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Healthcare Licensing and Surveys

PRINTED: 08/19/2020
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
	ALF006	A. BUILDING: _____ B. WING _____	08/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN WIND ASSISTED LIVING COMMUNITY	4010 NORTH COLLEGE DRIVE CHEYENNE, WY 82001

(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 8/5/20 through 8/6/20. The survey was prompted by complaint intake LIC-20-034. In addition, a COVID-19 focused infection prevention survey was performed. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the infection control survey. The following common abbreviations are used throughout this document. ADON: Assistant Director of Nursing CNA: Certified Nursing Assistant ED: Executive Director DON: Director of Nursing LPN: Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	S 000		
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	S5054	The facility will report all incidents to the Licensing Division.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brandy Rel — TITLE: Business Office Mgr — (X6) DATE: 8272020

This plan of correction was accepted on 8/27/20 with the ADON, Marijah Tafoya at 4:39PM.

Jean Yennie MT(ASCP)

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S5054	Continued From page 1 Division, or designated representative upon request. (i) Each folder shall include the following: (A) Information from the referring agent, if applicable; (B) History and physical performed by a physician or physician extender; (C) Individual admission form. The form shall, at a minimum, contain the following information: (I) Full name of resident and former address; (II) Date of admission; (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,	S5054	A) All Incidents will be reported to the Licensing Division within one business day. The facility's investigation will be reported to Licensing Division and Long Term Care Ombudsman within 5 business days. ED (Executive Director) and management team to review and sign all incidents each business. B) All staff to be provided education on the expectations of reporting incidents, abuse, and any and all concerns to management. C) Extensive training provided to all nurses covering all aspects of incident reporting including all triggering events and ensuring every incident family, PCP and management have been notified with names noted. D) CSD (Clinical Services Director) and ACSD (Assistant Clinical Services Director) will review nurse's notes daily for 30 days to ensure all incidents are reported per state regulations. After 30 days are completed CSD (Clinical Services Director) and ACSD (Assistant Clinical Services Director) will continue to review nurse's notes weekly indefinitely. E) All incidents will be reviewed at monthly safety meeting with QA (Quality Assurance) Team to ensure accuracy and completion.	10/3/2020

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S5054	Continued From page 2 illnesses, and allegations of abuse, neglect or exploitation shall be reported to the resident's family or responsible party and be documented in the individual resident records. All such occurrences shall also be reported to the appropriate entity for follow up and resolution. Reports of all incidents affecting the health, welfare or safety of a resident shall be provided to the Licensing Division immediately (within one business day). Reporting shall be done by telephone or fax. The facility's investigation of the incident shall be reported to the Licensing Division and the Long Term Care Ombudsman within five (5) working days. Documentation to support the facility reporting the situation and follow up must also be present in the resident records; (E) An accounting of all personal funds 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	S5054	F) Audit to be completed on previous 3 months of nurses' notes to ensure no incidents are missed and all are reported to the Licensing Division, family and PCP with names noted. G) All Incidents for resident #1, #2, #3, #4, and #5 have been submitted to the Licensing Division. Reports in question are 2020-2092, 2020-2091, 2020-2094, 2020-2095, 2020-2096, 2020-2097.	

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S5054	Continued From page 3 individual or probate jurisdiction administering the resident ' s estate. (4.) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare except for applicable deductible and coinsurance amounts. (F) A signed copy of the resident's rights; (G) The resident's assessment and individualized assistance plan; (H) Copies of all applicable resident assistance contracts, signed by both parties; (I) Written acknowledgment of the receipt and explanation of all facility policies including 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 review of facility incident reports, resident record review, staff and resident representative interview, review of the Licensing Division incident reporting log, and policy and procedure review, the facility failed to report 6 of 8 incidents reviewed to the Licensing Division and/or the resident's representative that required such reporting. These incidents involved residents #1, #2, #3, #4, and #5. The findings	S5054		

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S5054	Continued From page 4 were: 1. Review of progress notes showed a resident-to-resident altercation involving resident #3 and resident #4 occurred on 5/26/20. Review of the Licensing Division incident reporting log showed no evidence the incident was reported. Interview with LPN #1 on 8/5/20 at 3:02 PM confirmed she had not reported the incident to facility administration. 2. Review of an aggression/elopement behavior note dated 6/3/20 showed resident #5 eloped from the facility, was physically aggressive towards staff, and was unable to be directed back into the facility. Law enforcement, emergency medical services, and the fire department arrived and transported the resident to the emergency department. The facility discharged the resident at that time. Review of the Licensing Division incident reporting log showed no evidence the incident was reported. 3. Review of progress notes showed a resident-to-resident altercation involving resident #1 and resident #3 occurred on 7/7/20. The note further showed the DON was aware and the resident's representative was to be notified. Review of the Licensing Division reporting log showed the incident was not reported until 7/29/20 (22 days after the incident). Interview with resident #1's representative on 8/6/20 at 8:34 AM revealed he was unaware of the incident. Interview with LPN #2 on 8/6/20 at 2:44 PM revealed she had spoken with the resident's representative following the incident, however she could not recall what was said. 4. Review of progress notes showed a resident-to-resident altercation occurred involving	S5054		

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S5054	Continued From page 5 resident #2 and resident #3. Review of the Licensing Division incident reporting log showed the incident was not reported until 7/29/20 (20 days after the incident). 5. Review of progress notes showed a resident-to-resident altercation occurred involving resident #1 and resident #3 on 7/12/20. There was no documentation the DON or the resident's representative had been notified. Review of the Licensing Division incident reporting log showed no evidence the incident had been reported. 6. Review of progress notes showed a resident-to-resident altercation occurred on 7/14/20 which involved resident #1 and resident #3. There was no documentation the DON or the resident's representative had been notified. Review of the Licensing Division incident reporting log showed no evidence the incident had been reported. 7. Interview with the ADON on 8/5/20 at 11:35 AM revealed she was responsible for investigating allegations of abuse and reporting incidents to the required agencies, however she had been out of the facility from 7/7/20 until 7/29/20. In addition, she was unsure what the time frame was for reporting to the Licensing Division, but thought it was 24 to 48 hours. 8. Interview with the DON on 8/5/20 at 2:33 PM confirmed the incidents which occurred on 7/7 and 7/9 were not reported timely to the Licensing Division because she was overwhelmed due to the ADON being out of the facility and an increase in COVID-19 surveillance and testing. In addition, she was not aware of the resident-to-resident incidents which occurred on 7/12 and 7/14.	S5054		

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S5054	Continued From page 6 9. Interview on 8/5/20 at 3:36 PM with the DON and the ED revealed more staff education was needed related to reporting of incidents to administration and to the required agencies. 10. Review of the Policy and Procedure "Abuse Prevention, Intervention, Reporting, and Investigation" dated May 2020 showed "1. Policy Guidelines Residents are to be free from verbal, sexual, physical, emotional/mental abuse, neglect, self-abuse/self-neglect, medical neglect, misappropriation of resident property, corporeal punishment, and involuntary seclusion at all times ...All staff are mandated reporters and must comply with state and federal regulations regarding reporting suspected abuse ...C. Reporting 1. The Executive Director is promptly notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after normal working hours, the Executive Director is called at home or paged. 2. The Executive Director notifies the following of a suspected abuse incident: a. Law enforcement officials. b. Adult Protective Services. c. Resident's attending physician. d. State licensing/certification agency. e. Resident's legal representative on record. f. The Chief Nursing Officer and Regional Vice President. g. local ombudsman ...D. Investigation 1. Residents and staff are to be protected during incident investigations by ensuring: ...c. The Executive Director and Chief Nursing Officer is immediately informed. D. A resident who is allegedly mistreated by another resident is removed from contact with that resident during the investigation ...8. The Executive Director keeps the resident and his/her representative informed of the progress of the investigation. 9. When the investigation is completed, the Executive Director informs the resident and his/her representative of the results and	S5054		

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S5054	Continued From page 7 corrective action taken. 10. Investigative findings should be reported to the Executive Director and others as may be required by state and local laws within the required time frame."	S5054		
S5069	Ch 12 Sec 7 (i)(i) Assisted Living Facility (ALF) Core Services (i) Adult Protection. (i) The facility must assure that all residents are protected from abuse. This includes the resident's right to be free from verbal, physical, mental, or sexual abuse in accordance with the definition of abuse as stated in Section 4(a) of these rules. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, resident record review, facility incident report review, and review of policy and procedure, the facility failed to ensure 2 of 4 residents (#1, #2) identified in reported allegations of resident-to-resident abuse were protected from further abuse. The census of the Precious Memories unit was 27. The findings were: 1. Review of the master care plan, last updated 7/6/20, for resident #3 showed the resident was admitted on 5/20/19 with a diagnosis of dementia; was independent with transfers and mobility; not at risk of abusive behavior; and had no behaviors that required interventions. The following concerns were identified: a. Review of a progress note for resident #1 dated 7/7/20 and timed 2:18 PM, showed the resident was hit on the right side of his/her jaw and knocked to the floor by a wandering resident	S5069	The facility will ensure resident's rights are implemented to prevent physical, psychological, sexual, or verbal abuse, humiliation, intimidation, or punishment. A) Education for all staff will be covered in October and quarterly thereafter for 1 year and yearly after 1 year: Resident Bill of Rights, Abuse Prevention, Intervention, Reporting, and Investigation Policies. B) Additional education provided to nurses on incident reporting including noting family/PCP/management name notified, comprehensive assessment of resident completed, monitoring resident and nurses' noted each shift until incident resolved. C) CSD (Clinical Services Director) and ACSD (Assistant Clinical Services Director) educated Nurses on use of Abuse Response Protocol. D) A monthly teleconference between resident council president, other residents, and Long Term Care Ombudsman will be held. E) All incidents will be reviewed at monthly safety meeting with QA (Quality Assurance) Team to ensure accuracy and completion.	10/3/2020

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S5069	Continued From page 8 (the resident was later identified as resident #3). The resident landed on his/her buttocks and the right side of his/her head hit the door jam. The resident had a skin tear on the left upper arm and had the "potential for bruising all over." The note further showed the DON was aware and the resident's representative was to be notified. b. Review of a progress note for resident #2, dated 7/9/20 and timed 7:45 PM, showed the resident had been pushed down and landed on his/her back. The resident told the facility "that man [resident #3] came into my room." The resident was transported to the emergency department for evaluation. Review of the incident report submitted to the Licensing Division showed the resident had a fractured femur which required surgery. The resident later expired from cardiac complications. c. Review of a progress note, dated 7/12/20 and timed 8:03 AM, showed resident #1 was in his/her room when resident #3 entered. The resident "began yelling for help and yelling at [resident #3] to 'get out of my room.'" Resident #1 was "slapped" across the face. The note further showed resident #1 was assessed by the nurse and found to have bruising on the left cheek. The resident was noted to be "very upset." There was no documentation the DON or the resident's representative were notified. d. Review of a progress note for resident #3, dated 7/14/20 and timed 8:57 PM, showed resident #1 had told the nursing staff that resident #3 had come into his/her room and hit him/her on the top of the head and had slapped his/her face. There was no documentation the DON or the resident's representative were notified. e. Further review of progress notes dated 7/4/20 through 7/24/20 showed resident #3 had multiple incidents of physical aggression toward staff which included kicking, hitting, and	S5069	F) Audit to be completed on previous 3 months of nurses' notes to ensure no incidents are missed and all are reported to the Licensing Division, family and PCP with names noted. G) Resident #3 was sent Colorado Plains Gero-Psych Hospital to for evaluation and treatment.	

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S5069	Continued From page 9 punching. The resident was also noted to have been wandering into other resident's rooms and "taking their items", rearranging furniture and breaking a lamp. 2. Observation on 8/5/20 at 1:30 PM showed resident #3 was pacing the main hallway in the Precious Memories unit and then sat in a chair located next to resident #1's open door. Resident #1 was in his/her room. Also in the hallway was resident #4. There were no staff in the vicinity. 3. Interview with CNA #1 on 8/5/20 at 11:10 AM revealed resident #3 wandered the hallways and would go into other resident's rooms to take a nap. The resident was also resistant to care and could be physically aggressive. The CNA stated if another resident was involved in an altercation with resident #3, she would separate the residents to keep them safe and notify the nurse and DON. Interventions for resident #3 included distracting him/her with food and activities. 4. Interview with LPN #1 on 8/5/20 at 11:25 AM revealed resident #3 had behavioral issues and his/her medications had been adjusted. Interventions included trying to keep the resident "close by" and engaged in activities. Further, any incident should be reported to the DON and administration. 5. Interview with the ADON on 8/5/20 at 11:35 AM revealed the resident had shown an increase in behaviors since COVID-19 had caused the closing of the facility. The resident was no longer able to participate in activities outside of the facility with family as was his/her routine. Further, the resident had become more aggressive with staff and residents, perhaps due to the isolation, and often without warning. To keep other	S5069		

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S5069	Continued From page 10 residents safe the facility had the residents stay in their rooms with the doors closed and locked, if it was safe for them to do so. In addition the facility had been working with the physician on medication management and had started behavioral charting to identify possible triggers. The ADON stated she was responsible for investigating allegations of abuse and reporting incidents to the required agencies, however she had been out of the facility from 7/7/20 until 7/29/20. 6. Interview with the DON on 8/5/20 at 2:33 PM revealed the interventions to keep residents safe from the physical aggression of resident #3 in the Precious Memories unit was to have the physician evaluate the resident's medication, have the other residents on the unit close and lock their doors, and to increase supervision. However, the facility was not providing 1-to-1 supervision of the resident. Further, the DON was not aware of the incidents involving resident #1 on 7/12 and 7/14 as they were not reported to the administration by the nurse. 7. Interview on 8/5/20 at 3:36 PM with the DON and the ED revealed after the first incident on 7/7/20 the facility's "first line of defense" was to notify the physician and have the resident's medications evaluated, educate the staff on redirection, and ensure the resident was checked on every 30 minutes. They further described that behavioral charting was begun and the facility attempted to keep residents away from each other. At that time, discussions concerning the transfer of the resident to another facility were started. After the incident on 7/9/20 the residents were asked to keep their doors shut and locked, if feasible, and the facility moved forward with finding an appropriate placement. However, the	S5069		

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S5069	Continued From page 11 facility did not provide 1-to-1 supervision of the resident to ensure the safety of other residents, due to non-essential personnel not being allowed in the facility and the lack of adequate staff to provide that supervision. The resident was scheduled to be transferred to a geriatric psychiatry facility on 8/7/20. Neither the DON nor the administrator were aware of the incidents which occurred on 7/12 and 7/14. 8. Review of the Policy and Procedure "Abuse Prevention, Intervention, Reporting, and Investigation" dated May 2020 showed "1. Policy Guidelines Residents are to be free from verbal, sexual, physical, emotional/mental abuse, neglect, self-abuse/self-neglect, medical neglect, misappropriation of resident property, corporeal punishment, and involuntary seclusion at all times ...All staff are mandated reporters and must comply with state and federal regulations regarding reporting suspected abuse ...C. Reporting 1. The Executive Director is promptly notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after normal working hours, the Executive Director is called at home or paged. 2. The Executive Director notifies the following of a suspected abuse incident: a. Law enforcement officials. b. Adult Protective Services. c. Resident's attending physician. d. State licensing/certification agency. e. Resident's legal representative on record. f. The Chief Nursing Officer and Regional Vice President. g. local ombudsman ...D. Investigation 1. Residents and staff are to be protected during incident investigations by ensuring: ...c. The Executive Director and Chief Nursing Officer is immediately informed. D. A resident who is allegedly mistreated by another resident is removed from contact with that resident during the investigation ...8. The Executive Director	S5069		

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S5069	Continued From page 12 keeps the resident and his/her representative informed of the progress of the investigation. 9. When the investigation is completed, the Executive Director informs the resident and his/her representative of the results and corrective action taken. 10. Investigative findings should be reported to the Executive Director and others as may be required by state and local laws within the required time frame."	S5069		