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Healthcare Licensing and Surveys

PRINTED: 02/07/2018
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF002	A. BUILDING: _____ B. WING _____	01/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN SQUARE OF CASPER	1960 SOUTH BEVERLY STREET CASPER, WY 82601

(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 06/29/2001 A licensure survey was conducted by Healthcare Licensing and Surveys from 1/24/18 to 1/25/18. The following common abbreviations are used throughout the document: RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	S 000	W.S. 35-2-901 Chapter4 (a) "Acceptable Plan of Correction" means the Licensing Division approved the plan to correct the deficiencies identified during an on-site survey conducted by the Survey Division's designated representative. The plan of correction shall be a written document and shall provide: (i) Who is responsible for the correction? (ii) What was done to correct the problem? (iii) Who will monitor to ensure that the situation does not reoccur? (iv) An appropriate date, not to exceed sixty (60) days after the last day of survey, for the correction of deficiencies.	
S5018	Ch 12 Sec 7 (a)(ix)(A) Assisted Living Facility (ALF) Core Services (a) The assisted living facility core services include the following: (ix) Assessments completed by a Registered Nurse. (A) Registered Nurse medication review every two (2) months or sixty-two (62) days or whenever new medication is prescribed or the resident's medication is changed; This State Rule and Regulation is not met as evidenced by: Based on medical record review, review of medication review forms, policy and procedure review, and staff interview, the facility failed to ensure 11 of 42 residents (#12, #14, #16, #17,	S5018	S5018 The Administrator, RN and Health Services Coordinator are responsible for all corrective action related to S5018. Corrective actions that will be accomplished for residents #12, #14, #16, #17, #18, #32, #33, #35, #37, #39, and #42 who were found to have been affected by the deficient practice will be to perform a medication administration review and take appropriate action on these residents by 2/23/18. This review and appropriate action will be repeated every 60 days. The RN and Health Services Coordinator were educated on the Ridgeline Policy regarding the MAR review by the Administrator and documented on the newly revised staff training sign in and acknowledgment. The corrective action that will be taken to prevent other residents from being affected by same deficient practice will include an RN review of MAR at least every 60 days as stated in the medication documentation policy and address any discrepancies.	

3.6.18 PoC accepted with DoC 3.14.18

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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 from 1/24/18 to 1/25/18. The following common abbreviations are used throughout the document: RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	S 000	W.S. 35-2-901 Chapter4 (a) "Acceptable Plan of Correction" means the Licensing Division approved the plan to correct the deficiencies identified during an on-site survey conducted by the Survey Division's designated representative. The plan of correction shall be a written document and shall provide: (i) Who is responsible for the correction? (ii) What was done to correct the problem? (iii) Who will monitor to ensure that the situation does not reoccur? (iv) An appropriate date, not to exceed sixty (60) days after the last day of survey, for the correction of deficiencies.	
S5018	Ch 12 Sec 7 (a)(ix)(A) Assisted Living Facility (ALF) Core Services (a) The assisted living facility core services include the following: (ix) Assessments completed by a Registered Nurse. (A) Registered Nurse medication review every two (2) months or sixty-two (62) days or whenever new medication is prescribed or the resident's medication is changed; This State Rule and Regulation is not met as evidenced by: Based on medical record review, review of medication review forms, policy and procedure review, and staff interview, the facility failed to ensure 11 of 42 residents (#12, #14, #16, #17,	S5018	S5018 The Administrator, RN and Health Services Coordinator are responsible for all corrective action related to S5018. Corrective actions that will be accomplished for residents #12, #14, #16, #17, #18, #32, #33, #35, #37, #39, and #42 who were found to have been affected by the deficient practice will be to perform a medication administration review and take appropriate action on these residents by 2/23/18. This review and appropriate action will be repeated every 60 days. The RN and Health Services Coordinator were educated on the Ridgeline Policy regarding the MAR review by the Administrator and documented on the newly revised staff training sign in and acknowledgment. The corrective action that will be taken to prevent other residents from being affected by same deficient practice will include an RN review of MAR at least every 60 days as stated in the medication documentation policy and address any discrepancies.	

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	ALF002	A. BUILDING: _____ B. WING _____	01/26/2018

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GARDEN SQUARE OF CASPER	1960 SOUTH BEVERLY STREET CASPER, WY 82601

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S5018	Continued From page 1 #18, #32, #33, #35, #37, #39, #42) had a review of medications completed every 60 days by a RN. The findings were: 1. Review of facility medication review forms showed the RN completed a medication review form each time she reviewed individual resident medication regimes. Further review revealed the forms were completed between July 2017 and January 2018; a review form had not been completed for all of the residents; and some of the forms did not include the identity of the resident. Interview on 1/25/18 at 1:22 PM with the administrator revealed the RN completed medication reviews for residents when new medications were prescribed, medication orders were changed or discontinued, and when orders expired. She further stated unless residents had these orders, their medications were not reviewed. She also stated she was unable to provide evidence of a medication review process prior to July 2017. Interview on 1/25/18 at 2:17 PM with the business office manager revealed the facility did not have a monitoring system for ensuring medication reviews were done for all residents every 62 days. The following concerns were identified: a. Review of the medical record showed resident #12 was admitted on 8/27/16. This review and review of the July 2017 to January 2018 medication forms revealed no evidence an RN had reviewed the resident's medications at any time after admission. b. Review of the medical record showed resident #14 was admitted on 5/14/16. This review and review of the July 2017 to January 2018 medication forms revealed no evidence an RN had reviewed the resident's medications at any time after admission. c. Medical record review of resident #16	S5018	Continued From page 1 Following the RN review, the Health Services Coordinator and the Administrator will audit to ensure all discrepancies have been addressed. The measures that have been put in place to ensure the deficient practice does not reoccur will be to ensure the medication documentation Policy and Procedure is followed using an audit checklist. The effectiveness of this practice will be measured weekly during the Health Service Review Audit, which is part of the Quality Assurance Program. The corrective action will be completed by 3/10/2018.	

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S5018	Continued From page 2 showed s/he was admitted to the facility on 2/26/11. Further review showed the resident's medications were reviewed by an RN on 11/30/17 due to a medication change, however there was no evidence his/her medications had been reviewed prior to that date. d. Review of the medical record showed resident #17 was admitted on 3/11/17. This review and review of the July 2017 to January 2018 medication forms revealed no evidence an RN had reviewed the resident's medications at any time after admission. e. Review of the medical record showed resident #18 was admitted on 4/15/15. This review and review of the July 2017 to January 2018 medication forms revealed no evidence an RN had reviewed the resident's medications at any time after admission. f. Review of the medical record showed resident #32 was admitted on 5/2/16. This review and review of the July 2017 to January 2018 medication forms revealed no evidence an RN had reviewed the resident's medications at any time after admission. g. Review of the medical record showed resident #33 was admitted on 9/14/12. This review and review of the July 2017 to January 2018 medication forms revealed no evidence an RN had reviewed the resident's medications at any time after admission. h. Review of the medical record showed resident #35 was admitted on 2/9/17. This review and review of the July 2017 to January 2018 medication forms revealed no evidence an RN had reviewed the resident's medications at any time after admission. i. Review of the medical record showed resident #37 was admitted on 6/21/17. This review and review of the July 2017 to January 2018 medication forms revealed no evidence an	S5018		

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S5018	Continued From page 3 RN had reviewed the resident's medications at any time after admission. j. Review of the medical record showed resident #39 was admitted on 12/10/15. This review and review of the July 2017 to January 2018 medication forms revealed no evidence an RN had reviewed the resident's medications at any time after admission. k. Review of the medical record showed resident #42 was admitted on 1/3/15. This review and review of the July 2017 to January 2018 medication forms revealed no evidence an RN had reviewed the resident's medications at any time after admission. 2. Review of the facility policy and procedure entitled "Medication Documentation", revised 9/22/15 showed "review or audits of the medication record will be done routinely."	S5018		
S5021	Ch 12 Sec 7 (b)(ii)(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. (ii) Admission orders. A resident shall be admitted only if accompanied by a history and physical completed by a physician extender within ninety (90) days prior to admission. The facility shall confirm the resident's medication regimen and special treatment orders at the time of admission. (A) Admission orders shall include an	S5021	S5021 The Administrator, RN, and Health Services Coordinator are responsible for all corrective action related to S5021. Corrective action was accomplished for residents #24 and #29 who were found to have been affected by the deficient practice on 2/3/18. The residents were identified as not having a Tuberculosis screening prior to admission. Both resident's #24, #29 along with all residents admitted to the community will have Physician orders updated to reflect Tuberculosis (TB) screening and TB testing as appropriate per orders. The corrective action that will be taken to prevent other residents from being affected by the same deficient practice will be to 1) Update the current admission Physician form to include TB screening, Influenza and Pneumococcal immunizations status accompanied by a consent form indicating acceptance or declination.	

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S5021	Continued From page 4 order for TB screening, influenza and pneumococcal immunization status and others for immunization if required, unless contraindicated. The facility must develop and implement policies and procedures to ensure the following: (I) Residents, or their legal representative are educated regarding the risks and benefits of these immunizations. (II) The immunizations are offered unless medically contraindicated or the resident is currently immunized. (III) If the resident is not vaccinated, the medical record must reflect the reason, such as medical contraindication or refusal. This State Rule and Regulation is not met as evidenced by: Based on medical record review, staff interview, review of policy and procedure, and review of the facility's Physician Orders, History & Physical" form, the facility failed to ensure tuberculosis screening was completed on admission for 2 of 6 sample residents (#24, #29). The findings were: 1. Review of the medical record for resident #24 showed s/he was admitted to the facility on 12/14/17. Further review showed no evidence tuberculosis screening was completed prior to admission. 2. Review of the medical record for resident #29 showed s/he was admitted to the facility on 11/4/17. Further review showed no evidence, tuberculosis screening was completed prior to admission.	S5021	Continued from page 4 2) Ensure the admission Physician orders are completed prior to admission into this facility. 3) Ensure the consent form has been completed and signed by Resident. This consent form will also be used as an education tool at times of admission and orientation. 4) The TB and immunization status information will be entered into the electronic chart. Measures that will be put in place to ensure the deficient practice does not reoccur will be for the Health Services Coordinator to ensure completion of Physician order form prior to move in including the TB screening and consent form. Any residents that screen appropriate for TB testing will be tested per orders. Current Policy and Procedures have been updated to reflect Wyoming regulations for Admission orders per Chapter 12. The effectiveness of this practice will be monitored by the Health Services Coordinator and the RN reviewing the electronic chart reports and taking action as appropriate. The review will be done on a monthly basis and included in the Quality Assurance Program. The corrective action will be completed by 3/10/2018.	

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S5021	Continued From page 5 3. Review of the "Physician Orders, History & Physical" form last revised 12/12/17 and used for new admissions showed tuberculosis screening was not included. 4. Review of the policy "Immunizations/Vaccinations" last revised 9/22/15 addressed tuberculosis screening prior to admission in the state of Oregon, but did not include state of Wyoming requirements. 5. Interview with the administrator on 1/25/18 at 12:21 PM revealed the facility did not have a system in place to ensure tuberculosis screening was completed prior to admission to the facility.	S5021		
S5065	Ch 12 Sec 7 (g)(iii) Assisted Living Facility (ALF) Core Services (g) Grievance Procedure. The written grievance procedure shall establish a system of receiving, reviewing, and alleviating concerns, complaints and allegations of resident rights violations, and poor service provided to include, but not limited to: (iii) List of agencies, with address and telephone numbers for residents to contact if grievances are not addressed satisfactorily (e.g. State Long Term Care Ombudsman and the Department of Health, Office of Licensing and Surveys); and This State Rule and Regulation is not met as evidenced by: Based on review of policy and procedure and staff interview, the facility failed to ensure the grievance policy contained all required information. The census was 42. The findings	S5065	S5065 The Administrator is responsible for all corrective action related to S5065. The corrective action that will be accomplished for residents found to have been affected by the deficient practice will be to edit the current grievance policy to reflect accurate agencies. This updated policy will be given to all current residents by 3/10/18 by the Administrator, and reviewed with all current residents at next resident council meeting on 3/14/18. Residents not in attendance will be reviewed one on one with those residents. The corrective action that will be taken to prevent other residents from being affected by the same deficient practice will be to include updated grievance policy in all future resident handbooks. The administrator and Business Office Manager are educated on the grievance policy per Ridgeline Policy and are responsible to ensure this policy has been acknowledged by all current residents and new admits.	

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S5065	Continued From page 6 were: Review of the "Complaint Resolutions and Grievances" policy showed the list of agencies to contact if grievances were not addressed satisfactorily was incomplete. The list failed to include the Department of Healthcare Licensing and Surveys and failed to list addresses for the other agencies listed. Interview with the administrator on 1/25/18 at 12:10 PM confirmed the contact information contained in the policy was incomplete.	S5065	Continued from page 6 Measures that will be put into place to ensure hat the deficient practice does not recur will be o provide all new admits with a copy of the grievance policy and obtain a signed receipt from resident/POA. The effectiveness of this practice will be evaluated by completing the admission checklist after each move in. This form will contain a confirmation that the grievance policy was given and receipt signed. A signed receipt will be obtained by all current residents by 3/14/18 and kept in their file . The corrective action will be completed by 3/10/2018.	
S5076	Ch 12 Sec 7 (j)(v) Assisted Living Facility (ALF) Core Services (j). Food Service and Nutrition. (v). Individuals with food preparation responsibilities shall be in good health and shall practice safe food handling techniques in accordance with the current edition of the Food Code published by the U.S. Public Health Service, Food and Drug Administration. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, and review of food code requirements, the facility failed to ensure food was prepared under sanitary conditions in 1 of 1 kitchens. The findings were: Observation on 1/24/18 at 2:15 PM showed 8 cutting boards of various sizes and colors, and the cutting board attached to the steam table were visibly scored which created surfaces that could not be effectively cleaned. Interview with the dietary supervisor on 1/24/18 at 2:40 PM confirmed the cutting boards were in poor	S5076	S5076 The Administrator and Dietary Manager are responsible for all corrective action related to S5076. Corrective action that will be accomplished to correct this deficient practice will be to include a weekly checklist in which the status of the cutting boards and other equipment are inspected per the current edition of the Food Code, and to have all cutting boards found to be deficient replaced by 3/9/2018. The corrective action that will be taken to prevent the same deficient practice from taking place will include food sanitation and safe food handling in-services to kitchen staff. An in-service will be completed on 2/26/18. Staff will be trained on acceptable status of cutting boards. Measures that will be put in place to ensure that the deficient practice does not reoccur will be to have the Dietary Manager review the checklist weekly as part of the Quality Assurance Program and report discrepancies to the Administrator for action. The effectiveness of this practice will be monitored monthly during our Registered Dietitian Survey of Quality Assurance Program.	

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S5076	Continued From page 7 condition and needed to be replaced. According to Food Code 2013, U.S. Public Health Service 4-501.12 "Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and SANITIZED or discarded if they are not capable of being resurfaced."	S5076	Continued from page 7 The corrective action will be completed by 3/10/18.	

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