PRINTED: 06/12/2018
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
	ALF002	A. BUILDING: _____ B. WING _____	C 06/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN SQUARE OF CASPER	1950 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 06/28/2001 A complaint survey was conducted by Healthcare Licensing and Surveys on 6/5/18. The survey was prompted by complaint intake LIC-18-031. The following common abbreviations are used throughout the document: CNA- Certified Nursing Assistant LPN - Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	S 000	W.S. 35-2-901 Chapter 4 (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:) Who is responsible for the correction? i) What was done to correct the problem? ii) Who will monitor to ensure that the situation does not reoccur? v) An appropriate date, not to exceed sixty (60) days after the last day of survey, for the correction of deficiencies.	
S5052	Ch 12 Sec 7 (d)(iv)(A) Assisted Living Facility (ALF) Core Services (d) Medications. (iv) Medication assistance. (A) The staff shall be responsible for providing necessary assistance to residents deemed capable of self-medicating, but are unable to do so because of a functional disability, in taking oral medications. Non-licensed staff can only assist with oral medications. Medication assistance may include: (I) Reminding resident to take medications;	S5052	S5052 This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies. This plan of correction is being submitted as required by the regulation. The Administrator will ensure all corrective action in the following Plan of Correction has been completed. S5052 – Chapter 12 Sec 7 (d)(iv)(A) Assisted Living Facility ALF Core Services. (d) Medications (iv) Medication Assistance (A) (i) Who is responsible for the correction; The Administrator, RN and Health Services Coordinator are responsible for all corrective action related to S5052 (ii) What was done to correct the problem; Residents' #8, #22, #24, #26, #27, #28, #30, #33, #34, #35, #38, and #40 were reassessed to ensure the need for medication administration services were met.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Meredith Dailey | TITLE: Administrator | (X6) DATE: 6-22-18

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This plan of correction has been accepted. The administrator was notified on 6/27/18 at 1:24 pm.
Jean Yenni MT (ASCP)

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S6052	Continued From page 1 (II) Removing medication containers from storage; (III) Assisting with removal of cap; (IV) Assisting with the removal of a medication from a container for residents with a disability which prevents independence in this act; (V) Observing the resident take the medication; and (VI) Documentation of observation. This State Rule and Regulation is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure residents who required assistance with medication administration received medication from a licensed nurse for 6 of 6 residents reviewed (#8, #22, #24, #28, #34, #35). The findings were: Observation on 6/5/18 at 11:30 AM showed LPN #1 was administering medications to residents during the noon meal. Residents who received medication included residents #8, #22, #24, #28, #34, and #35. Interview with the LPN at this time revealed 42 current residents required assistance with medication administration. The following concerns were identified: 1. Review of the May 2018 MAR (medication administration record) for resident #8 showed the administrator, who was not a nurse, gave 12 medications to the resident on the morning of 5/1/18. In addition, the MAR showed the administrator gave medications on 5/9/18, three	S6052	continued from page 1 Their Medication Administration Records (MARs) were reviewed by the RN and completed on 6/22/18. The review included medication delivery accuracy by the CNA for the dates of 5/1/18 and 5/9/18. The RN has initiated medication self-administration assessments for all current residents in order to evaluate their medication management needs. Moving forward, initial and ongoing assessments will include a documented review of the Resident's ability to self-manage medications and ensure appropriate licensed staff are scheduled accordingly. The administrator, and all unlicensed staff will be in-serviced on the State Regulations of Level I licensing regarding the rules for medication assistance and medication administration to prevent any recurrence of this deficiency. The Health Services Coordinator (HSC) position will be filled by a licensed nurse. The HSC position description has been updated to include the responsibility of ensuring adequate licensed staff are available for medication administration. The community has scheduled implementation of an electronic medication software (EMAR). This software requires login security access which can be monitored remotely. Once implemented the Health Services Coordinator and RN will monitor medication dispensing to ensure appropriate licensed staff are scheduled. (iii) Who will monitor to ensure that the situation does not reoccur, The RN will complete ongoing audits of the EMAR system for effectiveness of the corrective action. The RN will ensure residents receive the appropriate medication assistance or medication administration as deemed from current medication management assessment.	

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S5052	Continued From page 2 medications were administered on the afternoon shift and 4 medications at bedtime. These medications included treatment for Parkinson's disease, seizures, depression, diabetes, blood pressure, an antipsychotic, and a narcotic for pain. 2. Review of the May 2018 MAR for resident #22 showed the administrator gave 13 medications to the resident on the morning of 5/1/18. In addition, on 5/9/18 ten medications were shown as given by the administrator on the afternoon shift and 2 medications at bedtime. These medications included treatment for blood pressure, anxiety, chronic pulmonary obstructive disease, and a narcotic for pain. 3. Review of the May 2018 MAR for resident #24 showed the administrator gave 7 medications to the resident on the morning of 5/1/18 and 6 medications on the afternoon shift of 5/9/18. These medications included medications for blood pressure, a narcotic for pain, and a heart medication which required a pulse to be taken before administration. 4. Review of the May 2018 MAR for resident #28 showed the administrator gave 5 medications on the morning of 5/1/18 and 6 medications on the afternoon shift of 5/9/18. These medications included an antipsychotic and an anticoagulant. 5. Review of the May 2018 MAR for resident #34 showed the administrator gave 6 medications on the morning of 5/1/18. In addition, on 5/9/18 two medications were shown as given by the administrator on the afternoon shift and 1 medication at bedtime. These medications included a narcotic for pain and an antidepressant.	S5052	Continued from page 2 The Administrator, HSC and RN will review resident medication delivery schedules weekly to ensure appropriately licensed staff are assigned where needed. (iv) An appropriate date, not to exceed sixty (60) days after This will be completed by 7.31.2018.	

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S5052	Continued From page 3 6. Review of the May 2018 MAR for resident #35 showed the administrator gave 8 medications on the morning of 5/1/18. In addition on 5/9/18 three medications were shown as given by the administrator on the afternoon shift, and 2 medications at bedtime. One of the medications/treatments administered on 5/1/18 was a foam dressing used for wound care. 7. Interview with the administrator on 6/5/18 at 2:45 PM revealed she was a CNA in addition to being the administrator of the facility. On 5/1/18 the nurse scheduled for the day was a "no show, no call" and when the administrator was not able to find a nurse to cover the shift she passed the medications. In addition, she stated she only passed the medications on 5/1/18 and denied passing medications on 5/9/18. She thought perhaps she had failed to log out of the system, and the nurse on duty administered the medications under her initials.	S5052		