Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9019	A. BUILDING: _____ B. WING _____	R 07/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN LODGE LLC	1110 BIRCH STREET DOUGLAS, WY 82633

(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 08/28/2001 An onsite revisit to the 6/5/18 initial licensure survey was conducted by Healthcare Licensing and Surveys on 7/31/18.	{S 000}	6. Administrator or designee will educate ML on the importance resident assessments and services that include but not limited to all residents receive Tuberculosis screening and that all residents have admission orders and medications confirmed at admission. 7. An audit on all TB screening on new admissions will be brought to QAPI monthly until resolved. 7. All new admissions will be audited to ensure that there are admission orders and medications confirmed at admission. The results from audits will be brought to QAPI on a monthly basis until resolved.	8/31/18
{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 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:	{S5021}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 8/21/18

STATE FORM 6899 7JUW12

Changes made per phone conversation with Brook Bukerfield, Administrator on 10/3/18 at 10:50am. POC accepted.

Janelle Cox

Healthcare Licensing and Surveys

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{S5021}	Continued From page 1 (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 and staff interview, the facility failed to ensure tuberculosis screening was completed on admission for 5 of 8 sample residents reviewed (#2, #5, #6, #9, #10) and in addition the facility failed to ensure admission orders were received and medications confirmed for 2 of 8 sample residents reviewed (#2, #6). The findings were: 1. Review of the medical record for resident #2 showed the resident was admitted to the facility on 4/26/18. A history and physical was completed on 4/25/18, however it failed to include admission orders. In addition, there was no evidence the resident's medication regimen had been confirmed or a tuberculosis screening had been done prior to admission. 2. Review of the medical record for resident #5 showed an admission date of 4/4/18. Further review of the medical record showed no evidence tuberculosis screening had been done prior to admission. 3. Review of the medical record for resident #6 showed an admission date of 4/4/18. Further	{S5021}	**S5021: Core Services** 1. The facility will ensure tuberculosis screening will be completed on all residents that reside at Mountain Lodge. 2. Mountain Lodge (ML), will ensure that residents #2, 5, 6, 9 and 10 will have Tuberculosis screening complete. 3. ML will ensure that all residents will have Tuberculosis screening complete at admission. 4. ML will ensure that resident #2 and #6 have admission orders and medications confirmed. 5. ML will ensure that all residents have admission orders and medications confirmed at admission.	

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{S5021}	Continued From page 2 review of the medical record showed no evidence admission orders were received, the resident's medication regimen had been reviewed, or tuberculosis screening had been done prior to admission. 4. Review of the medical record for resident #9 showed the resident was admitted to the facility on 7/5/18. Further review of the medical record showed no evidence tuberculosis screening had been done prior to admission. 5. Review of the medical record for resident #10 showed the resident was admitted to the facility on 7/5/18. Further review of the medical record showed no evidence tuberculosis screening had been done prior to admission. 6. Interview with the interim administrator on 7/31/18 at 11:10 AM revealed the previous administrator was unable to complete the education, audits, and correct this deficient practice, which was previously cited on 6/5/18.	{S5021}		
{S5022}	Ch 12 Sec 7 (b)(iii)(A-B) 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. (iii) The Registered Nurse shall make an initial assessment of the resident's needs, which describes the resident's capability to perform ADLs and notes all significant impairments in functional capability.	{S5022}		

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{S5022}	Continued From page 3 (A) Initial assessment. A current assessment shall be maintained in each resident's file. (B) The assessment shall include at least the following information: (I) Medically defined conditions and prior medical history; (II) Physical status; (III) Sensory and physical impairments; (IV) Nutritional status and requirements; (V) Special treatments and/or procedures; (VI) Mental and psychosocial status; (VII) Discharge potential; (VIII) Dental condition; (IX) Activities potential; (X) Rehabilitation potential; and (XI) Medication regimen. (1.) Documentation of resident's ability to self-medicate. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure an initial	{S5022}	**S5022: ALF Core Services.** 1. The facility will ensure an initial nursing assessment is completed by an RN on admission. 2. Mountain Lodge will in ensure that the staff/contracted RN will conduct initial and at a minim annually, an accurate standardized, reproducible assessment of each resident's functional capacity, physical assessment and medication review. 3. An initial nursing assessment will be completed by an RN on for residents #2, #5, #7, and #8. 4. All residents will have an initial nursing assessment conducted by an RN at admission. 5. The Administrator or designee will educate nursing staff on the importance of an initial nursing assessment be conducted by an RN at admission. 6. An audit of new admissions will be done to ensure that the initial nursing assessment is done and conducted by an RN at admission. The results of the audit will be brought to QAPI until resolved.	8/31/18

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{S5022}	Continued From page 4 nursing assessment was completed by a RN on admission for 4 of 8 sample residents (#2, #5, #7, #8) reviewed. The findings were: Review of the medical record for residents #2, #5, #7, and #8 showed no evidence an initial nursing assessment was conducted by a RN. Interview with the interim administrator on 7/31/18 at 11:10 AM revealed the previous administrator was unable to complete the education, audits, and correct this deficient practice, which was previously cited on 6/5/18.	{S5022}		
{S5054}	Ch 12 Sec 7 (e)(i)(A-K) Assisted Living Facility (ALF) Core Services (e) Resident Records and Reports. Each resident's records shall be current, organized and maintained in individual folders which shall be made available to the resident, the Licensing Division, or designated representative upon request. (i) Each folder shall include the following: (A) Information from the referring agent, if applicable; (B) History and physical performed by a physician or physician extender; (C) Individual admission form. The form shall, at a minimum, contain the following information: (I) Full name of resident and former address; (II) Date of admission;	{S5054}		

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{S5054}	Continued From page 5 (III) Sex, race, date of birth, social security number, and former occupation; (IV) Name, home address, and telephone number of relative, friend, Power of Attorney, or guardian; (V) Name, address, and telephone number of resident's personal physician, dentist, ophthalmologist or optometrist; (VI) Medicare number of other medical insurance identifying data; (VII) A written inventory of all personal possessions; however, this inventory need not include personal clothing. (D) All accidents, injuries, incidents, illnesses, and allegations of abuse, neglect or exploitation shall be reported to the resident's family or responsible party and be documented in the individual resident records. All such occurrences shall also be reported to the appropriate entity for follow up and resolution. Reports of all incidents affecting the health, welfare or safety of a resident shall be provided to the Licensing Division immediately (within one business day). Reporting shall be done by telephone or fax. The facility's investigation of the incident shall be reported to the Licensing Division and the Long Term Care Ombudsman within five (5) working days. Documentation to support the facility reporting the situation and follow up must also be present in the resident records; (E) An accounting of all personal funds	{S5054}	**S5054:** 1. The facility will maintain complete residents records for all residents residing at Mountain Lodge. 2. Resident #1 will have a completed resident record. 3. All residents will have complete resident records including but not limited to residents that are discharged. 4. The Administrator or designee will educate staff on the importance of residents having completed records. 5. An audit will be done on all ~~new~~ admissions to ensure that there are completed records ~~for those new admissions~~. The results of the audit will be taken to QAPI until resolved. Discharges and with residents illnesses je	8/31/18

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{S5054}	Continued From page 6 deposited with and disbursed by the facility; (I) Upon written authorization of a client, the facility must hold, safeguard, manage and account for the personal funds of the client. (1.) The facility must deposit any personal funds in excess of $100 in an interest bearing account. (2.) The facility must establish and maintain a system that assures a full and complete and separate accounting according to generally accepted accounting principles of each resident's personal funds entrusted to the facility. (3.) Upon the death of a resident with a personal fund deposited with the facility, the facility must convey, within 30 days, the resident ' s funds a final accounting of those funds, to the individual or probate jurisdiction administering the resident ' s estate. (4.) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare except for applicable deductible and coinsurance amounts. (F) A signed copy of the resident's rights; (G) The resident's assessment and individualized assistance plan; (H) Copies of all applicable resident assistance contracts, signed by both parties; (I) Written acknowledgment of the receipt and explanation of all facility policies including	{S5054}		

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{S5054}	Continued From page 7 admission/discharge policies; (J) Copy of all ALF 102's; and (K) Copy of outside contractual responsibilities, if applicable. This State Rule and Regulation is not met as evidenced by: Based on medical record review, the 6/5/18 Healthcare Licensing and Surveys (HLS) statement of deficiencies, and staff interview, the facility failed to maintain a complete resident record for 1 of 9 residents (#1) reviewed. The findings were: 1. Review of the 6/5/18 HLS statement of deficiencies revealed the administrator at that time had transported resident #1 to the emergency department for an acute illness on 5/26/18. The resident was then hospitalized. Interview on 7/31/18 at 3:15 PM with the interim administrator revealed the resident had not returned to the facility after the hospitalization and had subsequently moved out of state. In addition, she officially discharged the resident on 7/16/18. Review of the medical record showed no documentation of the resident's illness or that the resident had been discharged. Interview with the interim administrator on 7/31/18 at 11:10 AM revealed the previous administrator was unable to complete the education, audits, and correct this deficient practice, which was previously cited on 6/5/18.	{S5054}		

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{S5093}	Continued From page 8	{S5093}		
{S5093}	Ch 12 Sec 7 (o)(ii)(A) Assisted Living Facility (ALF) Core Services (o) Evacuation Capability, Emergency Procedures, and Fire Safety. (ii) Emergency Procedures. (A) Disaster and Emergency Preparedness. (I) The facility shall have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. A copy of the plans shall be available at all times within the facility. (1.) Emergency plans in the event of a fire shall be in accordance to the Life Safety Code Operating Feature sections. (II) The facility shall train all employees in the emergency procedures. New staff shall be trained within the first week of employment. The facility shall review the procedures with all staff at least every twelve (12) months. A training record shall be kept in each personnel file. This State Rule and Regulation is not met as evidenced by: Based on policy review, and staff interview the facility failed to provide detailed written plans and procedures to meet all potential emergencies. The findings were: Interview with the interim administrator on 7/31/18 at 2:10 PM revealed she was unable to locate the emergency plans and procedures.	{S5093}	**S5093** 1. The facility will provide detailed written plans and procedures to meet all potential emergencies. 2. The facility will have detailed written plans and procedures to meet all potential emergencies and disasters. 3. A copy of the detailed written plans and procedures will be available at all times with in the facility. 4. All staff will be educated on the importance of have a detailed written plans and procedures to meet all potential emergencies and they will be available at all times in the facility. 5. An audit will be done that there are written plans and procedures for all potential emergencies and that they are readily available in the facility at all times. The results of the audit will be taken to QAPI until resolved.	8/31/18

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{S5093}	Continued From page 9 Review of the Emergency Preparedness Policy created 11/17 showed, "...The facility shall have detailed written plans and procedures to meet all potential emergencies and disasters...A copy of the plans shall be available at all times within the facility..."	{S5093}		
{S5094}	Ch 12 Sec 7 (o)(iii)(A-E) Assisted Living facility (ALF) Core Services (o) Evacuation Capability, Emergency Procedures, and Fire Safety. (iii) Fire Safety. (A) Portable fire extinguishers shall be installed, inspected, and maintained according with NFPA 10, Standard for Portable Fire Extinguishers. (I) State of Wyoming certified individuals shall inspect and service the extinguishers. All extinguishers shall have a tag or label securely attached that indicate the month and year the maintenance was performed and that identifies the person performing the service. (B) Readily available and clearly readable telephone numbers for emergency contacts shall be located near all telephones. (C) Clearly readable floor diagrams reflecting the actual floor arrangement showing the exit locations and evacuation routes shall be posted in conspicuous places. Each resident shall be instructed with its use on the first day of admission. (D) Resident training for the fire	{S5094}		

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{S5094}	Continued From page 10 emergency plan shall be in accordance with the Life Safety Code Operating Features sections. (I) On the first day of admission, each resident shall be instructed in the proper action of the fire emergency plan, including the location of all the exits. A record of this instruction shall be in each resident file. (E) Fire exit drills shall be conducted in accordance to the Life safety Code Operating Features sections. The minimum number of drills, as amended, shall be held at least twelve (12) times per year on a monthly basis with a minimum of one drill conducted each quarter on each shift. Fire exit drill records over a two-year period shall be available upon request at the facility. (I) The facility shall be responsible for recording fire exit drills on an evaluation form that include at least the following: (1.) Date of drill; (2.) Time of day; (3.) Type of drill (Practice, Announced, Surprise); (4.) Residents who participated including staff and family members; (5.) Time required (minutes and seconds) to evacuate all residents (including staff) from the occupied areas to a point of assembly as defined in the Life Safety Code; (6.) List of anyone, including staff	{S5094}	**SS5094** 1. The facility will provide written documentation of education on the fire emergency plan. 2. Residents #2,#3,#5,#6, #7, #8, #9, #10 will all be provided written documentation of education on the fire emergency plan. 3. All residents will be provided written documentation of education on the fire emergency plan. 4. All staff will be educated by the Administrator or designee the importance of written documentation of education on the fire emergency plan. 5. An audit will be done on current and new admissions that they receive written documentation of education on the fire emergency plan.	8/31/18

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{S5094}	Continued From page 11 and family members, who did not evacuate in the required time allowed by the evacuation capability rating of the facility. Evacuation capability rating for each facility shall be listed on the form; (7.) Comments on the factors that contributed to each individual's inability to evacuate successfully and any corrective actions recommended; and (8.) Signature and date of the person completing the form. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide written documentation of education on the fire emergency plan for 8 of 8 sample residents (#2, #3, #5, #6, #7, #8, #9, #10) reviewed. The findings were: Review of the medical record for residents #2, #3, #5, #6, #7, #8, #9, #10 showed no evidence the residents had been educated on the fire emergency plan. Interview with the interim administrator on 7/31/18 at 2:10 PM revealed the previous administrator was unable to complete the education, audits, and correct this deficient practice.	{S5094}		