Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF004	A. BUILDING: _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING COMMUNITY	1930 EAST 12 STREET CASPER, WY 82601

(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) COMPLETION 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 licensure survey was conducted by Healthcare Licensing and Surveys on 10/16/19 to 10/17/19. Also reviewed in the course of the survey was complaint #LIC-19-019.	S 000		
S5049	Ch 12 Sec 7 (d)(i)(A-K) Assisted Living Facility (ALF) Core Services (d) Medications. (i) An individual record shall be kept for each resident, recording any prescription drugs administered by the facility. This record shall include: (A) Name of resident; (B) Name and telephone number of primary physician; (C) Name and telephone number of the primary pharmacy; (D) Name and description of the medication, including prescribed dosage; (E) Dosage administered; (F) Quantity; (G) Times and dates administered;	S5049		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia Thompson — TITLE: Executive Director — (X6) DATE: 11/27/19

This plan of correction was accepted on 12/6/19.
Patricia Thompson was notified at 10 AM.
The date of correction is 12/15/19
Jean Gennie

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S5049	Continued From page 1 (H) Method of administration; (I) Any adverse reactions to the medication; (J) Signature of licensed staff administering medication; and (K) RN review date and signature. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure nurses who administered medications to residents signed the medication administration record (MAR) for 5 of 5 open sample residents (#1, #2, #3, #4, #5). The findings were: Review of the September and August 2019 MARs showed residents #1, #3, #4, and #5 received medications. The following concerns were identified: a. Review of the admission documentation for resident #1 showed s/he was admitted to the facility on 9/9/10. Review of the September and October 2019 MARs showed the resident received medications daily, and nurses who administered medications to the resident initialed the MAR when the medication was given. Further review showed a place on the back side of each MAR for the nurses' signatures. However, the review showed that area was left blank and no signatures were on the MAR. b. Review of the admission documentation for resident #2 showed s/he was admitted to the facility on 9/20/19. Review of the September and October 2019 MARs showed the resident	S5049		

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S5049	Continued From page 2 received medications daily, and nurses who administered medications to the resident initialed the MAR when the medication was given. Further review showed a place on the back side of each MAR for the nurses' signatures. However, the review showed that area was left blank and no signatures were on the MAR. c. Review of the admission documentation for resident #3 showed s/he was admitted to the facility on 3/17/17. Review of the September and October 2019 MARs showed the resident received medications daily, and nurses who administered medications to the resident initialed the MAR when the medication was given. Further review showed a place on the back side of each MAR for the nurses' signatures. However, the review showed that area was left blank and no signatures were on the MAR. d. Review of the admission documentation for resident #4 showed s/he was admitted to the facility on 3/19/18. Review of the September and October 2019 MARs showed the resident received medications daily, and nurses who administered medications to the resident initialed the MAR when the medication was given. Further review showed a place on the back side of each MAR for the nurses' signatures. However, the review showed that area was left blank and no signatures were on the MAR. e. Review of the admission documentation for resident #5 showed s/he was admitted to the facility on 9/25/18. Review of the September and October 2019 MARs showed the resident received medications daily, and nurses who administered medications to the resident initialed the MAR when the medication was given. Further review showed a place on the back side of each MAR for the nurses' signatures. However, the review showed that area was left blank and no signatures were on the MAR.	S5049		

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S5049	Continued From page 3 f. Interview with the resident care director on 10/17/19 at 5:11 PM confirmed the nurses failed to sign the September and October 2019 MARs.	S5049		
S5073	Ch 12 Sec 7 (j)(ii) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (ii) There must be organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome and sanitary in accordance with the rules. The dietetic service must ensure that food prepared is nutritionally adequate in accordance with the Dietary Reference Intakes (DRI) for adults. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure food was stored in a safe manner in the kitchen area. The findings were: 1. Observation on 10/17/19 at 9:38 AM to 10:45 AM of the kitchen area, which included pantry storage, refrigerator storage, and freezer storage identified the following concerns: a. Two pounds of ground beef was being thawed for use in the refrigerator with a "use by" date of 10/14/19. b. One quart of cream cheese frosting available for use in the refrigerator had an expiration date of 10/16/19. c. One quart of cottage cheese with an expiration date of 10/12/19 was in the refrigerator and was taken for use by dietary aide #1 during the observation.	S5073		

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S5073	Continued From page 4 d. One opened quart of half and half had a date of 10/7/19 on it, but no date as to when the container was opened. e. One opened quart of buttermilk had a date of 10/7/19 on it, but no date as to when the container was opened. 2. Interview with the dietary manager confirmed her expectation was for staff to discard items by the expiration date, and to date items when opened. The original dates were to show when the item was received.	S5073		
S5074	Ch 12 Sec 7 (j)(iii)(A) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (iii) Food service supervision: (A) Day to day responsibilities for food production and management of the dietary services shall be assigned to a person with nutrition and food service management experience equivalent to that of a Certified Dietary Manager. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the dietary manager was certified. The findings were: Observation on 10/17/19 at 10:30 AM showed there was no certificate on the wall for the dietary manager to show she was certified. Interview with the dietary manager at that time confirmed she was not certified. She stated a certified dietary	S5074		

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S5074	Continued From page 5 manager from a nearby assisted living facility came to the facility to assist "about once every 6 months." She further stated her last day of employment at the facility would be 10/25/19, and the facility had not hired a certified dietary manager or registered dietitian.	S5074		
S5077	Ch 12 Sec 7 (j)(vi) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (vi) The kitchen and dining area shall be kept clean and sanitary in accordance with standards established in the current edition of FDA Food Code. The dining area shall provide suitable furniture and adequate space to comfortably seat all residents. This State Rule and Regulation is not met as evidenced by: Based on observation, review of food temperature logs, and staff interview, the facility failed to ensure a clean and sanitary environment in the kitchen. The findings were: Observation on 10/17/19 at 9:38 AM to 10:45 AM of the kitchen area showed there were two staff members in the prep area; one was the cook and the other was a dietary aide who performed various tasks. The following concerns were identified: a. The observation showed a baked sheet of cake next to the dietary aide, and she was not wearing a hairnet or any other covering over her hair. She continued to work in the area without hair covering until after interview with the dietary manager on 10/17/19 at 10:30 AM. b. Review of the temperature log for recorded	S5077		

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S5077	Continued From page 6 temperatures of food during each meal showed the temperatures for breakfast items for 10/17/19 were not recorded. At that time, the cook was preparing the lunch meal. Interview with the cook confirmed the temperatures were not recorded for the breakfast meal. He stated that his routine was to record temperatures for meals at the end of the shift for all meals that he prepared. c. Interview with the dietary manager on 10/17/19 at 10:30 AM revealed it was her expectation that staff wear hair covering in the food prep areas, and food temperatures be recorded in a timely manner so as not to rely on memory.	S5077		
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.	S5094		

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S5094	Continued From page 7 (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 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	S5094		

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S5094	Continued From page 8 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 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, staff interview, and policy and procedure review, the facility failed to ensure education regarding the fire emergency plan was completed for 1 of 6 sample residents (#5). The findings were: Review of the admission documentation for resident #5 showed s/he was admitted to the facility on 9/25/18. The following concerns were identified: a. Review of the entire medical record showed no documentation regarding education to the resident concerning the fire emergency plan. b. Interview with the resident care director on 10/17/19 confirmed there was no documentation	S5094		

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S5094	Continued From page 9 to show the resident was ever educated on the fire emergency plan. c. Review of the 12/1/15 revised policy and procedure manual titled, "Emergency & Disaster Policy and Procedures," the "Department Heads and Supervisors-General Duties" showed, ...4. Teach new residents and new personnel to recognize the fire signal and what to do when they hear it. Provide regular training to reinforce safety procedures..."	S5094		

PARK PLACE ASSISTED LIVING COMMUNITY
1930 EAST 12TH STREET
CASPER, WY 82601

SURVEY DATE: 10/17/2019
DATE SUBMITTED: 11/8/2019, 11/21/2019, 11/27/19

TAG #: S5049: Ch 12 Sec 7 (d)(i)(A-K) Assisted Living Facility (ALF) Core Services
(d) Medications

1. Corrective Action

MARS were signed for residents #1, #2, #3, #4, #5.

2. Identification of others affected by the audit and corrective action.

Review of MARS showed all residents were at risk.

3. System Measures

The back of all September and October MARS will be initialed and signed by the nurses by December 1, 2019.

4. Monitoring

CSD will audit MARs monthly for signatures. The process is implemented effective the audit and corrections process with the assigned initial completion date of December 1, 2019. Monthly audits will continue until the paper MAR system is deemed obsolete with the implementation of the electronic medical record.

5. QA

Park Place has monthly QA meetings. Plan of correction items will be reviewed at each meeting. Documentation of status will be in meeting minutes.

JY

TAG # S5073 Ch 12 Sec 7 (j)(ii) Assisted Living Facility (ALF) Core Services

(j) Food Service and Nutrition

1. Corrective Action
   All expired items were discarded. There is a new dining manager as of 10/31/2019.
2. Identification of others affected by audit
   All residents were at risk for consumption of expired items.
3. System measures

The new dining services director has implemented new safety measures to ensure that all state and company rules and regulations are followed.

   a. New prep and pull charts will utilize freshness/"use by" tags. By using the new chart, all products are being checked daily and old products will be discarded with new product in place.
   b. Twice weekly when truck delivery arrives, product will be inventoried for expiration dates as the delivery is stocked. A system of rotation known as 'first in/first out' will be used.

4. Monitoring
   The dining services director will monitor inventory twice weekly at time of truck delivery. The new chart system will be checked daily to identify old product needing to be discarded.
5. QA
   Park Place ALF conducts monthly QA meetings and the dining services plan of correction will be reviewed for current status and meeting notes will reflect the discussion.

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CASPER, WY 82601

SURVEY DATE: 10/17/2019
DATE SUBMITTED: 11/8/2019, 11/21/2019, 11/27/19

Tag # S5074 Ch 12 Sec 7 (j)(iii)(A) Assisted Living Facility (ALF) Core Services

1. Corrective Action
   Park Place ALF has filled the position of Dietary Services Director with an individual who is serv-safe certified as are both cooks currently working in the kitchen.

Park Place ALF operates under the corporate umbrella of Edgewood. The corporate registered dietitian oversees a quarterly menu cycle that is distributed to all Edgewood facilities to be followed per the dietary guidelines established by that professional.

The current Dietary Services Director is working with the corporate registered dietitian to register for the course that would provide dining service certification upon completion. It is anticipated that the course will take one year to complete. Registration shall be completed by December 15.

2. Identification of others impacted by the audit.

With the professional oversight and strict adherence to the menu cycle provided by the corporate registered dietitian, staff, residents, and guests have well-balanced meals which reflect variety and interesting food presentations.

3. System measure

The corporate consult of a registered dietitian is available on an ongoing basis. Menu development is overseen by this professional. Menus are rotated quarterly.

The Dietary Services Manager will enroll in the dining certification course with the assistance of the corporate registered dietitian by December 15. Course completion is anticipated in approximately a year.

4. Monitoring

The Executive Director will monitor the Dining Service Director for course progress inmonthly intervals during QA meetings.

5. QA

Park Place holds monthly QA meetings during which this plan of correction will be reviewed, updated and documented in the meeting notes.

Tag #55077 Ch 12 Sec 7 (j)(vi) Assisted Living Facility (ALF) Core Services

(j) Food Service and Nutrition

1. Corrective action
   a. The new Dining Services Director implemented the policy that everyone that is in contact with food either wears a hairnet or hat. This policy is in effect and has been as "one of the first things I made happen".
   b. Temperatures are taken within a timely manner and documented on the appropriate sheets every day.
   c. The Dining Services Director will enforce and monitor policy regarding hairnets and food temperature documentation in a timely manner on a daily basis. The Executive Director will complete the dining room audit on a weekly basis per corporate standard.

2. Identification of others affected by this audit
   a. There is no indication at this time that others were impacted by the absence of staff wearing hairnets. Those most affected are staff who become relaxed in adherence to safety, sanitation and overall policy guidelines.
   b. Those primarily affected by this audit are staff who had adapted unreliable documentation practices.
   c. The staff was impacted by a manager that set expectations and did not enforce them.

3. System measures
   a. The new Dining Services Manager implemented policies and communicated them to staff as expectations for performance. These verbalized expectations are subject to corrective action when nonadherence is observed.
   b. The Executive Director will audit temperature recordings during weekly dining audits.
   c. The Dining Services Manager is accountable to the Executive Director for enforcement and adherence to dining policies.
4. Monitoring
   a. The Executive Director will monitor the adherence to the use of hairnets around food during weekly dining audits and sporadically throughout the food preparation process.
   b. The Executive Director will audit temperature recording during weekly dining audits.

c. The Executive Director and Dining Services Director will discuss findings of the independent audits conducted for real time corrections.

5. QA
   a. The Dining Service Director will provide monitor updates during Park Place monthly QA meetings. The updates will be documented in meeting notes.
   b. The Executive Director will provide audit results to the Dining Services Director in real time with weekly audits
   c. The Dining Services Director will uphold the standards of the state and company policies in real time.

Tag #5094 Ch 12 Sec 7 (o)(iii)(A-E) Assisted Living Facility (ALF) Core Services

(o) Evacuation Capability, Emergency Procedures, and Fire Safety

1. Corrective action

Education pertaining to the fire emergency evacuation was completed with the identified resident on 11/5/2019.

2. Identification of others affected by the audit

All residents are at risk. A full chart audit and fire emergency education will be completed with additional residents by 12/15/19.

3. System measures

Fire emergency education will be completed on admission with all residents by the CSD to ensure compliance.

All residents participate in monthly fire evacuation drills conducted by the facility Maintenance Director.

4. Monitoring

Monitoring will be ongoing. Documentation included in the admissions packet will ensure compliance.

3y

5. QA

Park Place ALF has scheduled monthly QA meetings. Plan of Corrections as written will be reviewed for compliance and documented in the meeting notes.

Respectfully submitted,

Patricia Thompson

Patricia Thompson, Executive Director