PRINTED: 06/02/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF028	A. BUILDING: _____ B. WING _____	C 05/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN PLAZA ASSISTED LIVING	4184 TALON DRIVE CASPER, WY 82604

(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 was conducted on 5/18/16 at Mountain Plaza Assisted Living in Casper, Wyoming. The survey was prompted by complaint intake LIC-16-020.	S 000		
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 medical record review and staff interview the facility failed to ensure medications were administered as ordered by the physician for 1 of 13 sample residents (#11). The findings were: Review of the physician orders for resident #11 showed memantine 10 milligrams (mg), Preservision Areds softgel 1 tablet, and sertraline 50 mg were to be administered every morning. Further review showed alendronate 70 mg was	S5053	**Tag: S5053** **Violation:** The facility failed to ensure medications were administered as ordered by the physician for 1 of 13 samples. **Correction:** A daily log of refused medications has been created and will be sent to doctors for notification. **Identify Others:** A chart audit was completed during the week of 6/6/16 to identify any other errors. **System Measures:** A nurses meeting was scheduled and completed 6/8/16 to review how to document medications refused by residents. **Responsibility:** Nurses. **Quality Improvement and Monitoring:** The Director of Nursing will monitor the daily log on a daily basis for completion.	6/8/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: K Humphrey — TITLE: Administrator — (X5) DATE: 6/12/16

STATE FORM 6899 E6V211 If continuation sheet 1 of 2

POC accepted. Cert. K Kenyne Humphrey, Administrator on 6/23/16 @ 3:17pm.

Jennifer Cr

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Healthcare Licensing and Surveys

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S5053	Continued From page 1 ordered once weekly. Review of the 5/1/16 to 5/17/16 main event log and medication administration record showed the weekly dose of alendronate was last administered on 5/8/16 and was due again on 5/13/16. This review also showed this medication was not administered on 5/13/16 or at anytime after it was due. Review of the 5/1/16 to 5/17/16 main event log and medication administration record showed the memantine, Preservision Areds softgel, and sertraline 50 mg were not administered on 5/7/16, 5/8/16, 5/12/15, 5/13/16, 5/14/16, and 5/15/16. A review of the medical record and medication logs revealed no evidence the omissions were reported to the physician or documentation of a rationale for why the medications were not given. This review also revealed no evidence of additional attempts to administer the daily and weekly medications at a later time. Interview with the director of nursing on 5/18/16 at 12:40 PM revealed they were unable to utilize their software to enter information about administering medications at a time later than the scheduled time; and they did not have a system for documenting rationale for medication omissions. She further stated staff usually reported to the physician when mediations were not administered, but she did not have documentation that verified the physician was aware of resident #11's omitted medications.	S5053		