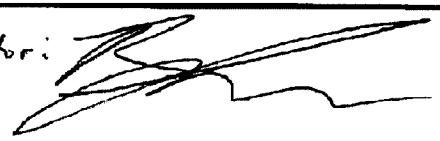
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF014	A. BUILDING: _____ B. WING _____	01/24/2018

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 licensure survey was conducted by Healthcare Licensing and Surveys on 1/24/18. The following common abbreviations are used throughout the document: CSD: Clinical Services Director ALF: Assisted Living Facility Less commonly used abbreviations will be annotated in each deficiency.	S 000	SURVEY POC ATTACHED AS A SEPERATE DOCUMENT	
S5008	Ch 12 Sec 6 (d)(ii)(A-F) Personnel and Staffing Requirements (d) Infection Control. Written policies shall be in effect to ensure that newly hired and current employees do not spread a communicable disease that could be transmitted through usual job duties. These shall not be limited to: (ii) Tuberculin Testing. (A) Tuberculin testing must be accomplished for each employee prior to employment and annually thereafter. (B) Employees having known positive skin tests shall provide a certificate of noninfectiousness, recommendations, if any, for treatment, and evidence they have complied with	S5008		

P.O.C. accepted on 2/22/18 Spoke with Ron Schriner, executive director on 2/22/18 at 2:27pm. The latest POC is 3/18/18. Colleen Logan

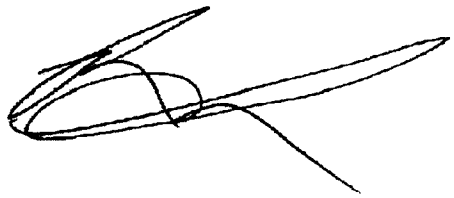
ID Prefix Tag	Summary of Statement of Deficiencies	Plan of Correction
S5008	*Based on employee record review and staff interview, the facility failed to ensure 2 of 5 employees had an annual Tuberculin test or screening completed.*	**Corrective Action:** Upon researching TB screening guidelines - Spring Wind has revised their TB screening process. After completion of the Wyoming Department of Health Facility Risk Assesment- Spring Wind has been identified as a Low Risk Facility. Facility Screening Tool is attached. Reccomendations from the Wyoming Department of Health for Screening Frequency for Low Risk Facilities are as follows: A Baseline two-step TST and NO ANNUAL TESTING (unless other risks occur) when standard contact investigation (TB Screening) is completed annualy. Based on this reccomendation- only TB screening will be completed annualy, rather than serial TST exams every 12 months. The Names of CNA#1 and RN#1 were not provided with the survey results, from HLS but an audit of all employees was completed for compliance- and TB screenings administered as appropriate on a case by case basis. **Methods to Identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken:** The Business office director will complete an audit of employee files to ensure that all employees are current on their TB tests, and complete TB testing with TST serum when indicated, or have employees complete the attached TB screening on an annual basis. **Methods of Monitoring the corrective action to make sure correction is achieved and sustained:** Employees who are approaching the annual time frame for TB screening will be discussed at the interdicplinary QA meeting so respective department heads can follow up with employees needing to complete the screening. A QA meeting Template is attached. **Date when corrective action will be completed:** Revised TB screening policy will be institued going forward from January 30th, 2018 when the Facility Risk Assesment was completed. Employe chart audit has been completed, all charts not in compliance will be corrected and back to compliance by March 18, 2018.

Executive Director:  2/16/18

Ron Schriner: Executive Director

2/16/18

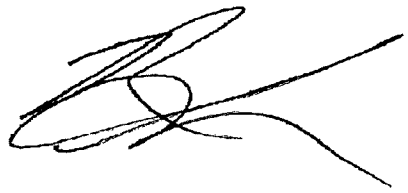
ID Prefix Tag	Summary of Statement of Deficiencies	Plan of Correction
S5001	*The Facility failed to ensure residents did not require care or services which could not be provided by a Level 1 Assisted Living Facility staff for 1 of 1 sample residents (#1) with wandering which jeopardized his/her health and safety.*	**Corrective Action:** A 30 day notice was issued and will be submitted with the plan of correction. The notice was issued for Resident #1 on 2/16/18 with a 30-day notice date of 3/18/18. The residents POA is aware of this and actively looking at other, appropriate facilities. **Methods to Identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken:** Other residents at risk for wandering will be identified through the Edgewood Elopement Screening tool. If medication changes in coordination with the physcian, or changes to the plan of care do not minimize, or mitigate risk, a 30 day notice will be issued when their wandering jeopardizes their health and safety. **Methods of Monitoring the corrective action to make sure correction is achieved and sustained:** The Edgewood Elopement Screening Tool will be completed annualy (at a minimum), or when any wandering or exit seeking behavior is noted. Residents identified as high risk will be discussed at interdisciplinary QA meetings, and the CSD will communicate these risks to the Edgewood regional QA nurse on an ongoing basis. QA meeting Template is attached. **Date when corrective action will be completed:** The notice was issued on 2/16/18 with a 30-day notice date of 3/18/18.



Ron Schriner: Executive Director

2/16/18

ID Prefix Tag	Summary of Statement of Deficiencies	Plan of Correction
S5104	*The Facility failed to ensure residents did not require care or services which could not be provided by a Level 1 Assisted Living Facility staff for 1 of 1 sample residents (#1) with inappropriate social behavior.*	**Corrective Action:** A 30 day notice was issued and will be submitted with the plan of correction. The notice was issued for Resident #1 on 2/16/18 with a 30-day notice date of 3/18/18. The residents POA is aware of this and actively looking at other, appropriate facilities. **Methods to identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken.** A care plan meeting will be held with appropriate parties for any resident displaying inappropriate social behavior. These residents will be discussed, as applicable at the interdiciplinary QA meetings and with the Edgewood reigonal QA nurse as appropriate. If medication changes in coordination with the physician, or changes to the plan of care do not mitigate inappropirate social behavior, a 30 day notice will be issued. QA Meeting Template is attached. **Methods of Monitoring the corrective action to make sure correction is achieved and sustained:** The behavior section of the plan of care will be completed annualy (at a minimum), or when any behavioral changes are noted. Residents identified as having inappropriate social behavior will be discussed at interdisciplinary QA meetings, and the CSD will communicate these risks to the Edgewood reigonal QA nurse on an ongoing basis. **Date when corrective action will be completed:** The notice was issued on 2/16/18 with a 30-day notice date of 3/18/18.



Ron Schriner: Executive Director

2/16/18