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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
	ALF014	A. BUILDING: _____ B. WING _____	C 05/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING WIND ASSISTED LIVING COMMUNITY	1072 NORTH 22ND STREET LARAMIE, WY 82072

(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 5/4/16. The survey was prompted by complaint intakes LIC-16-006 and LIC-16-009. The following common abbreviations were used throughout this document: ADLs: Activities of daily living CNA: Certified nurse aide CSD: Clinical service director	S 000		
S5020	Ch 12 Sec 7 (b)(i)(A) 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. (i) The completion of the ALF 102. (A) The current version of the ALF 102 is the designated screening tool. The form may be updated and/or revised periodically by the Program Division. Providers will be notified of changes in the form. The following guidelines apply to the ALF 102; (I) The ALF 102 is only valid if	S5020	**S5020 CH 12 Sec 7 (b)(i)(A) Assisted Living Facility (ALF) Core Services** **A)Corrective Actions:** Resident #1 was discharged on 5/5/16, one day after HLS survey. No actions were taken to correct this ALF because of the timeliness of discharge of resident #1. Resident #2 ALF has been updated as of 5/6/2016. B)To identify other residents having the potential to be affected and to ensure the deficit practice does not recur, the	5/6/2016

POC accepted. Spoke with Ron Schriner 6/9/16 10 am. 80002 State Surveyor

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S5020	Continued From page 1 completed within forty-five (45) days prior to admission and there is no change in the resident's condition. (II) The ALF 102 must be completed and signed by an RN. (III) The ALF 102 may be completed telephonically; however, it must be verified in person by an RN. (IV) A new ALF 102 shall be completed at least annually, and when there is a change in the resident's condition. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the ALF 102 was accurate for 2 of 9 sample residents (#1, #2). The findings were: 1. Medical record review showed resident #2 had a functional screening assessment for assisted living completed on 4/4/16. The resident was determined to be independent with mobility, including transfers. The following concerns were identified: a. Review of the care plan dated 4/4/16 showed the resident required support of 1-2 staff members to transfer to/from bed, lounge chair, wheelchair, and on and off the toilet. b. Review of the nurse's notes dated between 1/21/16 and 4/27/16 showed the resident required staff assistance with transfers and positioning in bed and chair. c. Interview with CNA#1 on 5/4/16 at 2:35 PM confirmed the resident needed physical assistance of at least one staff member for transfers.	S5020	community Registered Nurse or LPN where applicable by regulation or Nurse Practice Act, shall evaluate/document at least annually on the ALF 102 and with any significant change in condition the services that each resident is receiving. Services should be modified as needed to meet the resident's needs. For each resident, the completed assessments/evaluations should indicate status with brief comments to describe any change in condition. C)To ensure systemic changes are implemented, and evaluate the plan for effectiveness, the Executive Director and Clinical Service Director will audit, at random, a minimum of 3 charts monthly to ensure consistency between services being provided, the ALF 102 and the resident care plan. These audits will be integrated into the QA program, with the first audits scheduled for June and continue at minimum of six months. All audits completed each month will be documented to track completion.	

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S5020	Continued From page 2 2. Medical record review showed resident #1 had a functional screening assessment for assisted living completed on 3/1/2016. The resident was determined to be intermittently confused and/or agitated, occasionally incontinent, independently mobile and appropriately able to transfer and/or ambulate with or without a device. Additionally, the resident had a diagnosis of COPD [chronic obstructive pulmonary disease] and did not require oxygen administration by facility staff. The following concerns were identified: a. Review of the care plan dated 3/1/2016 revealed the resident had a diagnosis of dementia, was incontinent of bladder and bowel, did not wear incontinence products and needed assistance to the toilet. b. Review of a nurse note dated 3/22/2016 disclosed "[Resident] has had increased confusion after moving in. [Resident] has been incont [incontinent] of B & B [bowel and bladder] and unable to understand how to help clean [herself/himself] up. [S/he] has needed help with toileting and getting dressed in the morning." c. Review of the nurse's notes from 3/23/2016 thru 4/10/2016 showed an increase in confusion and an increase in the need for assistance with ADLs including incontinence care. d. Review of the nurse's notes from 4/15/2016 thru 4/28/2016 revealed the need for continuous monitoring, toileting every two hours, redirection, and reminders to wear oxygen. 3. Interview with the administrator and CSD on 5/4/16 at 4:10 PM confirmed the ALF 102 did not accurately reflect these residents' care needs.	S5020		
S5054	Ch 12 Sec 7 (e)(i)(A-K) Assisted Living Facility (ALF) Core Services	S5054	S5054 Ch 12 Sec 7 (e)(i)(A-K)	

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S5054	Continued From page 3 (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 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;	S5054	**Assisted Living Facility (ALF) Core Services** **A)Corrective actions:** To correct the deficit, all incidents dating back to 4/1/2016 will be reported to the healthcare licensing agency by 6/30/2016 B)Effective immediately, all incidents, involving injury or not, will be reported to the Healthcare Licensing Agency. C)An internal checklist for fall reporting has been developed and will be used to ensure reporting of incidents. This checklist will be in full use and used consistently for a minimum of 60 days to systematically change the process of incident reporting, and on an as needed basis. D)To ensure correction is achieved and sustained, the ED and CSD will audit fall reporting. These audits will be integrated into the QA program during the monthly safety meetings. A discussion of incidents and reconciliation of incidents and reporting will take place at the monthly safety meeting. This will become effective at the June 2016 Safety meeting and will continue for a minimum of 6 months.	6/30/2016

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S5054	Continued From page 4 (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. (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.	S5054		

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S5054	Continued From page 5	S5054		

(3.) Upon the death of a resident with a personal funds 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.

This State Rule and Regulation is not met as evidenced by:
Based on medical record review, staff interview, review of Licensing Division logs, and review of incident logs the facility failed to report incidents or accidents affecting the health, welfare or safety

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S5054	Continued From page 6 of the resident to the Licensing Division, for 3 of 4 sample residents (#1, #4, #6). The findings were: 1. Review of the nursing/progress notes for resident #6 revealed two separate falls occurred on 4/12/2016 and 4/21/2016. 2. Review of the nursing/progress notes for resident #1 revealed three separate falls occurred on 3/25/2016, 3/30/2016, and 4/25/2016. 3. Review of the medical record for resident #4 showed 7 falls between 2/13/16 and 5/2/16. 4. Review of the Licensing Division reporting records on 5/4/2016 showed only one of the above falls was reported to Healthcare Licensing and Surveys. 5. Interview with the CSD at 4:09 on 5/4/2016 revealed that she thought only falls "with injury" needed to be reported. She further confirmed falls that did not result in injury were not reported to the Licensing Division. 6. Review of the facility's incident log received on 5/4/2016 revealed 23 falls between 4/1/2016 and 4/30/2016. Review of the Licensing Division reporting records revealed that 2 falls had been reported to Healthcare Licensing and Surveys during the same timeframe.	S5054		
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.	S5095	**S5095 Ch 12 Sec 8 (a)(i) Services Which Cannot Be Provided by Level 1**	

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S5095	Continued From page 7 (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 caregiver interview, staff interview, medical record review, and review of the facility's policies and procedures, the facility failed to ensure 1 of 9 sample residents (#2) did not require continuous assistance with transfers and mobility. The findings were: 1. Medical record review showed resident #2 had a functional screening assessment for assisted living completed on 4/4/16. The resident was determined to be independent with mobility. Further review showed the resident was intermittently confused and medically stable. The following concerns were identified: a. Review of the care plan dated 4/4/16 showed the resident required support of 2 staff members to transfer to/from bed, lounge chair, wheelchair, on and off the toilet, and to assist the legs into bed. Further review showed the resident had private caregivers 3 times a day. b. Review of "Outside Healthcare Agency Service Acknowledgement" dated 1/21/16, 1/22/16, and 1/25/16 showed the resident was receiving outside services to assist with "ADLs, toileting, transfers." Further review showed an "Outside Healthcare Agency Service Acknowledgement" dated 1/21/16 showing the resident was receiving hospice services "PRN" (as needed). c. Review of the nurse's notes dated between 1/21/16 and 4/27/16 showed the resident required staff assistance with transfers, mobility, and	S5095	**A)Corrective Actions:** Coordination of outside services and/or discharge planning is underway for resident #2. Family has been notified of the need to hire additional caregivers or relocate to a skilled nursing facility. ED and CSD met with Resident's son on 5/11/16 to explain regulations and options. Son is investigating the cost of private caregivers- and a 30 day notice will be issued no later than 6/3/2016 if sufficient private care is not a viable option. B)Effective immediately - To identify other residents who require continuous assistance and mobility and so the deficit practice does not recur, The Community Registered Nurse or LPN where applicable by regulation or Nurse Practice Act, shall evaluate/document at least annually and with any significant change in condition the services that each resident is receiving. Services should be modified as needed to meet the resident's needs. For each resident, the completed assessments/evaluations should indicate status with brief comments to describe any change in condition. C)Effective immediately - Discharge planning, or contracting of outside services will be initiated when the residents needs exceed the ability of the Community to safely provide care to the resident or when the residents needs exceed the scope of care the Community	6/3/2016

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S5095	Continued From page 8 positioning in bed and chair. d. Interview with CNA #1 on 5/4/16 at 2:35 PM revealed the resident required physical assistance of at least one staff member for transfers. Further, when the resident did not have a private duty caregiver present, the facility staff provided the assistance. e. Interview with the resident's private duty caregiver on 5/4/16 at 12:40 PM revealed the resident had private caregivers to assist 3 times a day for one hour shifts. She further revealed not all available caregiver shifts were able to be filled. f. Interview with the administrator and CSD on 5/4/16 at 4:10 PM confirmed the resident required a higher level of care than was appropriate for the facility. They added the hospice services consisted of a nurse who provided nursing services as needed. They further revealed they had not started discharge planning. 2. Review of the policy and procedure titled "Admission Policy- Assisted Living/Independent Living," dated 1/2015, showed "G. Discharge: 1. "When the resident's needs exceed the ability of the Community to safely provide care to the resident... or when the resident's needs exceed the scope of care the Community is licensed to provide, discharge planning is initiated."	S5095	is licensed to provide. Discharge planning will be initiated when transfer assistance becomes continuous. Services provided by outside agencies will be detailed in the Edgewood outside Services Agreement. Discharge planning will be printed and made available in the chart. D)To ensure systemic changes are implemented, and evaluate the plan for effectiveness, at risk residents will be assessed and reviewed by the CSD and ED, these reviews will be integrated into the resident update meetings as part of our communities QA program, held at least monthly. First meeting is scheduled for June. This practice will continue for a minimum of 6 months.	
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	S5099	**S5099 Ch 12 Sec 8 (a)(v)(A-C) Services Which Cannot Be Provided by Level 1** **A) Corrective Actions:** Resident #1 has been discharged to skilled nursing, and then subsequently taken to her family's home with 24 hour care and hospice	

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S5099	Continued From page 9 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 staff interview, medical record review and review of facility policies and procedures, the facility failed to ensure a resident did not require continuous monitoring of oxygen for 1 of 5 sample residents (#1) on oxygen therapy. The findings were: 1. Medical record review showed resident #1 had a functional screening assessment for assisted living completed on 3/1/2016. The resident was determined to be "intermittently confused and/or agitated", and was "medically stable". Further, the resident had a diagnosis of COPD (chronic obstructive pulmonary disease) and did not require oxygen administration by facility staff. The following concerns were identified. a. Review of the care plan dated 3/1/2016 showed the resident had a diagnosis of dementia. b. Review of nurse's notes dated 3/3/2016 thru 3/26/2016 showed the resident needed continuous reminders to wear oxygen and was confused and lethargic. c. Review of the nurse's note dated 4/8/2016 and timed 7:01 PM revealed "Resident sitting on couch slouched over sleeping. Oxygen tubing and cannula on CNA reports oxygen saturation of 77%. RN assessment: resident did not turn on oxygen concentrator"	S5099	services as of 5/5/16. All discharge plans and or conversations will be documented in the chart rather than via email. B)Effective immediately, to identify other residents who require continuous monitoring of oxygen and so the deficit practice does not recur, The Community Registered Nurse or LPN where applicable by regulation or Nurse Practice Act, shall evaluate/document at least annually and with any significant change in condition the services that each resident is receiving. Services should be modified as needed to meet the resident's needs. For each resident, the completed assessments/evaluations should indicate status with brief comments to describe any change in condition. C)Discharge planning, or contracting of outside services will be initiated when the residents needs exceed the ability of the Community to safely provide care to the resident or when the residents needs exceed the scope of care the Community is licensed to provide. Discharge planning will be initiated when monitoring of oxygen becomes continuous. Services provided by outside agencies will be detailed in the Edgewood outside Services Agreement. Discharge planning will be printed and made available in the chart.	5/5/2016

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S5099	Continued From page 10 d. Review of a nurse's note dated 4/13/2016 showed the CSD informed the resident's family that the "resident's care is beyond facility scope of assisted living and without significant change we will need to find alternative placement." e. Review of the nurse's note dated 4/25/2016 showed the resident was found on the floor with an oxygen saturation of 71-75%. "Per CNA oxygen was not on when res [resident] on floor" and, in addition, the CNA reported "Res freq [frequently] removes oxygen during the noc [night]." f. Review of the nurse's note dated 4/27/2016 showed "Continues to remove oxygen. Oxygen sats [saturations] decrease to 60's." g. Interview with the CSD on 5/4/2016 at 4:09 PM revealed the resident was on a waiting list for a skilled nursing facility. h. Review of the medical record on 5/4/2016 showed no evidence of discharge planning, such as documentation related to actively seeking alternative placement or a discharge notice. 2. Review of the policy and procedure titled "Admission Policy- Assisted Living/Independent Living," dated 1/2015, showed "G. Discharge: 1. "When the resident's needs exceed the ability of the Community to safely provide care to the resident... or when the resident's needs exceed the scope of care the Community is licensed to provide, discharge planning is initiated."	S5099	D)To ensure systemic changes are implemented, and evaluate the plan for effectiveness, at risk residents will be assessed and reviewed by the CSD and ED, these reviews will be integrated into the resident update meetings as part of our communities QA program, held at least monthly. First meeting is scheduled for June. This practice will continue for a minimum of 6 months.	
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:	S5101	**S5101 Ch 12 Sec 8 (a)(vii) Services Which Cannot Be Provided by Level 1** **A)Corrective Actions:** Resident #1 has been discharged to skilled nursing, and then subsequently taken to her family's	

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S5101	Continued From page 11 (vii) Incontinence care by facility staff; This State Rule and Regulation is not met as evidenced by: Based on staff interview, medical record review and review of the facility policies and procedures, the facility failed to ensure residents did not require incontinence care by facility staff for 1 of 5 sample residents (#1) with incontinence. The findings were: 1. Medical record review showed resident #1 had a functional screening assessment for assisted living completed on 3/1/2016. The resident was determined to be independent with mobility and had occasional incontinence requiring "occasional help to clean self." a. Review of the care plan dated 3/1/2016 showed the resident had a diagnosis of dementia, was incontinent of bladder and bowel, and needed assistance to the toilet. b. Review of the nurse's notes dated 3/22/2016 thru 4/10/2016 showed an increase in confusion and an increase in the need for assistance with ADLs including incontinence care. c. Review of a nurse's note dated 4/13/2016 showed the CSD informed the resident's family that the "resident's care is beyond facility scope of assisted living and without significant change we will need to find alternative placement." d. Review of nurse's note dated 4/15/2016 and timed 3:30 PM showed the resident required staff to "toilet every two hours." e. Interview with the CSD on 5/4/2016 at 4:09 PM revealed the resident was on a waiting list for a skilled nursing facility. f. Review of the medical record on 5/4/2016 showed no evidence of discharge planning, such as documentation related to actively seeking	S5101	home with 24 hour care and hospice services as of 5/5/16. All discharge plans and or conversations will be documented in the chart rather than via email. B)Effective immediately, To identify other residents who require incontinence care by facility staff and so the deficit practice does not recur, The Community Registered Nurse or LPN where applicable by regulation or Nurse Practice Act, shall evaluate/document at least annually and with any significant change in condition the services that each resident is receiving. Services should be modified as needed to meet the resident's needs. For each resident, the completed assessments/evaluations should indicate status with brief comments to describe any change in condition. C)Discharge planning, or contracting of outside services will be initiated when the residents needs exceed the ability of the Community to safely provide care to the resident or when the residents needs exceed the scope of care the Community is licensed to provide. Discharge planning will be initiated when incontinence care is being provided by facility staff. Services provided by outside agencies will be detailed in the Edgewood outside Services Agreement. Discharge planning will be printed and made available in the chart.	5/5/2016

PRINTED: 05/18/2016
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
	ALF014	A. BUILDING: _____ B. WING _____	C 05/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING WIND ASSISTED LIVING COMMUNITY	1072 NORTH 22ND STREET LARAMIE, WY 82072

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S5101	Continued From page 12 alternative placement or a discharge notice. 2. Review of the policy and procedure titled "Admission Policy- Assisted Living/Independent Living," dated 1/2015, showed "G. Discharge: 1. "When the resident's needs exceed the ability of the Community to safely provide care to the resident... or when the resident's needs exceed the scope of care the Community is licensed to provide, discharge planning is initiated."	S5101	D)To ensure systemic changes are implemented, and evaluate the plan for effectiveness, at risk residents will be assessed and reviewed by the CSD and ED, these reviews will be integrated into the resident update meetings as part of our communities QA program, held at least monthly. First meeting is scheduled for June. This practice will continue for a minimum of 6 months.	