PRINTED: 10/04/2017
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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 09/20/2017

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 complaint survey was conducted by Healthcare Licensing and Surveys on 9/19/17 through 9/20/17. The survey was prompted by complaint Intake #LIC-17-041. The following common abbreviations are used throughout the document: ALF: Assisted Living Facility CNA Certified Nursing Assistant DON Director of Nursing Services Less commonly used abbreviations will be annotated in each deficiency.	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	S5020		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 13 Oct. 2017

STATE FORM 6899 CW6J11 If continuation sheet 1 of 8

RECEIVED
OCT 13 2017
Healthcare Licensing and Surveys

10/24/17 @ 3:30 PM
POC accepted per telephone call with Jeff Smith, adm. - PPince

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S5020	Continued From page 1 changes in the form. The following guidelines apply to the ALF 102; (I) The ALF 102 is only valid if 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 observation, medical record review, and family and staff interview, the facility failed to ensure ALF 102 assessments were completed within 45 days prior to admission for 1 of 6 sample residents (#1), annually for 3 of 6 sample residents (#2, #3, #4), and after a change in condition for 1 of 3 sample residents (#6) who required this assessment. The findings were: 1. Medical record review revealed resident #1 was admitted on 1/29/15. Further review revealed an ALF 102 assessment was lacking. Interview with the DON on 9/20/17 at 4:40 PM revealed she was unable to find a previous or current ALF 102 assessment for this resident. 2. Medical record review showed resident #2 had a completed ALF 102 assessment dated 2/15/16. Further review failed to show an ALF 102 with a	S5020		

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S5020	Continued From page 2 more recent date. 3. Medical record review showed resident #3 had a completed ALF 102 assessment dated 1/7/16. Further review failed to show an ALF 102 with a more recent date. 4. Medical record review showed resident #4 had a completed ALF 102 assessment dated 12/11/15. Further review failed to show an ALF 102 with a more recent date. 5. Interview with the DON on 9/20/17 at 4:40 PM confirmed the lack of current ALF 102 assessments for residents #2, #3, and #4. She further stated she had been working to review and update the ALF 102 assessments for all residents but she had not completed this task. 6. Medical record review revealed resident #6 was admitted to the facility on 5/18/13 with diagnosis that included dementia and arthritis. Review of the admission nursing assessment showed the resident ambulated with a walker, was continent of bowel and bladder, and dressed with set up assistance. Observation on 9/20/17 from 9 AM to 9:30 AM revealed the resident self-propelled in his/her wheelchair in the halls and his/her room. Interview with a family member on 9/20/17 at 9:16 AM revealed the resident was unable to use a walker due to weakness. Interview with CNA #1 on 9/20/17 at 4:20 PM revealed she first noticed the resident needed more assistance approximately 5 months ago. The CNA stated the resident currently required the assistance of 2 staff for toileting; could no longer use the walker due to weakness and poor balance, and had increased episodes of urinary incontinence. Review of the most current ALF 102 assessment, dated 4/22/15, showed the resident	S5020		

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S5020	Continued From page 3 required little or minimal assistance with transfers, mobility, dressing, and bathing. During interview on 9/20/17 at 4:40 PM, the DON revealed the resident required more assistance with most activities of daily living than s/he had needed in the past. The DON also stated an ALF 102 assessment should have been completed to reflect the resident's current status, but she had not done this.	S5020		
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;	S5054		

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S5054	Continued From page 4 (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, 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	S5054		

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S5054	Continued From page 5 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 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	S5054		

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S5054	Continued From page 6 (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 facility incident logs, and policy review, the facility failed to report incidents affecting the health, welfare or safety of the residents to the Licensing Division for allegations of abuse involving 2 of 6 sample residents (#3, #5). The findings were: 1. Review of the medical record revealed resident #5 was admitted on 9/1/17 with diagnoses that included dementia. Review of nursing notes, dated 9/3/17, showed the resident pushed another resident and made verbal threats to other residents. Review of the nursing notes, dated 9/7/17, showed the resident walked up to another resident who was sitting in a chair and slapped that resident. This resident to resident contact resulted in a bruise on the slapped resident's face. Review of the 9/9/17 nursing notes showed resident #5 was aggressive toward another resident and threaten to hit the resident. Review of the 9/11/17 nursing notes showed resident #5 was grabbing at other residents and the other residents in the facility expressed fear of resident #5. 2. Review of the medical record revealed resident #3 was admitted on 1/7/16 with diagnoses that included dementia. Review of the nursing notes, dated 4/25/17, 5/20/17, 5/22/17, 8/22/17, revealed documented incidents of the resident's	S5054		

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S5054	Continued From page 7 combative, agitated, and physically aggressive behaviors directed at staff. However, review of the nursing notes, dated 7/8/17 showed the resident punched another resident in the face on 7/7/17. 3. Review of the Licensing Division logs and review of the facility incident logs showed the above incidents involving residents #3 and #5 did not appear in either log. This was confirmed during interview with the DON on 9/20/17 at 1:20 PM. 4. Review of the Abuse and Neglect Policy, developed 10/27/11, showed staff were directed to investigate and report all allegations of abuse to the Licensing Division and Long Term Care Ombudsman within 5 days. Interview on 9/20/17 at 1:20 PM with the DON revealed appropriate action was taken to protect the residents; but a formal investigation was not conducted and the incidents were not reported as directed by the policy.	S5054		

10/24/17 @ 3:30pm
POC accepted - PPrince

DEER TRAIL
ASSISTED LIVING & MEMORY CARE

Response to survey of September 20, 2017

ID Prefix Tag 5020

1. A review of our electronic record shows that the DON at that time indicated an ALF 102 was complete before admission. That ALF 102 cannot be found. A review of all records was started before the survey of September 20, 2017 to ensure resident charts are complete and current. Resident #1 was found to be missing the ALF 102. While we are unable to replicate an ALF 102 for the past, we will ensure a checklist for admission is complete, including the ALF 102. This checklist will be reviewed for all new residents at Quality Assurance meetings.
2. A review of all records was started before the survey of September 20, 2017 to ensure resident charts are complete and current. Resident #2 was found to be missing a current ALF 102. While we are unable to replicate an ALF 102 for the past, we will ensure a checklist for admission is complete, including the ALF 102. This checklist will be reviewed for all new residents at Quality Assurance meetings.
3. A review of all records was started before the survey of September 20, 2017 to ensure resident charts are complete and current. Resident #3 was found to be missing a current ALF 102. While we are unable to replicate an ALF 102 for the past, we will ensure a checklist for admission is complete, including the ALF 102. This checklist will be reviewed for all new residents at Quality Assurance meetings.
4. A review of all records was started before the survey of September 20, 2017 to ensure resident charts are complete and current. Resident #4 was found to be missing a current ALF 102. While we are unable to replicate an ALF 102 for the past, we will ensure a checklist for admission is complete, including the ALF 102. This checklist will be reviewed for all new residents at Quality Assurance meetings.
5. The DON will complete the chart audit, which is in progress, for all residents and ensure their records, including current ALF 102s, are properly in place. This will be completed by October 31, 2017 and reviewed at the Quality Assurance meeting on November 2, 2017.
6. Current policies and procedures state a complete assessment, including an ALF 102, will be administered when a resident experiences a change of condition. To ensure this policy is followed, the DON will review all residents who experience a change of condition for proper documentation. Change in conditions will be reviewed at Quality Assurance meetings as well.

DEER TRAIL
ASSISTED LIVING & MEMORY CARE

Response to survey of September 20, 2017

ID Prefix Tag 5054

1. I agree with this statement
2. I agree with this statement
3. I agree with this statement
4. While a policy is in place for timely reporting of abuse and neglect, the policy was not followed completely in the above noted incidents. The 'formal investigation' and companion report to the state will be complete going forward. To ensure the policy is followed, the DON is now aware of requirements included in the policy as well as Chapter 12. The DON will be timely in investigating and reporting to the state. All incidents will be reviewed during Quality Assurance meetings to ensure the DON has properly investigated, followed up, and completed reporting.

Respectfully submitted,

Jeffrey Smith
Executive Director
Deer Trail Assisted Living