PRINTED: 10/20/2021
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
	ALF003	A. BUILDING: _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MEADOW WIND	3955 EAST 12TH STREET CASPER, WY 82609

(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 08/24/2020. 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 10/6/21 to 10/7/21. The survey was prompted by complaint intakes LIC-21-025, LIC-21-028, and LIC-21-029. In addition, a COVID-19 focused infection control survey was conducted by Healthcare Licensing and surveys from 10/6/21 to 10/7/21. Based on the findings of the survey team, it was determined that no deficiencies were identified pertaining to the infection control survey.	S 000		
S5020	Ch 12 Sec 7 (e) 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; (B) History and physical performed by a physician or physician extender; (C) Individual admission form. This form	S5020		

10/27/21 2:21PM POC accepted. I talked with Nora
JSC 11/15/21

PRINTED: 10/20/2021
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
	ALF003	A. BUILDING: _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MEADOW WIND	3955 EAST 12TH STREET CASPER, WY 82609

(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
S5020	Continued From page 1 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 or 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, welfare of 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	S5020		

PRINTED: 10/20/2021
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
	ALF003	A. BUILDING: _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MEADOW WIND	3955 EAST 12TH STREET CASPER, WY 82609

(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
S5020	Continued From page 2 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 the 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 personal funds 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 of Medicare except for applicable deductible and coinsurance amounts. (F) A signed copy of the resident's rights; (G) The resident's assessment and	S5020		

PRINTED: 10/20/2021
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
	ALF003	A. BUILDING: _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MEADOW WIND	3955 EAST 12TH STREET CASPER, WY 82609

(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
S5020	Continued From page 3 individualized assistance plan; (H) Copies of al 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. (ii) The resident shall be assured of confidential treatment of all information in the record, and the resident's written consent (or the consent of the guardian) shall be required for the release of information to persons not otherwise authorized for receive it. (iii) All residents' records shall be retained in a physically secure area for a minimum of six (6) years after the resident has left the facility and may be disposed of, by shredding or burning, after that time. (iv) In the event of dissolution of the facility, the manager shall notify the Licensing Division as to the location of all residents' records. (v) All records shall be protected from damage by fire, water and other hazards. (vi) All entries in each resident's record shall be made in ink, signed and dated.	S5020		

PRINTED: 10/20/2021
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
	ALF003	A. BUILDING: _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MEADOW WIND	3955 EAST 12TH STREET CASPER, WY 82609

(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
S5020	Continued From page 4 This State Rule and Regulation is not met as evidenced by: Based on medical record review, family interview, and staff interview, the facility failed to ensure a family member was contacted regarding a change in condition for 1 of 2 (#1) sample residents who had a change in condition. The findings were: Medical record review of the medical information for resident #1 showed s/he was admitted to the facility on 9/30/19 with diagnoses which included cervical spine arthritis, lymphedema, osteoporosis, sciatica, and rheumatoid arthritis. Review of the primary contact information showed the resident's daughter was the primary contact, with a contact phone number. Review of a 6/24/21 MD Contact (physician contact) note [not timed] showed the following, "Resident used call light...CNA went to answer...resident found on floor on left side...left foot backwards. Resident rating pain 10/10...states [s/he] did not hit head. States [s/he] was walking to living area from kitchen and fell. Denies being dizzy, states lost [his/her] balance...walker near [him/her]. Wear non skid footwear. 911 called to transfer to [local emergency department]. {Physician] called and left message as no answer. [Clinical Services Director] notified." Review of the corresponding RTasks note dated 6/24/21 at 6:21 PM confirmed the information on the MD Contact note, and added that the daughter of the resident was left a phone message, and the family nurse practitioner was faxed the information. The following concerns were identified: a. Review of an RTasks note dated 6/26/21 and timed 2:11 PM showed the following, "Daughter-[daughter's name] called at this time, concerned they have not been able to reach [resident #1]. Informed of fall on 6/24 and	S5020		

PRINTED: 10/20/2021
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
	ALF003	A. BUILDING: _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MEADOW WIND	3955 EAST 12TH STREET CASPER, WY 82609

(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
S5020	Continued From page 5 admission to [local hospital] for fracture, nursing note read to daughter to provide details and the fact that she was called and did not answer. Daughter informed me that she had informed another nurse of her phone number change-#verified and updated in the system, apologized for situation/events." b. Interview with the daughter of the resident on 10/6/21 at 2:45 PM confirmed that approximately 2 weeks prior to the resident's 6/24/21 fall with fracture, she had provided a different contact phone # to registered nurse (RN) #1, as the number to call for any contact. c. Interview with RN #1 on 10/7/21 at 8:15 AM confirmed the daughter of resident #1 had provided him with a different contact phone number approximately 2 weeks prior to the resident's 6/24/21 fall, and he had failed to make that change in the medical record, which resulted in the message for the daughter on 6/24/21 being left on the wrong contact number.	S5020		

Plan of Correction for Meadow Wind Assisted Living, October 7th, 2021 survey date.

Tag #S5020

Facility updated phone number for resident that was involved in current problem. All demographic information for this resident was reviewed and update at the time the daughter called our facility. Resident moved out the next week.

A letter will be sent to all families of residents currently in the facility with a copy of current demographic information that is on file. The letter will request that families update the facility with any new or change in contact information. Any updates or new information received will be updated in residents online file by Meadow Wind staff. Any new residents that move into the facility will be asked to complete a demographic form to include all contact information. This will be reviewed by Clinical Services Director and Assistant Services Director.

Education has been provided to all staff during monthly all staff meeting. Employees acknowledge understanding that new demographic information must be entered into the online resident chart immediately following knowledge of change. Education will also be provided to any new hires.

All resident and family information such as phone number, address, and any additional demographic items will be reviewed at the 30-day care plan, 6-month care plan and ongoing. Any new information or any changes will be completed by Clinical Services Director or Assistant Clinical Services Director.

Any changes in demographic information will be reviewed and addressed in monthly quality assurance meeting.

Completion date: 11/15/2021