting the situation and follow up must also be present in the resident records; (E) An accounting of all personal funds deposited with and disbursed by the facility; (I) Upon written authorization of a client, the facility must hold, safeguard, manage and account for the personal funds of the client.	S5054		

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S5054	Continued From page 6 (1.) The facility must deposit any personal funds in excess of $100 in an interest bearing account. (2.) The facility must establish and maintain a system that assures a full and complete and separate accounting according to generally accepted accounting principles of each resident's personal funds entrusted to the facility. (3.) Upon the death of a resident with a personal fund deposited with the facility, the facility must convey, within 30 days, the resident ' s funds a final accounting of those funds, to the individual or probate jurisdiction administering the resident ' s estate. (4.) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare except for applicable deductible and coinsurance amounts. (F) A signed copy of the resident's rights; (G) The resident's assessment and individualized assistance plan; (H) Copies of all applicable resident assistance contracts, signed by both parties; (I) Written acknowledgment of the receipt and explanation of all facility policies including admission/discharge policies; (J) Copy of all ALF 102's; and (K) Copy of outside contractual responsibilities, if applicable.	S5054		

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S5054	Continued From page 7 This State Rule and Regulation is not met as evidenced by: Based on medical record review, staff interview, and Licensing Division record review, the facility failed to report incidents involving the health, safety, or welfare of residents to the Licensing Division for 1 of 1 sample residents (#43) with a reportable incident. The findings were: 1. Medical record review showed resident #43 had an ALF 102 assessment completed on 6/13/15. The resident was determined to be able to transfer and/or ambulate with minimal or standby assistance was intermittently confused and/or agitated, and was medically stable at that time. The following concerns were identified: a. Review of a progress note dated 12/20/15 and timed 1:45 PM showed the resident attempted to elope 3 times "in the last 2 hours by going out the front door without accompaniment." After the third attempt, the resident was found by staff "in parking lot where [s/he] had fallen on the ice." b. Review of an Incident Report and Investigation of Incident dated 12/20/15 showed the resident stated "I want to leave this place" after the fall in the parking lot and the resident "had dementia-not understanding where [s/he] is." 2. Review of Licensing Division records on 1/7/16 showed no report of the incident was made to that agency. 3. Interview with the Administrator on 1/6/16 at 9:30 AM revealed the incidents were not reported to the Licensing Division because the facility did	S5054	<u>S5099 Ch 12 Sec 8 (a)(v)(A-C) Services Which Cannot Be Provided By Level 1</u> *The corrective action that will be accomplished for Resident # 2 who	

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S5054	Continued From page 8 not think the resident was attempting to elope.	S5054	was found to have been affected by the deficient practice will be to educate the resident, family, and staff of our limitations regarding maintaining oxygen in a Level 1 ALF.	
S5099	Ch 12 Sec 8 (a)(v)(A-C) 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: (v) Care of resident who is on continuous oxygen, if; (A) The resident is unable to determine if oxygen is on or off; (B) The resident is unable to adjust the flow or turn the oxygen on or off; (C) Continuous monitoring is required. This State Rule and Regulation is not met as evidenced by: Based on medical record review, resident and staff interview, and policy and procedure review, the facility failed to ensure residents were appropriate for the core services level of care for 1 of 2 sample residents (#2) who required assistance with oxygen administration. The findings were: 1. Review of the Service Plan for resident #2 dated 1/27/15 showed the staff "maintain and ensure oxygen is available. The resident relies on staff to maintain oxygen supplies and ensure administration of Oxygen at 2 liters per nasal cannula." 2. Interview with resident #2 on 1/5/16 at 3:13 PM	S5099	*The corrective action that will be taken to prevent other residents from being affected by the same deficient practice is for training to be provided to staff on what our limitations regarding maintaining oxygen in a Level 1 ALF are. Additionally, we will ask that staff report to the RN immediately when a resident who utilizes oxygen begins to display signs that they are unable to maintain their oxygen as stated within the regulations set by the OHLS. Should staff report such instances to the RN, the RN will work with the resident to retrain them how to maintain their oxygen. Should the retraining be unsuccessful, an update will be made to the Service Plan, and a change in condition assessment will be completed. If through the change in condition assessment it is determined that the resident is unable to maintain oxygen as stated in the regulations set by the OHLS, and outside services are unable to be secured, a 30-day written notice will be issued to the resident to notify them of the need for them to move to a facility that can maintain their oxygen. *Measures that will be put in to place to ensure the deficient practice does not recur will be to assess residents currently utilizing oxygen to ensure	

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S5099	Continued From page 9 revealed the resident could not change the oxygen and facility staff turned the oxygen on and off. Further, the resident was not able to adjust the oxygen level. 3. Review of the policy titled "Oxygen" revised 2008 showed "...the CNA will NOT adjust the liter flow rate." 4. Interview with the administrator on 1/6/15 at 9:30 AM confirmed that staff provided oxygen care for the resident.	S5099	that they are able to maintain their oxygen as stated within the regulations set by the OHLS. *The effectiveness of this practice will be evaluated monthly during the Quality Assurance meetings through the Service Plan audit and documented in the minutes. *This corrective action will be completed by 4.1.16	
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 medical record review, incident report review, and staff interview, the facility failed to ensure appropriate level of care for an assisted living facility for 1 of 1 sample residents (#43) where wandering and/or elopement potentially jeopardized the health and safety of the resident. The findings were: 1. Review of an Elopement Risk Assessment for resident #43 dated 3/21/15 showed the resident was at medium risk for elopement. Further, the resident was marked as having the cognitive	S5100	<u>S5100 Ch 12 Sec 8 (a)(vi) Services Which Cannot Be Provided By Level 1</u> *The corrective action that will be accomplished for Resident # 43, who was found to have been affected by the deficient practice will be to complete a new "Elopement Risk" assessment to ensure that the resident is appropriately	

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S5100	Continued From page 10 ability to make relevant decisions, did not have a history of elopement, did not say s/he wants to leave, did not have risky behaviors such as trying to open doors, did not have relevant factors from the resident's history, and did not have any other factors that contribute to the resident's risk for elopement. The following concerns were identified: a. Review of a progress note dated 12/20/15 and timed 1:45 PM showed the resident attempted to elope 3 times "In the last 2 hours by going out the front door without accompaniment." After the third attempt, the resident was found by staff where "In parking lot where [s/he] had fallen on the ice." b. Review of an Incident Report and Investigation of Incident dated 12/20/15 showed the resident stated "I want to leave this place" after the fall in the parking lot and the resident "had dementia-not understanding where [s/he] is." c. Review of a progress note dated 12/24/15 and timed 6 PM showed the resident was "found outside laying on the ground bleeding" and the facility called 911. d. Review of a progress note dated 12/29/15 and not timed showed the resident returned to the facility in a wheelchair and had a splint to the left arm due to fracture of both the ulna and radius. The resident was alert and oriented to self only. The facility placed the resident on a 2 hour toileting plan and alert charting. 2. Interview with the Administrator on 1/6/15 at 9:30 AM revealed the resident should have had a change of condition assessment completed and confirmed that the elopement assessment was no longer accurate for the resident.	S5100	placed. If it is determined through the assessment that the risk level has changed to a level that is beyond the services we can provide, a change in condition assessment will be completed. If it is determined through the change in condition assessment that the resident is no longer appropriate for a Level 1 ALF, an outside services are unable to be secured, a 30-day written notice will be issued to the resident to notify them of the need to move to a facility who can manage their level of risk for elopement. *The corrective action that will be taken to prevent other residents from being affected by the same deficient practice is for residents who display signs or verbalize the intent to "elope", a new elopement risk assessment shall be completed. If it is evident that they are at high risk for elopement, a change in condition assessment will be completed. If it is determined through the assessment that the resident is no longer appropriate for Level 1 services, and outside services are unable to be secured, a 30-day written notice will be issued to the resident to move to a facility that can better meet their needs. *Measures that will be put into place to ensure that the deficient practice does not recur will be to review all incident reports that have occurred since 1.1.16, and report any necessary incidents to OHLS.	

*The effectiveness of this practice will be evaluated monthly during the Quality Assurance meeting and documented in the minutes.

*This corrective action will be completed by 4.1.16