OCT 26 2020

Healthcare Licensing and Surveys

PRINTED: 04/21/2020
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9014	A. BUILDING _____ B. WING _____	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION AT THE VILLA	14 UINTA DR GREEN RIVER, WY 82935

(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 3/9/20 to 3/12/20. The survey was prompted by complaint intake WY-LIC-20-002.	S 000		
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: (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, review of facility	S5023	S5023 Immediate corrective action: **Residents 1 and 2's charts have been reviewed and neither resident resides at the Villa at this time.** **Education to all care-partners at the Villa on significant change. Education with the nurse to complete assessment when a significant change is noted and new PCC assessment to be used.** How the facility will identify other residents having the potential to be affected: **All residents have the potential for being affected. Reviewed Incidents for the last 60 days to ensure that immediate nursing assessment occurred.** Measures put in place or system correction in this area include: **A completed documented assessment will be done by the nurses with every significant changes.** Who will monitor the new system: **Villa Director or Designee** How frequently will we monitor:	10/26/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan K Medcalf | TITLE: Villa Director | (X6) DATE: 10/26/2020

Accepted on 10/27/20. Susan, Director notified. DOC = 10/26/20

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S5023	Continued From page 1 incident reports, and staff interview, the facility failed to ensure a nursing assessment was completed for incidents/change in conditions for 2 of 3 sample residents (#1, #2). The findings were: 1. Review of the 6/11/19 timed at 7 PM incident report showed resident #1 had an unwitnessed fall while attempting to shower. The report showed a nurse was called and evaluated the resident finding a small 1 inch cut under the resident's left shoulder blade. Review of the 6/13/19 timed at 9:40 PM incident report showed the resident had an unwitnessed fall in his/her room. The actions taken showed a nurse was called and assessed the resident. There were no injuries identified. Although the reports showed a nurse assessment was done, review of the resident record failed to show the nurse documented any assessments of the resident related to these falls. 2. Review of the 6/15/19 timed at 9 AM incident report showed resident #1 had a change in physical condition, was having significant pain in his/her lower stomach, pelvis area and left leg upon weight bearing. The report showed a nurse was called to assess the resident, and the physician and family were also notified. The following concerns were identified: a. Review of the CNA note dated 6/14/19 timed at 6:42 AM showed the resident had 3 abrasions on the left shoulder, and the resident had complaints of difficulty breathing, walking and severe pain in his/her groin with movement. The note showed "A nurse did come to assess [the resident's name]." The resident's vital signs were taken and oxygen saturation was recorded as 82% on room air. The note showed supplemental oxygen was applied. Further review of the resident record showed no evidence of a nurse	S5023	**Weekly audit to monitor completion of Significant Change Assessment** How will we incorporate the new system into our QAPI system: **Identified Trends will be reviewed/ reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate.**	

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S5023	Continued From page 2 assessment being done the morning of 6/14/20. b. Review of the CNA note dated 6/14/19 timed at 1:38 AM showed the resident was lethargic and appeared to be confused. The resident refused to get dressed, eat a meal or get out of bed all day. The CNA further documented the resident was unable to walk without assistance and was dragging his/her feet. A sample was obtained for a urinary analysis (UA) and the CNA noted reporting this to the facility director, with the family being notified. c. Review of the nurse's note dated 6/14/19 timed at 7 PM showed the nurse was in to assess the resident. The nurse documented the resident was "lethargic compared to baseline. Sitting in recliner during assessment. [Oxygen saturation level] above 90% via [the nasal canula]...able to extend [bilateral lower extremities] upon request, Able to follow commands appropriately. Pulses present..." The nurse documented the resident complained of pain to his/her back but did not state it was an increase from baseline pain. "Awaiting UA results sent to lab this day. Spoke with care partners to observe resident [every] hour and report change in status." d. Review of the facility director's note dated 6/15/19 timed at 12:10 PM showed the director had been notified at 9 AM related to the resident having increased pain in his/her pelvic area and difficulty walking. After talking to the daughter and the nurse from skilled nursing it was determined the resident should be sent to the hospital via EMS. The nurse and physician were notified. e. Interview with the facility director and the administrator on 3/12/20 at 8:51 AM revealed they were unaware of the rules required the nurse to perform and document an assessment when there was a significant change in resident condition. They verified the documentation was lacking. Further, the director stated the delay in	S5023		

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S5023	Continued From page 3 sending the resident to the hospital was related to his/her refusal to go. They then verified this detail was lacking in the notes. 3. Review of the 9/9/19 timed at 12:30 AM incident report showed resident #2 had an unwitnessed fall in his/her room and was complaining of pain in his/her chest, and legs were "very weak." The report showed a nurse was called to complete an assessment of the resident's condition. Review of the 9/11/19 timed 6:40 AM incident report showed the resident had an unwitnessed fall and required 3 people to get him/her up. The resident required full assistance to get dressed. The report showed 2 nurses were called to assess the resident. Review of the 9/23/19 timed 2:15 AM incident report showed the resident had an unwitnessed fall in his/her room. The note showed a nurse was called to assess the resident. The following concerns were identified: a. Review of CNA progress notes showed on 9/9/19 at 1:38 AM the resident reported his/her pain in the breast area as an "8" (indicating signficant pain). Review of the CNA note dated 9/9/19 at 5:57 PM showed the resident had a bruise to the right hip, to his/her face, right breast, left wrist, and a small cut on the lip. The note showed the resident complained of trouble taking deep breaths due to rib pain. b. Review of a CNA note dated 9/13/19 at 1:09 PM showed the resident was incontinent of urine, was a full 2 person assist and complaining of pain. Review of the 9/15/19 timed at 2:41 PM CNA note showed the resident was feeling weak and tired and "in excruciating pain." c. Review of the CNA note dated 9/25/19 at 11:10 PM showed the resident was a full assist after returning from physician appointment. The 9/26/19 timed at 2:07 PM CNA note showed the	S5023		

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S5023	Continued From page 4 resident was requiring full assistance and was unable to walk without assistance. d. Review of the resident record failed to show evidence of any nurse assessment for the 9/9/19 and 9/11/19 falls. The nurse's note related to the 9/23/19 fall showed it was dated 9/24/19 at 3:27 PM. The note showed the resident had complaints of pain to the right ankle when pressure was applied to the area with swelling noted. The family had been notified and did not wish to have the resident sent to the hospital. 4. Interview with the facility director and the facility administrator on 3/12/20 at 8:51 AM revealed they were unaware the rules required the nurse to perform and document an assessment when a resident had a significant change in condition.	S5023		