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Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF028	A. BUILDING: _____ B. WING _____	C 10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN PLAZA ASSISTED LIVING	4154 TALON DRIVE CASPER, WY 82604

(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 investigation was conducted by Healthcare Licensing and Surveys on 10/8/18. The survey was prompted by complaint intake LIC-19-002. The following common abbreviations are used throughout this document. ALF: Assisted Living Facility DON: Director of Nursing Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5020	Ch 12 Sec 7 (b)(i)(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. (i) The completion of the ALF 102. (A) The current version of the ALF 102 is the designated screening tool. The form may be	S5020		

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Revised 12/5/18

12-17-18 P.O.C accepted spoke with Kanyne Humphrey, administrator. Colleen Logan LN

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S5020	Continued From page 1 updated and/or revised periodically by the Program Division. Providers will be notified of changes in the form. The following guidelines apply to the ALF 102; (I) The ALF 102 is only valid if completed within forty-five (45) days prior to admission and there is no change in the resident's condition. (II) The ALF 102 must be completed and signed by an RN. (III) The ALF 102 may be completed telephonically; however, it must be verified in person by an RN. (IV) A new ALF 102 shall be completed at least annually, and when there is a change in the resident's condition. This State Rule and Regulation is not met as evidenced by: Based on resident record review, and resident and staff interview, the facility failed to ensure the ALF 102 screening tool was completed as required for 2 of 4 sample residents (#2, #3). The findings were: 1. Review of the resident record showed resident #2 moved into the facility on 9/4/14 with diagnoses that included depression, atrial fibrillation with a pacemaker, and nerve pain. Interview with the resident on 10/8/18 at 1:37 PM revealed s/he fell at the facility and had a fracture in the neck for which s/he received therapy. The resident stated s/he was still able to get up independently and ambulated using a walker. Review of nurse's notes dated 9/12/18 and timed 4:07 PM showed the resident was found on the	S5020		

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S5020	Continued From page 2 floor, sustained a cervical fracture, and was transferred to a rehabilitation hospital. The resident returned to the facility on 9/27/18. Review of the ALF 102 form showed a completion date of 10/5/17. There was no evidence an updated ALF 102 had been completed. 2. Review of the 8/17/17 ALF 102 screening tool for resident #3 showed it was not completed annually as required and was past due. 3. Interview with the DON and the Executive Director on 10/8/18 at 4:40 PM revealed they were behind on getting annual assessments and ALF 102 screening tools completed.	S5020		
S5023	Ch 12 Sec 7 (b)(iv)(A-C) 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. (iv) Frequency of assessment. An assessment must be conducted: (A) No earlier than one (1) week prior to admission; (B) Immediately upon any significant change in the resident's mental or physical condition; or (C) No less than once every twelve (12) months.	S5023		

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S5023	Continued From page 3 This State Rule and Regulation is not met as evidenced by: Based on resident record review, and resident and staff interview, the facility failed to ensure resident assessments were completed as required for 3 of 4 sample residents (#2, #3, #4). The findings were: 1. Review of the resident record showed resident #3 moved into the facility on 4/4/15. Review of the 8/25/18 physician orders showed the resident had diagnoses which included "senile dementia." Review of the 8/20/17 evaluation/assessment showed the resident was independent in mobility, had not had any elopement or wandering, and required regular prompting due to confusion and disorientation. Review of the 9/28/18 incident investigation showed the resident had left the facility without the awareness of staff and was found 4 miles away and confused. A stranger saw the resident "struggling" and called the family member who was identified on an emergency card the resident had with them. Continued review showed the facility was unaware the resident had left the building, and the resident leaving the building was "very unlike [him/her]." Back at the facility the resident was tested for a urinary tract infection through the use of a "home dip kit" and did not test positive. The investigation further showed "Staff did frequent checks for several days but no other odd behavior was noticed." The following concerns were identified: a. Review of the resident record showed a change in condition assessment was not completed after the elopement incident and the most current annual assessment was past due. b. Interview with the DON and the Executive Director on 10/8/18 at 4:40 PM confirmed the resident was not assessed following the incident except for the home urine dip. They further	S5023		

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S5023	Continued From page 4 revealed there was no documentation of increased monitoring/checks for the resident. 2. Review of the resident record showed resident #2 moved into the facility on 9/4/14 with diagnoses that included depression, atrial fibrillation with a pacemaker, and nerve pain. Interview with the resident on 10/8/18 at 1:37 PM revealed s/he fell at the facility and had a fracture in the neck for which s/he received therapy. The resident stated s/he was still able to get up independently and ambulated using a walker. Review of the nurse's notes dated 9/12/18 and timed 4:07 PM showed the resident was found on the floor, sustained a cervical fracture, and was transferred to a rehabilitation hospital. The resident returned to the facility on 9/27/18. The following concerns were identified: a. Review of the assessment/plan of care showed it was dated 10/19/17, and the resident had not sustained any falls. b. Interview on 10/8/18 at 2:52 PM revealed a new assessment was required for this resident. A new DON was in place and some of the assessments were not completed during the transition. 3. Review of the resident record face sheet showed resident #4 moved into the facility 2/27/18 with diagnoses that included diabetes, scoliosis, gastroesophageal reflux disease, and confusion. Review of the nurse's notes dated 9/2/18 and timed 3:45 AM showed the resident was found lying on the floor next to the bed. The resident was transferred to the hospital and returned to the facility alert and responding pleasantly. Continued review of the nurse's notes showed the resident had negative neuro checks, and spent 9/3/18, and 9/4/18 in bed. Further review of the nurse's notes showed the physician	S5023		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN PLAZA ASSISTED LIVING	4184 TALON DRIVE CASPER, WY 82604

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S5025	Continued From page 6 was notified of the resident's decline in condition and on 9/7/18 the physician ordered hospice to care for resident. The resident passed away on 9/13/18. The following concerns were identified: a. Interview with the DON on 10/8/18 at 4:47 PM revealed the resident fell in August which resulted in a fractured clavicle, and had another fall on 9/2/18. She also stated the resident's condition declined and the resident went into hospice care. b. Review of the assessment/plan of care showed it was dated 4/19/18. A new assessment was not completed related to the resident's change in condition. c. Interview on 10/8/18 at 2:52 PM revealed a new assessment was required for this resident. A new DON was in place and some of the assessments were not completed during the transition.	S5023		
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	S5054		

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	ALF628	A. BUILDING: _____ B. WING _____	C 10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN PLAZA ASSISTED LIVING	4154 TALON DRIVE CASPER, WY 82604

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S5054	Continued From page 6 shall, at a minimum, contain the following information: (I) Full name of resident and former address; (II) Date of admission; (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	S5054		

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MOUNTAIN PLAZA ASSISTED LIVING	4164 TALON DRIVE CASPER, WY 82604

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S5054	Continued From page 7 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 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	S5054		

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MOUNTAIN PLAZA ASSISTED LIVING	4154 TALON DRIVE CASPER, WY 82604

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S5054	Continued From page 8 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 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 resident record review, incident log review, and staff interview, the facility failed to ensure safety incidents were reported to the Licensing Division for 6 of 6 incidents reviewed. These incidents involved residents #1, #2, #3, and #4. The findings were: 1. Review of the incident log showed resident #1 resided on the memory care unit and had falls on 9/2/18 and 9/7/18 neither of which resulted in injury. The resident also had a fall on 9/12/18 which resulted in a skin tear and bruise to his/her right forearm. Review of the record failed to show these safety incidents were reported to the Licensing Division. 2. Review of the resident record showed resident #3 moved into the facility on 4/4/15. Review of the 9/28/18 incident investigation showed the resident had left the facility without the awareness of staff and was found 4 miles away and confused. A	S5054		

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S5054	Continued From page 9 stranger saw the resident "struggling" and called the family member who was identified on an emergency card the resident had with them. Review of the record failed to show this safety incident was reported to the Licensing Division. 3. Review of the incident log showed resident #2 sustained a fall on 9/12/18 which resulted in an injury and an admission to the rehabilitation hospital. Review of the record failed to show this incident was reported to the Licensing Division. 4. Review of the incident log showed resident #4 sustained a fall on 9/2/18 with an injury and was transferred to the emergency department. Review of the record failed to show this incident was reported to the Licensing Division. 5. Interview on 10/8/18 at 4:40 PM with the Executive Director and the DON verified these incidents were not reported. Due to staff turn over they stated they were behind in some areas, including the reporting.	S5054		
S5100	Ch 12 Sec 6 (a)(vi) Services Which Cannot Be Provided By Level I Services which cannot be provided by the Level I Assisted Living Facility staff. (a) The following services cannot be provided: (vi) Care of resident whose wandering jeopardizes the health and safety of the resident; This State Rule and Regulation is not met as evidenced by: Based on resident record review, incident	S5100		

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S5100	Continued From page 10 investigation notes, and staff interview, the facility failed to ensure 1 of 1 residents (#3) with a known elopement was provided effective safety interventions. The findings were: Review of the resident record showed resident #3 moved into the facility on 4/4/16. Review of the 8/25/18 physician orders showed the resident had diagnoses which included "senile dementia." Review of the 8/20/17 evaluation/assessment showed the resident was independent in mobility, had not had any elopement or wandering, and required regular prompting due to confusion and disorientation. Review of the 9/29/18 incident investigation showed the resident had left the facility without the awareness of staff and was found 4 miles away and confused. A stranger saw the resident "struggling" and called the family member who was identified on an emergency card the resident had with them. Continued review showed the facility was unaware the resident had left the building, and the resident leaving the building was "very unlike [him/her]." Back at the facility the resident was tested for a urinary tract infection through the use of a "home dip kit" and did not test positive. The investigation further showed "Staff did frequent checks for several days but no other odd behavior was noticed." The following concerns were identified: a. Review of the resident record showed a change in condition assessment was not completed and the annual assessment was past due. Further, there were no updates to the resident service delivery plan. b. Interview with the DON and the Executive Director on 10/8/18 at 4:40 PM confirmed the resident was not assessed following the incident except for the home urine dip. They further revealed there was no documentation of increased monitoring/checks for the resident.	S5100		

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S5100	Continued From page 11 However, there had been discussion with the resident's family regarding additional supervision needs and placement on a memory care unit.	S5100		

Kenyne Humphrey, Administrator
E-mail to: Kenyne@mountaiplazaal.com
Mountain Plaza Assisted Living
4154 Talon Drive
Casper, WY 82604
(307) 232-0100
Survey Date: October 08, 2018
POC due: November 01, 2018
Ref: LH-2018-1237

Tag # S5020 – Ch 12 Sec 7 (b)(i)(A) Assisted Living Facility (ALF) Core Services

Goal: The Director of Nursing (DON) or an RN will conduct an audit of all resident (ALF) 102 assessments and will update any outstanding assessments to comply with State Regulation Ch12 Sec 7 guideline (I thru IV). Sample residents #2 and 3 have been completed as of 12/5/18.

Continued monitoring: The Director of Nursing (DON) or an RN will continue to comply with state rule and regulations in ordinance with Ch 12 Sec 7 by developing a spread sheet of Resident's (ALF) 102 assessments needing completed monthly and monitor resident change of conditions for further ALF updates. The administrator will review the spreadsheet monthly to ensure completion.

Responsibility: DON and Administrator

Completion date: 12/5/18

Tag # S5023 – Ch 12 Sec 7 (b)(iv) (A-C) (ALF) Core Services

Goal: Sample residents (#2, #3, #4) will have an accurate, completed, standardized, and reproducible assessment. A review of all resident assessments was completed, and missing assessments have been completed as of 12/5/18.

Continued monitoring: A review of the assessment schedule in the nursing software program will occur bimonthly by the DON and the administrator will review on a monthly basis to ensure completion. Nurses were provided with an update policy on reporting changes in condition to the DON/Administrator on 12/5/18.

Responsibility: DON and administrator

Completion date: 12/5/18

Tag # S5054 – Ch 12 Sec 7 (e)(i)(A-K) (ALF) Core Services; Resident Records and Reports.

Goal: MPAL will report all incidents (as defined by the state of Wyoming) that affect the health, welfare and safety of a resident through the online portal system or by fax. The DON will audit all falls in the past six months and ensure all reportable incidents have been reported.

Continued Monitoring: Every incident will be reported to the DON/Administrator and be included in the QA meetings each month to verify compliance.

Completion date: 12/5/18

Kenyne Humphrey, Administrator
E-mail to: Kenyne@mountaiplazaal.com
Mountain Plaza Assisted Living
4154 Talon Drive
Casper, WY 82604
(307) 232-0100
Survey Date: October 08, 2018
POC due: November 01, 2018
Ref: LH-2018-1237

Tag # S5100 – Ch 12 Section 8 (a)(vi) Services Which Cannot Be Provided By Level 1

Goal: MPAL will ensure residents living in the level 1 assisted living category meet level 1 requirements as per state regulations and complete the corresponding change of condition assessment.

MPAL has implemented a new "Sign In/Sign Out Sheet" identifying: Date, Room Number, Resident Name, Accompanied By, Destination, Time out, and Time in as of 10/10/2018. The documentation is located at the front desk.

All staff completed elopement drill training 10/4/18.

Resident #4 has had an update assessment to include an elopement risk evaluation which scored a zero. Resident was signed up for Wander Guard through the Natrona County Sheriff's office.

Continued Monitoring: All residents with a diagnosis of cognitive impairment or history of wandering will be evaluated using the elopement risk evaluation tool in the admission software program.

Completion date: 12/5/18