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FORM APPROVED

Healthcare Licensing and Surveys

SEP 02 2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WY9019	(X2) MULTIPLE CONSTRUCTION BUILDING: Healthcare Licensing and Surveys B. WING	(X3) DATE SURVEY COMPLETED 08/13/2020
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MOUNTAIN LODGE LLC

1110 BIRCH STREET
DOUGLAS, WY 82635

(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 COVID-19 focused infection control survey was conducted by Healthcare Licensing and Surveys on 8/11/20.	S 000		
S5053	Ch 12 Sec 7 (d)(v)(A) Assisted Living Facility (ALF) Core Services (d) Medications. (v) Medication Administration (A) An RN shall be responsible for the supervision and management of all medication administration as required by the Wyoming Nurse Practice Act, and the Wyoming Board of Nursing Rules and Regulations. This State Rule and Regulation is not met as evidenced by: Based on review of Wyoming State Board of Nursing advisory opinions, interview with Wyoming State Board of Nursing staff, observation, resident record review, and staff interview, the facility failed to ensure safe medication administration practices were followed for 1 of 1 residents (#1) who received narcotic medications. The findings were: Review of the Wyoming State Board of Nursing advisory opinion "Practice During COVID 19 Declared State of Emergency", dated April 7,	S5053	<u>S5053</u> 1. Mountain Lodge will ensure that an RN will be responsible for the supervision and management of all medication administration as required by the Wyoming Nurse Practice Act, and the Wyoming Board of Nursing Rules and Regulations. 2. Resident #1 will have scheduled Narcotic in a locked, timed pill dispenser in room that RN will refill every 4 days. Resident #1 was assessed and can take her narcotic with assistance (pill dispenser). RN will check twice a shift to ensure meds are being dispensed at proper times and that Resident #1 is taking the Narcotic. 3. All residents who are on narcotics PRN will be given by an RN. If a resident is on a scheduled narcotic, they will be placed in a locked, timed, pill dispenser and evaluated by an RN before doing so. 4. AL administrator or designee will educate staff that an RN has to deliver scheduled narcotics as well as PRN narcotics. Staff will also be educated on the use of the pill dispenser. 5. An audit will be done on all residents who are on scheduled or PRN narcotics that an RN is delivering them or that they can pass the evaluation to have the pill dispenser in room. The audit will be brought to QAPI monthly for three months or until resolved.	9/17/20

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

R. Nickell RN

8.31.2020

STATE FORM

6599

V64L11

If continuation, sheet 1 of 3

9/17/20 3:16 PM The POC of Correction is accepted with a DOC 9/17/20, which
was agreed upon with the Don R. Nickell - Colleen Hogan RN

Healthcare Licensing and Surveys

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN LODGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1110 BIRCH STREET DOUGLAS, WY 82633
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S5053	Continued From page 1 2020, showed "...10) Registered Nurses may use a CNA to hand non-narcotic medications to patients and observe the patient swallowing..." Telephone interview on 8/13/20 at 8:30 AM with the Wyoming State Board of Nursing Practice and Education Consultant revealed "...the nurse should pull the medications, place them in a cup, give the cup to the CNA who then would take it to the resident." Observation on 8/11/20 at 10:03 AM showed the facility was on lockdown due to the COVID 19 pandemic. Continued observation showed the assisted living unit was staffed with 2 certified nursing assistants (CNA) and an administrative assistant. Interview with the administrator at that time revealed the director was at home on self-quarantine. She further stated the residents were quarantined to their rooms, and dedicated staff were working on the assisted living unit and the memory care unit, and they were not mixing staff. The following concerns were identified: 1. Interview with CNA #1 on 8/11/20 at 10:35 AM revealed she was the lead CNA and the activities director. She stated since the director was in self-quarantine she administered all the medications to the residents with the director supervising via Facetime (a video-calling application) on a cellular telephone. She stated she and the director would look at each resident's medication administration record (MAR), pull the medication out of the drawer, compare the medication with the MAR and she would place the pill in a medication cup. She then took the medication cup to the resident and administered the medication. 2. Review of the MAR for resident #1 showed an admission date of 7/24/20 with diagnoses which included chronic back pain. Continued review	S5053		



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S5053	Continued From page 2 showed the resident received oxycodone (narcotic pain medication) 10 mg every 4 hours. 3. Telephone interview with the director on 8/11/20 at 2:25 PM confirmed she supervised the CNA via Facetime during the medication administration process for all residents. She stated she did not want staff to go from the assisted living unit to the memory care unit. She utilized the 4/7/20 Wyoming State Board of Nursing advisory opinion "Practice During COVID 19 Declared State of Emergency", and felt the CNA could pass the medications with her supervising via Facetime. She confirmed the CNA passed narcotic medication to a resident who required pain medications every 4 hours. She also revealed she misread the Board of Nursing advisory opinion and did not realize the CNA could not pass narcotic medications. She said the CNA had passed medications, including narcotics on 8/8/20, 8/9/20, 8/10/20, and 8/11/20. She further stated the situation had been corrected, and the nurse who worked on the memory care unit would administer medications to all of the residents in the facility in the future.	S5053		