PRINTED: 11/27/2018
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
	ALF026	A. BUILDING: _____ B. WING _____	C 11/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER TRAIL ASSISTED LIVING	2360 REAGAN AVENUE ROCK SPRINGS, WY 82901

(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 11/10/18 and 11/11/18. The survey was prompted by complaint intake LIC-19-009. The following common abbreviations are used throughout this document: ALF- Assisted Living Facility CNA- Certified Nurses Aide DON- Director of Nursing RN- Registered Nurse 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 updated and/or revised periodically by the	S5020		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: EXECUTIVE DIRECTOR — (X6) DATE: 07Dec2018

1/2/19 - 9:50 AM - Spoke with executive director, Jeff. Received - 11Dec2018
Plan of correction accepted with agreed changes. TM

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S5020	Continued From page 1 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, resident and staff interview, incident review, and review of the 11/4/18 weather for the facility, the facility failed to ensure a new ALF 102 was completed concerning a change in condition for 1 of 4 sample residents (#2). The findings were: Resident record review showed resident #2 was admitted to the facility level I area on 10/20/18 with diagnoses which included dementia, osteoporosis, and poly-osteoarthritis. Review of the ALF-102 prior to admission dated 10/12/18 showed for Behavior/Motivation the resident was selected for "b. Intermittently confused and/or agitated; requires occasional reminders as to person, place, or time." Under the same area was a selection at "e." left blank that showed: "Safety concerns. In danger of self-inflicted harm or	S5020		

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S5020	Continued From page 2	S5020		

self-neglect. Continuous surveillance required. Excessive wandering." Review of the 10/19/18 "Resident Negotiated Service Plan Without Schedule" showed "Resident does not wander." Interview with the resident on 11/10/18 at 4:PM showed s/he was mildly confused, aware of being in some type of care facility, and unaware of the day or time. The following concerns were identified:

a. Review of a nursing noted dated 11/4/18 timed 19:26:18 [7:26 PM] revealed, "Resident was confused at diner [dinner] time [s/he] tried to go into kitchen and leave. [S/he] was redirected to [his/her] room. Then a little while later the CNAs reported that a woman had just pulled up outside with [the resident] in her car, she stated that she picked [him/her] up at the senior center, and brought [him/her] her asked another rt [resident] and her family if [the resident] lived here. [The questioned resident] said yes [the resident] is my neighbor. CNAs assisted into building. Karen [DON] notified via text message. Incident report filled out. Did not notify MD r/t no fax number for him/her. [Family member] called."

b. Review of an 11/4/18 Hot Note [CNA notes] revealed the following: "RT's [Resident's] pendant was going off after dinner. CNA [#5] and I looked for [him/her] and [s/he] wasn't there. We then searched the entire facility and [s/he] wasn't anywhere to be found we went room to room, outside the facility and could not find [him/her]. While we were looking for [him/her] a lady came into the facility asking if "a [resident's name] lives here?" The lady found [resident's name] by the senior center with not coat or jacket in the dark windy weather), and brought [him/her] back to us in her car. When I asked [resident's name] where [s/he] was going [s/he] told me, [s/he] had to be somewhere, but [s/he] didn't remember where [s/he] was going." RT [resident] was cold, and

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S5020	Continued From page 3 upset because of getting lost. [S/he] is doing okay, and has been in the room the rest of the night." c. Review of an 11/4/18 incident timed 6 PM with an 1800 [6 PM] "occurred at" time for the resident revealed "Resident was missing and CNA's were looking for her. Checked rooms, bathrooms, common areas and outside near the building. Then a woman pulled up with the resident in her car and asked another resident's daughter if [s/he] lived here. Woman stated that she picked [him/her] up at the senior center." d. Review of the 11/4/18 weather documentation on timeanddate.com for the town the facility was located in, accessed via google.com by the surveyor, revealed the temperature at 6 PM was 36 degrees Fahrenheit and the wind was at 23 mile per hour. e. Review of the entire medical record showed the resident's ALF-102 was not updated as of the survey dates of 11/10/18 and 11/11/18. f. Interview with the DON on 11/10/18 at 3:50 PM confirmed the facility failed to update the ALF-102 to reflect the resident's change of condition concerning elopement.	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:	S5023		

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S5023	Continued From page 4 (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. This State Rule and Regulation is not met as evidenced by: Based on resident record review, resident and staff interview, incident review, and review of the 11/4/18 weather for the facility, the facility failed to ensure a new assessment concerning a change in condition was completed 1 of 4 sample residents (#2) with a change in condition. The findings were: Resident record review showed resident #2 was admitted to the facility level I area on 10/20/18 with diagnoses which included dementia, osteoporosis, and poly-osteoarthritis. Review of the ALF-102 prior to admission dated 10/12/18 showed for Behavior/Motivation the resident was selected for "b. Intermittently confused and/or agitated; requires occasional reminders as to person, place, or time." Under the same area was a selection at "e." left blank that showed "Safety concerns, In danger of self-inflicted harm or self-neglect. Continuous surveillance required. Excessive wandering." Review of the 10/19/18 "Resident Negotiated Service Plan Without Schedule" showed "Resident does not wander." Interview with the resident on 11/10/18 at 4:PM showed s/he was mildly confused, aware of being in some type of care facility, and unaware of the day or time. The following concerns were identified:	S5023		

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S5023	Continued From page 5 a. Review of a nursing noted dated 11/4/18 timed 19:26:18 [7:26 PM] revealed "Resident was confused at diner [dinner] time [s/he] tried to go into kitchen and leave. [S/he] was redirected to [his/her] room. Then a little while later the CNAs reported that a woman had just pulled up outside with [the resident] in her car, she stated that she picked [him/her] up at the senior center, and brought [him/her] her asked another rt [resident] and her family if [the resident] lived here. [The questioned resident] said yes [the resident] is my neighbor. CNAs assisted into building. Karen [DON] notified via text message. Incident report filled out. Did not notify MD r/t no fax number for him/her. [Family member] called." b. Review of an 11/4/18 Hot Note [CNA notes] revealed the following: "RT's [Resident's] pendant was going off after dinner. CNA [#4] and I looked for [him/her] and [s/he] wasn't there. We then searched the entire facility and [s/he] wasn't anywhere to be found we went room to room, outside the facility and could not find [him/her]. While we were looking for [him/her] a lady came into the facility asking if "a [resident's name] lives here?" The lady found [resident's name] by the senior center with not coat or jacket in the dark windy weather), and brought [him/her] back to us in her car. When I asked [resident's name] where [s/he] was going [s/he] told me, [s/he] had to be somewhere, but [s/he] didn't remember where [s/he] was going." RT [resident] was cold, and upset because of getting lost. [S/he] is doing okay, and has been in the room the rest of the night." c. Review of an 11/4/18 incident timed 6 PM with an 1800 [6 PM] "occurred at" time for the resident revealed "Resident was missing and CNA's were looking for her. Checked rooms, bathrooms, common areas and outside near the building. Then a woman pulled up with the	S5023		

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S5023	Continued From page 6 resident in her car and asked another resident's daughter if [s/he] lived here. Woman stated that she picked [him/her] up at the senior center." d. Review of the 11/4/18 weather documentation on timeanddate.com for the town the facility was located in, accessed via google.com by the surveyor, revealed the temperature at 6 PM was 36 degrees Fahrenheit and the wind was at 23 mile per hour. e. Review of the entire medical record showed the resident's assessment was not updated as of the survey dates of 11/10/18 and 11/11/18. f. Interview with the DON on 11/10/18 at 3:50 PM confirmed the facility failed to update the resident's assessment to reflect the resident's change of condition concerning elopement.	S5023		
S5025	Ch 12 Sec 7 (b)(vi)(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. (vi) Resident assistance plan. (A) An RN shall develop an assistance plan for each resident. (B) Each facility shall construct its own forms for such plans, which at a minimum shall contain documentation of the following: (I) Who will provide the care/services;	S5025		

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S5025	Continued From page 7 (II) What care/services will be provided; (III) When will care/services be provided; (IV) How the care/services will be provided; (V) The expected outcome; (VI) Resident participation in development of the assistance plan to the extent of his ability to do so. A relative or other interested party may also participate; and (VII) Dated signature of the RN, the facility manager, and the resident or the resident's responsible party. This State Rule and Regulation is not met as evidenced by: Based on resident record review, resident and staff interview, incident review, and review of the 11/4/18 weather for the facility, the facility failed to ensure the resident's assistance plan was updated for 1 of 4 sample residents (#2) with a change in condition. The findings were: Resident record review showed resident #2 was admitted to the facility level I area on 10/20/18 with diagnoses which included dementia, osteoporosis, and poly-osteoarthritis. Review of the ALF-102 prior to admission dated 10/12/18 showed for Behavior/Motivation the resident was selected for "b. Intermittently confused and/or agitated; requires occasional reminders as to person, place, or time." Under the same area was a selection at "e." left blank that showed "Safety concerns. In danger of self-inflicted harm or self-neglect. Continuous surveillance required.	S5025		

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S5025	Continued From page 8 Excessive wandering." Review of the 10/19/18 "Resident Negotiated Service Plan Without Schedule" showed "Resident does not wander." Interview with the resident on 11/10/18 at 4:PM showed s/he was mildly confused, aware of being in some type of care facility, and unaware of the day or time. The following concerns were identified: a. Review of a nursing noted dated 11/4/18 timed 19:26:18 [7:26 PM] revealed, "Resident was confused at diner [dinner] time [s/he] tried to go into kitchen and leave. [S/he] was redirected to [his/her] room. Then a little while later the CNAs reported that a woman had just pulled up outside with [the resident] in her car, she stated that she picked [him/her] up at the senior center, and brought [him/her] her asked another rt [resident] and her family if [the resident] lived here. [The questioned resident] said yes [the resident] is my neighbor. CNAs assisted into building. Karen [DON] notified via text message. Incident report filled out. Did not notify MD r/t no fax number for him/her. [Family member] called." b. Review of an 11/4/18 Hot Note [CNA notes] revealed the following: "RT's [Resident's] pendant was going off after dinner. CNA [#4] and I looked for [him/her] and [s/he] wasn't there. We then searched the entire facility and [s/he] wasn't anywhere to be found we went room to room, outside the facility and could not find [him/her]. While we were looking for [him/her] a lady came into the facility asking if "a [resident's name] lives here?" The lady found [resident's name] by the senior center with not coat or jacket in the dark windy weather), and brought [him/her] back to us in her car. When I asked [resident's name] where [s/he] was going [s/he] told me, [s/he] had to be somewhere, but [s/he] didn't remember where [s/he] was going." RT [resident] was cold, and upset because of getting lost. [S/he] is doing	S5025		

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S5025	Continued From page 9 okay, and has been in the room the rest of the night." c. Review of an 11/4/18 incident timed 6 PM with an 1800 [6 PM] "occurred at" time for the resident revealed "Resident was missing and CNA's were looking for her. Checked rooms, bathrooms, common areas and outside near the building. Then a woman pulled up with the resident in her car and asked another resident's daughter if [s/he] lived here. Woman stated that she picked [him/her] up at the senior center." d. Review of the 11/4/18 weather documentation on timeanddate.com for the town the facility was located in, accessed via google.com by the surveyor, revealed the temperature at 6 PM was 36 degrees Fahrenheit and the wind was at 23 mile per hour. e. Review of the entire resident record showed the resident's assistance plan was not updated as of the survey dates of 11/10/18 and 11/11/18. f. Interview with the DON on 11/10/18 at 3:50 PM confirmed the facility failed to update the assistance plan to reflect the resident's change of condition concerning elopement.	S5025		
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	S5054		

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S5054	Continued From page 10 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; (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.	S5054		

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S5054	Continued From page 11 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 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	S5054		

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S5054	Continued From page 12 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 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 review, review of the Licensing Division incident logs, and staff interview, the facility failed to ensure an elopement was reported to the state survey agency for 1 of 4 sample residents (#2). The findings were: Resident record review showed resident #2 was admitted to the facility level I area on 10/20/18 with diagnoses which included dementia, osteoporosis, and poly-osteoarthritis. The following concerns were identified: a. Review of an 11/4/18 incident timed 6 PM with an 1800 [6 PM] "occurred at" time for the resident revealed "Resident was missing and	S5054		

PRINTED: 11/27/2018
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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
	ALF026	A. BUILDING: _____ B. WING _____	C 11/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER TRAIL ASSISTED LIVING	2360 REAGAN AVENUE ROCK SPRINGS, WY 82901

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S5054	Continued From page 13 CNA's were looking for her. Checked rooms, bathrooms, common areas and outside near the building. Then a woman pulled up with the resident in her car and asked another resident's daughter if [s/he] lived here. Woman stated that she picked [him/her] up at the senior center." b. Review of the Licensing Division incident logs showed no evidence this incident was reported to the Division as required. c. Interview with the DON on 11/10/18 at 3:50 PM confirmed the facility failed to report the resident's elopement to the Licensing Division.	S5054		
S5089	Ch 12 Sec 7 (m)(i)(A-R) Assisted Living Facility (ALF) Core Services (m) Facility Policies and Procedures. (i) Management shall develop policies and procedures that are available to residents and staff, including but not limited to: (A) Resident rights; (B) Disciplinary procedures surrounding substantiated cases of resident abuse; (C) Admission, transfer, bed hold days, and discharge of residents; (D) Medication management; (E) Emergency are of residents (including missing resident, blizzard, water outage, etc.) (F) Fire/disaster plan; (G) Departure and return;	S5089		

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S5089	Continued From page 14 (H) Smoking; (I) Visiting hours; (J) Activities; (K) Management of resident trust accounts; (L) Personnel policies (M) Grievance procedures; (N) Per Diem rate/charges/fees, to include a listing of what is included in the established charges; (O) Incident reports; (P) Notification of change in established per diem rates/charges/fees; (Q) Outside contractual responsibilities; and (R) Identification and notification of change in resident's condition. This State Rule and Regulation is not met as evidenced by: Based on manufacturer's information review, staff interview, and incident review, the facility failed to ensure a policy and procedure was developed to address an alarm system for the facility doors. The findings were: Interview with the administrator on 11/10/18 at 12 noon revealed resident #1 eloped from the facility through the double doors by room #140 on	S5089		

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S5089	Continued From page 15 11/9/18 at around 1:37 AM according to review of the facility camera recordings. The administrator stated the facility had an alarm system on the entrance and exit doors that sent a signal to staff on their pagers when a door was opened. Review of the corresponding incident confirmed resident #1 eloped from the facility on the morning of 11/9/18. The following concerns were identified: a. Interview with CNA #1 on 11/10/18 at 12:55 PM confirmed the pagers utilized by staff alerted staff when anyone opened the exit doors, and showed which door was opened. She stated staff should be aware of who went in and out of the doors to ensure resident safety. However, she stated she had been provided no inservice that addressed what staff were required to do when the pager showed an exit door had been opened. Interview with CNA #2 on 11/10/18 at 1:30 PM confirmed staff utilized pagers for resident calls, and pagers also showed which exit doors opened or closed. She stated staff should check the doors to ensure resident safety when an exit door had been opened. However, she confirmed an inservice had not been provided concerning what to do when an exit door had been opened. Interview with CNA #3 on 11/10/18 at 2:05 PM confirmed the staff pagers would alert staff when exit doors were opened. Her expectation was for staff to check the door and check on residents if the door had been opened. She confirmed staff had not been provided education on staff response to exit doors when opened. Interview with RN #1 on 11/10/18 at 2:42 PM showed her expectation was for staff to tell her if an outside door had been opened to ensure resident safety. She confirmed she was on duty when resident #1 eloped. She stated she did not have a pager while working on that shift. She revealed she was unaware an exit door had been opened and was unaware resident #1 had eloped until after her	S5089		

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S5089	Continued From page 16 shift, which ended at around 7 AM. She confirmed staff had not been educated concerning what to do when an exit door had been opened. Interview with CNA #4 on 11/10/18 at 10:15 PM confirmed staff pagers showed which room a resident called from, or which exit door had been opened. She confirmed she worked on the night resident #1 had eloped, and her pager showed the exit double door by room #140 had been opened sometime after midnight. She stated her response was to check on the double door, and check on the resident in room #140 by the double door. She further stated the wind often triggered the exit door response as having been opened when it had not. She confirmed she had not been educated concerning what to do when an exit door had been opened. b. Review of manufacturer's information showed the facility utilized an Apollo Gold pager with a Cornell Aura 2.0 Emergency Response System, which was wireless. The product was used by multiple organizations, and no instructions were provided to show how to utilize the system in an assisted living environment. c. Interview with the administrator and DON on 11/11/18 at 12:30 PM confirmed the facility failed to ensure a policy for use and response concerning the pager system utilized by staff for resident call lights and facility exit and entrance doors. Each stated the use of the pager system had been discussed in staff meetings. However, they confirmed the facility failed to document education on the system to ensure continuity of staff response when the entrance and exit doors were opened. They stated the expectation was for staff to respond to call lights within 10 minutes, and door alarms as soon as possible to ensure resident safety.	S5089		

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S5100	Continued From page 17	S5100		
S5100	Ch 12 Sec 8 (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, resident and staff interview, incident review, and review of the 11/4/18 weather for the facility, the facility failed to ensure the facility did not provide services in level I for a resident who eloped concerning 1 of 4 sample residents (#2). The findings were: Resident record review showed resident #2 was admitted to the facility level I area on 10/20/18 with diagnoses which included dementia, osteoporosis, and poly-osteoarthritis. Review of the ALF-102 prior to admission dated 10/12/18 showed for Behavior/Motivation the resident was selected for "b. Intermittently confused and/or agitated; requires occasional reminders as to person, place, or time." Under the same area was a selection at "e," left blank that showed "Safety concerns. In danger of self-inflicted harm or self-neglect. Continuous surveillance required. Excessive wandering." Review of the 10/19/18 "Resident Negotiated Service Plan Without Schedule" showed "Resident does not wander." Interview with the resident on 11/10/18 at 4:PM showed s/he was mildly confused, aware of being in some type of care facility, and unaware of the day or time. The following concerns were	S5100		

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S5100	Continued From page 18 identified: a. Review of a nursing noted dated 11/4/18 timed 19:26:18 [7:26 PM] revealed "Resident was confused at diner [dinner] time [s/he] tried to go into kitchen and leave. [S/he] was redirected to [his/her] room. Then a little while later the CNAs reported that a woman had just pulled up outside with [the resident] in her car, she stated that she picked [him/her] up at the senior center, and brought [him/her] her asked another rt [resident] and her family if [the resident] lived here. [The questioned resident] said yes [the resident] is my neighbor. CNAs assisted into building. Karen [DON] notified via text message. Incident report filled out. Did not notify MD r/t no fax number for him/her. [Family member] called." b. Review of an 11/4/18 Hot Note [CNA notes] revealed the following, "RT's [Resident's] pendant was going off after dinner. CNA [#4] and I looked for [him/her] and [s/he] wasn't there. We then searched the entire facility and [s/he] wasn't anywhere to be found we went room to room, outside the facility and could not find [him/her]. While we were looking for [him/her] a lady came into the facility asking if "a [resident's name] lives here?" The lady found [resident's name] by the senior center with not coat or jacket in the dark windy weather), and brought [him/her] back to us in her car. When I asked [resident's name] where [s/he] was going [s/he] told me, [s/he] had to be somewhere, but [s/he] didn't remember where [s/he] was going." RT [resident] was cold, and upset because of getting lost. [S/he] is doing okay, and has been in the room the rest of the night." c. Review of an 11/4/18 incident timed 6 PM with an 1800 [6 PM] "occurred at" time for the resident revealed, "Resident was missing and CNA's were looking for her. Checked rooms, bathrooms, common areas and outside near the	S5100		

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S5100	Continued From page 19 building. Then a woman pulled up with the resident in her car and asked another resident's daughter if [s/he] lived here. Woman stated that she picked [him/her] up at the senior center." d. Review of the 11/4/18 weather documentation on timeanddate.com for the town the facility was located in, accessed via google.com by the surveyor, revealed the temperature at 6 PM was 36 degrees Fahrenheit and the wind was at 23 mile per hour. e. Review of the entire resident record showed the resident was not considered for a higher level of care concerning safety after s/he eloped. f. Interview with the DON on 11/10/18 at 3:50 PM confirmed the facility failed to ensure services were not provided in level I for a resident who eloped and was at an increased safety risk.	S5100		

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ID Prefix Tag S5020

1. ALF 102 for Resident #2 is complete and in resident's chart.
2. The DON will complete a chart audit for all residents to identify others who may be missing a current ALF 102. This will be completed by December 21, 2018.
3. A complete assessment, including an ALF 102, will be administered when a resident experiences a change in condition, this according to our current policies and procedures.
4. To ensure this policy is followed, the DON will evaluate all residents who are identified as having a change in condition. This change in condition can be communicated by any staff or family member. The DON will complete a new ALF 102, make appropriate changes and ensure its placement in the resident's chart.
    a. Education the nursing staff regarding reporting changes in condition will be completed with the nursing staff. This will include conditions to report and timeline to report them.
    b. Residents who are having a change in condition will be discussed during manager meetings, which are held weekly. Shorter daily meetings are also help with managers where immediate resident changes and needs will be addressed. Residents newly identified as having a change in condition will be discussed and a plan of action implemented. An update on plan of action for residents previously identified as having a change of condition will also be discussed.
    c. Changes in condition will be reviewed at Quality Assurance meetings. At risk residents will be identified and the implemented plan of action for them will be discussed. Trends and effectiveness of plans will be evaluated, and changes made as needed. Effectiveness of current system to identify residents having a change in condition will also be reviewed and revised as needed. Date of Compliance: 1/11/19

ID Prefix Tag S5023

1. A new assessment for Resident #2 is complete and in resident's chart.
2. The DON will complete a chart audit for all residents to identify others who may need an updated assessment. This will be completed by December 21, 2018.
3. A complete assessment will be administered when a resident experiences a change in condition, this according to our current policies and procedures.
    a. To ensure this policy is followed, the DON will evaluate all residents who are identified as having a change in condition. This change in condition can be communicated by any staff or family member. The DON will

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Response to survey of November 11, 2018

b. complete a new assessment, make appropriate changes and ensure its placement it in the resident's chart.
c. Education the nursing staff regarding reporting changes in condition will be completed with the nursing staff. This will include conditions to report and timeline to report them.
d. Residents who are having a change in condition will be discussed during manager meetings, which are held weekly. Shorter daily meetings are also help with managers where immediate resident changes and needs will be addressed. Residents newly identified as having a change in condition will be discussed and a plan of action implemented. An update on plan of action for residents previously identified as having a change of condition will also be discussed.
e. Changes in condition will be reviewed at Quality Assurance meetings. At risk residents will be identified and the implemented plan of action for them will be discussed. Trends and effectiveness of plans will be evaluated, and changes made as needed. Effectiveness of current system to identify residents having a change in condition will also be reviewed and revised as needed. Date of Compliance: 1/11/19

ID Prefix Tag S2025

1. A new Care Plan (assistance plan) for Resident #2 is complete and in resident's chart.
2. The DON will complete a chart audit for all residents to identify others who may need an updated Care Plan which would occur any time an ALF 102 or assessment is changed. This will be completed by December 21, 2018.
3. A complete assessment will be administered when a resident experiences a change in condition, this according to our current policies and procedures. Once the assessment is complete, the Care Plan will be updated as well.
4. To ensure this policy is followed, the DON will evaluate all residents who are identified as having a change in condition. This change in condition can be communicated by any staff or family member. The DON will complete a new assessment, make appropriate changes, update the Care Plan and ensure the placement of both in the resident's chart.
    a. Educating the nursing staff regarding reporting changes in condition will be completed with the nursing staff. This will include conditions to report and timeline to report them.
    b. Residents who are having a change in condition will be discussed during manager meetings, which are held weekly. Shorter daily meetings are also help with managers where immediate resident changes and needs will be addressed. Residents newly identified as having a change in condition will be discussed and a plan of action implemented. An update

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c. on plan of action for residents previously identified as having a change of condition will also be discussed.
d. Changes in condition will be reviewed at Quality Assurance meetings. At risk residents will be identified and the implemented plan of action for them will be discussed. Trends and effectiveness of plans will be evaluated, and changes made as needed. Effectiveness of current system to identify residents having a change in condition will also be reviewed and revised as needed. Date of compliance: 1/11/19

ID Prefix Tag S5054

1. The incident involving Resident #2 is reported to the state.
2. An audit of resident charts by the DON to identify any other incidents which should have been reported to the state but were not will be complete by December 21, 2018. If found, those incidents will be promptly reported to the state.
3. While a policy is in place for timely reporting of incidents, including wandering, the policy was not followed completely in the incident noted in S5054. To ensure the policy is followed, the DON is now aware of requirements included in the policy as well as Chapter 12.
4. All incidents will be reviewed during Quality Assurance meetings to ensure the DON has completed reporting. Date of compliance: 1/11/19

ID Prefix Tag S5089

1. While a verbal procedure is in place regarding notifications sent to pagers the dissemination of this information has been inconsistent. A written policy is being developed to address notifications sent to pagers. It will specifically address notifications from exterior doors. This policy will be completed by January 11, 2019.
2. The written policy and procedure will be presented to the Quality Assurance Committee. Changes will be made as recommended by the committee. Once satisfied with the policy and procedure, the Quality Assurance Committee will approve.
3. Once approved all staff will be trained on the written policy and procedure for pager answering notifications providing needed continuity to staff response. This process will be complete by January 11, 2019. Monitoring of the policy and procedure will continue after implementation. Adaptations will be made as needed. Date of compliance: 1/11/19

ID Prefix Tag S5100

1. A review of Resident #2's current condition is complete, and the community is not providing services beyond those appropriate in Level I.
2. A chart audit of resident conditions will be complete by December 21, 2018. The audit will identify any residents who are receiving services beyond those allowed by the Level I license.

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3. When an event indicates a change in condition needing services which may be beyond those allowed by the Level I license, the DON will complete an assessment, including a new ALF 102, to identify any new care needs of the resident. This assessment will determine appropriate placement within the community to ensure the safety of the resident.
4. To ensure this policy is followed, the DON will review all residents who experience a change in condition for proper placement. Changes in condition will be reviewed at Quality Assurance meetings as well. Date of Compliance: 1/11/19

Respectfully submitted,

11Dec2018

Jeffrey Smith
Executive Director
Deer Trail Assisted Living