11/20/17

PRINTED: 10/26/2017
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
	ALF003	A. BUILDING: _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MEADOW WIND	3955 EAST 12TH STREET CASPER, WY 82609

(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 10/12/17. The survey was prompted by complaint intakes LIC-17-035, LIC-17-040, and LIC-18-001.	S 000		
S5082	Ch 12 Sec 7 (k)(i) Assisted Living Facility (ALF) Core Services (k) Transfer and Discharge. (i) Residents shall receive a thirty (30) day written notice prior to any facility initiated transfer or discharge, unless the resident imposes an imminent danger to self and/or others or the resident's level of care exceeds that which can be provided by an assisted living facility. Residents shall have the right to object to the request, except where undue delay might jeopardize the health, safety or well-being of the resident or others. The notice shall include contact information for the Long Term Care Ombudsman. This State Rule and Regulation is not met as evidenced by: Based on medical record review, discharge notice review, and staff interview, the facility failed to ensure 1 of 3 facility initiated discharges (#1) reviewed met the requirements. The findings were: Review of the medical record showed resident #1	S5082	S5082 The facility will give residents thirty (30) day written notice prior to any facility initiated transfer or discharge, unless the resident imposes an imminent danger to self and/or others or the resident's level of care exceeds that which can be provided by and assisted living facility. Residents shall have the right to object to the request, except where undue delay might jeopardize the health, safety or well-being of the resident or others. The notice shall include contact information for the Long Term Care Ombudsman.	11/25/2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kandace R Brooks — TITLE: Executive Director — (X6) DATE: 10/31/17

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Healthcare Licensing and Surveys

Accepted on 11/20/17 by Loralee Rivers Kandace Brooks was notified

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S5082	Continued From page 1 was admitted on 6/2/17 and the resident resided on a memory care unit. Review of August 2017 progress notes showed the resident had a behavior monitoring plan in place. The resident was being monitored for behaviors that included "wandering/opening doors" and "continuous verbalizations/yelling." The notes showed on 9/1/17 the family was notified of the need for additional contracted services to provide 1 to 1 care to manage behaviors and provide safety for the resident and others who were disturbed by the behaviors. After failed attempts to get these additional services in place, on 9/18/17 the facility issued a 30 day discharge notice. Review of the 9/18/17 discharge notice showed an effective discharge date of 10/20/17. Additional notes on 9/18/17 and 10/3/17 showed communication about the ongoing needs for the family to provide the needed additional services and finding placement at a higher level of care. The following concerns were identified: a. Review of the untimed late entry note dated 10/3/17 showed the resident's family had made an appointment for the resident with the primary care physician due to complaints of a "distended/tender abdomen." b. Review of the 10/3/17 history and physical from the hospital showed the resident presented to the emergency department with the chief complaint of abdominal pain and delirium. The resident was admitted as an inpatient to treat a urinary tract infection and a stool impaction. c. Review of a progress note dated 10/4/17 not timed or signed, showed the facility called and left a message for the family they "would not be taking [the resident] back." Review of a 10/5/17 untimed, unsigned note showed an additional family member was contacted and notified the facility would not be taking the resident back from the hospital." This note further documented the	S5082	Executive Director and Clinical Services Director will review any resident that has a thirty (30) day written notice that is ongoing at this time. All those residents to be found with thirty (30) day notice will be reviewed by Executive Director, Clinical Services Director, Quality Assurance Nurse, and Regional Vice President to ensure all policies and procedures are being followed. All thirty (30) day written notices will be reviewed by the Executive Director and Clinical Services Director at the monthly Quality Assurance meetings to make sure all policies and procedures are being followed.	

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S5082	Continued From page 2 family member stated they did not want the resident to return to the facility. d. Interview with the Executive Director (ED) on 10/12/17 at 3 PM confirmed the resident was taken to the physician appointment and then to the ER by the family. The ED stated she had called and notified the family they would not be taking the resident back. The ED verified the reason for not accepting the resident back was related to the behaviors and safety concerns which resulted in the 9/18/17 discharge notice. She further stated there no additional discharge notice was issued.	S5082		