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
	ALF003	A. BUILDING: _____ B. WING _____	C 05/30/2018

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 complaint survey was conducted by Healthcare Licensing and Surveys on 5/29/18 to 5/30/18. The survey was prompted by complaint intakes LIC-18-019 and LIC-18-030.	S 000		
S5027	Ch 12 Sec 7 (b)(viii) 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. (viii) The RN shall periodically evaluate results of the plan. The plan shall reflect assessed needs and resident decisions (including resident's level of involvement); support principles or dignity, privacy, choice, individuality, independence, and home-like environment, and shall include significant others who may participate in the delivery of services. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure care plans were evaluated to reflect current resident status for 3 of 9 sample residents (#1, #2, #5). The	S5027		

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S5027	Continued From page 1 findings were: 1. Review of the nurse's notes dated 1/24/18 and 3/21/18 showed resident #1 had falls. Review of the care plan showed it was dated 2/7/18 and there was no documentation the resident was at a risk for or had falls. 2. Review of the nurse's notes dated 3/2/18 at 3 AM and 3/17/18 at 2 PM showed resident #2 had fallen in the bathroom while self-transferring. Review of the 1/17/18 care plan showed a "fall reduction protocol" was marked with a note "resident had fall 1/15/18 Please remind resident to wear non-slip footwear." There was no documentation of the more recent falls or evidence the care plan had been re-evaluated related to falls. 3. Review of the fall risk evaluations dated 4/20/18 and 5/8/18 showed resident #5 was at "High Risk for potential falls" with a score of 15. The 4/20/18 evaluation note showed "Resident fell on outing", and the care plan was updated. Additionally, the evaluation note from 5/8/18 showed "the resident has fallen in the last 3 months, will continue to monitor." This note also showed the care plan was updated. Review of the 5/8/18 care plan showed there was no documentation regarding the falls or potential risk for falls. 4. Interview with the director of nursing (DON) and the administrator on 5/30/18 at 12:12 PM revealed the care plans were only updated if there was a significant change in condition. The DON then verified fall status should be accurately documented on resident care plans.	S5027		

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S5134	Continued From page 2	S5134		
S5134	Ch 12 Sec 10 (e)(ii) Secure Dementia Units Secure Dementia Units. Level 2 assisted living facilities require adherence to all Level I requirements with the following additional criteria for a Level 2 Assisted Living Facility License. (d) Level 2 additional core services. In addition to the previously listed Core Services increased assistance may be required with activities of daily living depending upon assessed resident functional and cognitive ability: (ii) Assistance Plans for residents of secure units must, at a minimum, address the following: (A) Memory; (B) Judgement; (C) Self-care ability; (D) Ability to solve problems; (E) Mood and character changes; (F) Behavioral patterns; (G) Wandering; and (H) Dietary needs. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure a safety assessment	S5134		

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S5134	Continued From page 3 and plan was developed related to smoking for 1 of 1 sample residents (#9) who smoked. The findings were: Observation on 5/30/18 at 6:52 AM in the #1 Memory Care Unit showed resident #9 was let outside to a courtyard area by licensed practical nurse #1. Further observation showed the resident was unsupervised while smoking a cigarette. Review of a nurse's note dated 12/3/17 showed the nurse was informed the resident was now allowed to smoke. The following concerns were identified: a. Review of the "Resident Care Plan," dated 5/29/18, showed the resident had diagnoses that included Korsakoff syndrome, cognitive communication deficit, and alcohol induced amnesia. Further review showed the resident was independent with walking, was disoriented, and "wanders throughout the facility without rational purpose to another area- is oblivious to safety or needs," and was easily redirected. There was no evidence the resident's smoking status was included. b. Interview with the administrator and director of nursing on 5/30/18 at 12:10 PM confirmed the resident was allowed to smoke unsupervised. They stated the resident's lighter and cigarettes were kept at the nurse's station. They further verified the resident did not have a smoking assessment completed, and the resident's smoking status was not included on the care plan. c. Review of a blank "Smoking Assessment" form showed factors used to determine if a resident was safe to smoke without supervision included being able to smoke safely and communicate understanding of policies for smoking.	S5134		

Plan of Correction for Meadow Wind Assisted Living, May 30, 2018 survey date.

Tag #S5027

Resident #1, 2, & 5 fall risk assessment and care plans were all updated on 6/19/18, going forward with any fall, a fall risk assessment will be updated. Care plan will be updated and any interventions will be documented on care plan. Clinical Services Director was educated on process and expectations by QA nurse and Executive Director. Executive Director will review incident reports w/falls weekly to ensure fall risk assessment and care plan have been updated x 1 month and monthly x 2 weeks. An audit of the last 6 months of falls will be completed by Executive Director, QA Nurse, and Clinical Services Director to determine what residents care plans and fall risk assessments need updated.

Complete date 7/27/2018

Tag #S5134

Resident #9 smoking assessment was completed on 5/31/18. Care Plan updated 6/19/18, going forward smoking assessment will be completed upon admission or on day resident starts smoking. Care plan to be done on admission or updated when resident starts smoking to include individualized plan for each resident. Clinical Services Director was educated on process and expectations. Executive Director and Clinical Services Director completed audit of other smoker in the building to ensure smoking assessment was in place. Executive Director will audit on weekly basis x 1 month then monthly x 3 months to ensure that smoking plan is being followed.

Complete date 7/27/2018

This plan of correction was accepted on 6/27/2018. The ED was notified on 6/27/18 at 4:01 pm.

Jean Yennie MT(ASCP)
6/27/18