Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF004	A. BUILDING: _____ B. WING _____	C 01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING COMMUNITY	1930 EAST 12 STREET CASPER, WY 82601

(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 1/13/16 through 1/13/16. The survey was prompted by complaint intake LIC-15-037. 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		
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 referr'ng agent, if applicable;	S5054		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

2/1/16 — Executive Director

STATE FORM 6899 6H0M11 — If continuation sheet 1 of 6

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WY Dept of Health
FEB 02 2016
Healthcare Licensing and Surveys

spoke with Rob NHA. Plan/accepted & Agreed Changes. DOC is 3/4/16.

Tina Lozano

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S5054	Continued From page 1 (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 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,	S5054		

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S5054	Continued From page 2	S5054		

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.

(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

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S5054	Continued From page 3 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 medical record review, incident report review, staff interview, and policy and procedure review, the facility failed to record and/or report incidents or accidents for 2 of 8 sample residents (#35, #59) with occurrences affecting health, welfare, or safety of the resident to the Licensing Division. The findings were: 1. Review of the medical record for resident #59 showed the resident had diagnoses that included macular degeneration and anxiety. The resident was assessed to have minor forgetfulness; however, it was determined s/he could report abuse and neglect. The following concerns were identified. a. Review of an investigation note dated 5/19/15 showed that 2 staff members reported	S5054	After reviewing the file of resident #59 we did not report this correctly. This has been reported to state on 2/1/16. A. The Executive Director and Clinical Service Director have reviewed regulations pertaining to incident reporting to ensure understanding.	S5054

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S5054	Continued From page 4 the resident was visibly upset 2 days earlier when they attempted to assist the resident. At the time they were assisting, the resident reported that s/he felt as if s/he had been "broken in half" but was unable to elaborate. Further review showed the staff members assisted the resident on 5/19/15 and the resident was crying and "very upset. When asked why, the resident stated s/he had been "raped." b. Review of a progress note dated 5/21/15 and not timed showed the resident was "scared" and no longer wanted to live in the room assigned. At that time, the resident started crying and told staff that someone keeps coming back and they are coming through the patio door. c. Interview with the Executive Director and Clinical Services Manager on 1/13/15 at 4 PM revealed the facility reported the incident to local authorities; however, a report was not made to Healthcare Licensing and Surveys. 2. Review of the medical record for resident #35 showed the resident had diagnoses that included cervical spondylosis with myelopathy. The resident was assessed to have been alert and oriented and able to follow the facility smoking policy. The following concerns were identified: a. Review of a progress note dated 12/23/15 and untimed showed the resident had a "cut" to the top of his/her left hand. The resident had caught his/her hand between the door frame and wheelchair 2 days earlier. b. Review of the facility incident reports showed there was no evidence the incident had been reported or investigated by the facility. c. Review of a progress note dated 1/8/16 and timed 7:30 PM showed the resident had a "blister with redened [sic] outter [sic] ring on abd [abdomen]." The resident told staff s/he was smoking, dropped the cigarette, and "caught	S5054	B. The Director of Clinical Services, and Executive director will be in attendance at all monthly QA meetings we will be reviewing all Incident reporting for the community at these meetings on a monthly basis to make sure that these reports are not being missed. C. Executive Director will ensure incident reports are reported to the State of Wyoming Licensing Division. D. Any issues will be noted in the quality assurance program binder. This will be complete by 2/17/16 Clinical Service Director has reviewed the smoking policy of the community with resident #35. A. The Clinical Service Director will review the smoking policy and have them signed by all residents that smoke in house. This will be complete by 2/17/15. We will also assess each residents smoking habits and intervene with a course of action for residents deemed not safe to smoke. This will be complete by 2/17/15. A. We will educate all staff on the smoking policy.	

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S5054	Continued From page 5 [his/her] pants on fire." d. Interview with the Executive Director and Clinical Services Manager on 1/13/15 at 4 PM revealed that the incidents were not reported to Healthcare Licensing and Surveys. Further, it was confirmed that the facility was not aware of the hand injury on 12/23/15. 3. Review of the "Incident Management" policy dated December 2015 showed "All incident or adverse events occurring in the facility or on facility property must be reported immediately. All incidents/adverse events that occur in the facility are investigated to assure appropriate actions are taken to prevent reoccurrence and/or reduce risk of injury..." 4. Review of the "Abuse Prevention, Intervention, Reporting and Investigation" policy dated December 2015 showed "...All staff are mandated reporters and must comply with state and federal regulations regarding reporting suspected abuse. All staff must immediately report physical injuries, which are not reasonably explained, to the appropriate agency per state requirements..."	S5054	B. We will educate all clinical staff on the smoking policy, incident reports, active charting and state reporting guidelines. This will be completed by 2/17/15. Facility will complete audit of incident reports for last 90 day to ensure no other Reportable incidents have occurred. Any Reportable incidents will be sent to OHLS. All clinical staff will be educated on the state of Wyoming Guidelines for reporting incidents. We will also educate them on Park Place policy and guidelines of active charting and incident reporting. This will be complete by 2/17/15. The Executive Director and Clinical Service Director will meet with clinical staff on a daily basis to review all incident reports and active charting to assure that the State of Wyoming is notified appropriately. DOC 3/04/15	