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 04/01/2019

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 from 3/27/19 to 4/01/19. The survey was prompted by complaint intake LIC-19-021. The following common abbreviations are used through this document: CNA: Certified Nurse Aide DON: Director of Nursing Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5006	Ch 12 Sec 6 (c) Personnel and Staffing Requirements (c) Background checks. All staff of the assisted living facility shall successfully complete, at a minimum, a State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check and a Department of Family Services Central Registry Screening before direct resident contact. This State Rule and Regulation is not met as evidenced by: Based on employee record review, staff work schedule review, and staff interview, the facility	S5006		

Accepted on 5/28/19 by Louise Ann

RECEIVED
MAY 28 2019
Healthcare Licensing and Surveys

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S5006	Continued From page 1 failed to ensure successful completion of a fingerprint background check and a central registry screening for 1 of 7 employees (CNA #1) reviewed. The findings were: 1. Review of the employee file for CNA #1 showed the employee was hired on 3/4/19, and there was no evidence a Division of Criminal Investigation (DCI) fingerprint background check and a Department of Family Services (DFS) Central Registry Screening were completed. Review of the March 2019 work schedule showed the CNA worked 18 shifts between 3/4/19 and 3/28/19. 2. Interview with receptionist #1 on 3/28/19 at 4:05 PM revealed the facility conducted a "quick background" check and started the employee before a DCI fingerprint background check or DFS Central Registry Screening was completed. Further interview confirmed that the DCI fingerprint background check and DFS Central Registry Screening had not been submitted at that time.	S5006		
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;	S5054		4/30/19

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S5054	Continued From page 2 (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. Reports of all incidents affecting the health,	S5054		

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S5054	Continued From page 3	S5054		

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 under Medicaid or Medicare except for applicable

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S5054	Continued From page 4 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 medical record review, staff interview, and policy and procedure review, the facility failed to ensure allegations of abuse were reported timely for 1 of 3 sample residents (#1) who reported allegations to the facility. The findings were: 1. Review of a progress note for resident #1 dated 3/15/19 and timed 12:16 PM showed a "late entry for 3/14/19" which described an allegation the resident was "molested" during the night and reported this to a housekeeper. The resident described the perpetrator to staff and stated s/he thought "...they knocked me out or something." Review of a physician note dated 3/15/19 and time 9:18 AM showed an MoCa	S5054		

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S5054	Continued From page 5 (Montreal Cognitive Assessment) exam was completed and the resident scored 9/22 (cognitively impaired). The following concerns were identified: a. Interview with the DON on 3/28/19 at 12:45 PM revealed the resident had reported 2 different allegations of sexual abuse. The resident reported to his/her family s/he was kissed by a staff member on 3/9/19. Family left a message regarding this allegation for the facility, which was received by the facility on 3/11/19. The second allegation that someone had "molested" the resident was made to a staff member on 3/14/19. The DON revealed the resident's description of the perpetrator for the 3/9/19 allegation sounded like CNA #1 and the CNA was interviewed. During the interview with the CNA, the DON learned the CNA had assisted the resident to his/her room and was in the room with the resident without anyone else present; however, the staff member was not placed on suspension pending investigation. Further interview revealed the DON did not contact law enforcement following the 3/9/19 allegation, and did not contact law enforcement following the 3/14/19 allegation because the family "did not want to." b. Review of the State Licensing Agency's incident log showed an allegation of abuse of resident #1 dated 3/9/19 was reported on 3/21/19, 12 days after the allegation occurred. Further review showed no evidence the facility reported an allegation dated 3/14/19. c. Review of the policy titled "Abuse and Neglect Policy" received from the facility on 3/28/19 showed "...Investigation 1. The Administrator will conduct an investigation of any alleged abuse/neglect, injuries of unknown origin, or misappropriation of resident property in accordance with state law. Any employee alleged to be involved in an instance of abuse/neglect will	S5054		

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S5054	Continued From page 6 be suspended immediately and will not be permitted to return to work unless and until such allegations of abuse/neglect are unsubstantiated. 2. Deer Trail will report such allegation to the state, as per Wyoming regulations...Protection...2. Deer Trail will make referrals to the appropriate state agencies as necessary, to ensure the protection of the resident or resident's property...Reporting and Response 1. Deer Trail will report all accidents, injuries, illnesses, and allegations of abuse, neglect or exploitation shall be reported to the resident's family or responsible party and documented in the resident record. 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 1 business day)..."	S5054		
S5070	Ch 12 Sec 7 (i)(ii) Assisted Living Facility (ALF) Core Services (i) Adult Protection. (ii) The facility must adhere to written policies and procedures that prohibit the abuse of any resident. These policies and procedures must identify how the facility will screen employees before hiring, ongoing in-servicing of abuse topics with employees, and a protocol that specifies how allegations of abuse will be investigated. Each staff member must be accountable to report any suspicion or knowledge of abuse to the appropriate facility personnel immediately. This State Rule and Regulation is not met as evidenced by:	S5070		4/30/19

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S5070	Continued From page 7 Based on staff interview, and policy and procedure review, the facility failed to develop a policy and procedure that identified a protocol for investigating abuse and neglect allegations. The census was 60. The findings were: 1. Review of the policy titled "Abuse and Neglect Policy" received from the facility on 3/28/19 showed "...Investigation 1. The Administrator will conduct an investigation of any alleged abuse/neglect, injuries of unknown origin, or misappropriation of resident property in accordance with state law. Any employee alleged to be involved in an instance of abuse/neglect will be suspended immediately and will not be permitted to return to work unless and until such allegations of abuse/neglect are unsubstantiated. 2. Deer Trail will report such allegation to the state, as per Wyoming regulations. 3. Deer Trail will report all investigation findings as per Wyoming regulations. 4. Deer Trail will investigate all patterns, trends, or incidents that suggest the possible presence of abuse, neglect, injuries of unknown origin, or misappropriation of property, identified through analysis conducted by the Quality Improvement Program Committee, with intervention, reporting, or policy/procedure modification conducted as appropriate. 5. Deer Trail's Administrator will conduct a meeting with the resident, legal representative and/or family as to the findings of the investigation, and any changes to plan of care..." 2. Further review of the policy failed to show a protocol that specified how allegations of abuse would be investigated. 3. Interview with the administrator on 4/15/19 at 4:50 PM revealed he did not believe there was another policy on how to perform an investigation.	S5070		

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S5071	Ch 12 Sec 7 (i)(iii)(A-B) Assisted Living Facility (ALF) Core Services (i) Adult Protection. (iii) The facility is responsible to ensure all allegations of abuse are investigated expediently and that the resident(s) are protected from further, potential abuse while the investigation is in progress. (A) Instances of abuse, neglect, or exploitation of disabled adults shall be reported to the sheriff's department, the local police department, or to the department of family services in accordance with W.S. 35-20-103. (B) The facility must ensure that, if necessary, additional authorities are contacted if there is an allegation of abuse, neglect, or exploitation. These additional authorities may include the Wyoming State Board of Nursing, Office of Healthcare Licensing and Survey, and the State Long Term Care Ombudsman. This State Rule and Regulation is not met as evidenced by: Based on medical record review, resident and staff interview, policy and procedure review, and review of the Licensing Division's incident log, the facility failed to protect residents from further abuse while an investigation was in process, and failed to report allegations to law enforcement for 1 of 3 sample residents (#1) with allegations of abuse. The findings were: 1. Review of a progress note for resident #1 dated 3/15/19 and timed 12:16 PM showed a "late entry for 3/14/19" which described an allegation the resident was "molested" during the	S5071		4/30/19

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S5071	Continued From page 9	S5071		

night and reported this to a housekeeper. The resident described the perpetrator to staff and stated s/he thought "...they knocked me out or something." Further review showed the facility contacted the resident's family and asked if family wanted the facility to "...call the police, send [him/her] to the ER [emergency room] or just keep investigating..." Review of a physician note dated 3/15/19 and time 9:18 AM showed a MoCa (Montreal Cognitive Assessment) exam was completed and the resident scored 9/22 (cognitively impaired). Interview with resident #1 on 3/28/19 at 10:31 AM revealed the resident felt s/he had been "invaded." The resident revealed a man had entered his/her room and the resident asked the man to leave. The resident did not provide a date for the allegation.

2. Interview with the DON on 3/28/19 at 12:45 PM revealed the resident had reported 2 different allegations of sexual abuse. The resident told his/her family s/he was kissed by a staff member on 3/9/19. The family left a message regarding this allegation for the facility, which was received on 3/11/19. The second allegation that someone had "molested" the resident was made to a staff member on 3/14/19. The DON revealed the resident's description of the perpetrator for the 3/9/19 allegation sounded like CNA #1 and the CNA was interviewed. During the interview with the CNA, the DON learned the CNA had assisted the resident to his/her room and was in the room with the resident without anyone else present; however, the staff member was not placed on suspension pending investigation. Further interview revealed the DON did not contact law enforcement following the 3/9/19 allegation and did not contact law enforcement following the 3/14/19 allegation because the family "did not want to."

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S5071	Continued From page 10 3. Review of the State Licensing Agency's incident log showed an allegation of abuse for resident #1 dated 3/9/19 was reported on 3/21/19, 12 days after the allegation occurred. Further review showed no evidence the facility reported an allegation dated 3/14/19. 4. Review of the policy titled "Abuse and Neglect Policy" received from the facility on 3/28/19 showed "...Investigation 1. The Administrator will conduct an investigation of any alleged abuse/neglect, injuries of unknown origin, or misappropriation of resident property in accordance with state law. Any employee alleged to be involved in an instance of abuse/neglect will be suspended immediately and will not be permitted to return to work unless and until such allegations of abuse/neglect are unsubstantiated. 2. Deer Trail will report such allegation to the state, as per Wyoming regulations...Protection...2. Deer Trail will make referrals to the appropriate state agencies as necessary, to ensure the protection of the resident or resident's property...Reporting and Response 1. Deer Trail will report all accidents, injuries, illnesses, and allegations of abuse, neglect or exploitation shall be reported to the resident's family or responsible party and documented in the resident record. 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 1 business day)..."	S5071		

DEER TRAIL
ASSISTED LIVING & MEMORY CARE

Response to survey of April 1, 2019

ID Prefix Tag S5006

1. Division of Criminal Investigation (DCI) fingerprint background check and Department of Family Services (DFS) Central Registry Screening are complete for CNA #1and all working employees. The background checks for CNA #1 came back without any notations.
2. The administrative assistant has completed a chart audit for all employees to ensure they have the DCI fingerprint background check and DFS Central Registry Screening are complete and in place.
3. To ensure this policy is followed, the Executive Director will not allow any potential employee to work without the employee first completing a DCI fingerprint background check and DFS Central Registry Screening which are reviewed and approved by the Executive Director.
4. To ensure compliance on an ongoing basis the Executive Director will review the status of employee background checks with managers at each weekly Manager Meeting as well as at Quality Assurance meeting each quarter. Any discrepancies will be addressed immediately.
5. These changes were in effect April 30, 2019.

DoC

ID Prefix Tag S5054

1. The incident involving Resident #1 is reported to the Rock Springs Police, the Wyoming State Board of Nursing, the Office of Healthcare Licensing and Survey, and the State Long Term Care Ombudsman.
2. While reporting was done, it was not done in a timely fashion as required by the State in Chapter 12. All allegations of abuse and neglect will be reported to the State within the required timeframe. This will be completed by the Director of Nursing and compliance will be ensured by the Executive Director or designee.
3. The incident was reported to the Wyoming Department of Health, Division of Aging as well as to the Rock Springs Police Department.
4. An audit and review of previous incidents is complete and all appropriate action was taken in those cases.
5. To ensure compliance and timely reporting, the Executive Director will review incident submissions with the Director of Nursing and at our quarterly QA meetings.
6. These were implemented by April 30,2019.

DoC

DEER TRAIL
ASSISTED LIVING & MEMORY CARE

Response to survey of April 1, 2019

ID Prefix Tag S5070

1. The Abuse and Neglect Policy (22) will be updated with a more robust protocol for investigating abuse and neglect allegations.
2. The content of the policy will be followed more strictly including the suspension of employees alleged to be involved in an instance of abuse or neglect and reporting such incidents in a timely fashion.
3. The policy update was completed by April 30,2019.
4. All policies are reviewed and updated on an annual basis. The new policy will also be reviewed and updated on the same timeline.
5. The updated policy was submitted to the state Division of Aging for approval before April 30, 2019.
6. The policy will be presented to the Quality Assurance committee for approval and adoption. Training of the new policy has also take place.

DoC:

ID Prefix Tag S5071

1. The incident involving Resident #1 is reported to the Rock Springs Police Department, the Wyoming State Board of Nursing, the Office of Healthcare Licensing and Survey, and the State Long Term Care Ombudsman.
2. While a policy is in place for timely reporting of incidents, the policy was not followed completely in the incident noted in S5054.
3. To ensure the policy is followed, the Executive Director and Director of Nursing will be diligent in seeking information and reporting their investigations immediately, even while facts are being discovered.
4. An audit and review of previous incidents is complete and all appropriate action was taken in those cases.
5. All incidents will be reviewed during weekly Manager Meetings as well as at Quality Assurance meetings each quarter to ensure the Director of Nursing has completed reporting.
6. These changes were implemented by April 30, 2019.

DoC:

Respectfully submitted,

Jeffrey Smith
Executive Director
Deer Trail Assisted Living