PRINTED: 11/19/2021
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
	ALF014	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING WIND ASSISTED LIVING COMMUNITY	1072 NORTH 22ND STREET LARAMIE, WY 82072

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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 on 11/3/21 to 11/4/21. The survey was prompted by complaint intake LIC-22-002. In addition, a COVID-19 focused infection control survey was conducted by Healthcare Licensing and Surveys on 11/3/21 to 11/4/21. The following common abbreviations are used throughout this document: CDC: Centers for Disease Control CMS: Centers for Medicare and Medicaid CNA: Certified Nursing Assistant ED: Executive Director LPN: Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5003	Ch 12 Sec 6 (d) Personnel and Staffing Requirements (d) Infection Control. Written policies must be in effect to ensure that newly hired and current employees do not spread a communicable disease that could be transmitted through usual job duties. These written polices must, at a minimum:	S5003		

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Executive Director (X6) DATE 2/9/22

2/11/22

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S5003	Ch 12 Sec 6 (d) Personnel and Staffing Requirements (d) Infection Control. Written policies must be in effect to ensure that newly hired and current employees do not spread a communicable disease that could be transmitted through usual job duties. These written polices must, at a minimum:	S5003		

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S5003	Continued From page 1 (i) Ensure a safe and sanitary environment for residents and personnel; (ii) Require tuberculin testing, or screening as appropriate; and (iii) Prohibit any person with an airborne, contagious, or infectious disease from being employed until a work release is obtained. (A) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents and their food, if direct contact will transmit a disease. (B) The facility shall require staff to follow universal precautions when performing direct resident care. This State Rule and Regulation is not met as evidenced by: Based on observation, review of the COVID-19 employee symptom monitoring worksheets, staff interview, and review of CDC guidelines, the facility failed to ensure appropriate infection control practices were implemented. The census was 77. The findings were: Related to visitor and employee screening: 1. Observation on 11/3/21 at 9:40 AM showed visitors to the facility were to complete 3 different forms before entering the facility which included questions related to signs and symptoms of COVID-19 and a section to record body temperature, however a thermometer was not available. The following concerns were identified: a. Interview with the ED at the time of the observation revealed the facility had stopped obtaining a body temperature because they "had	S5003		

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yet to identify a case of COVID-19 because of a fever" and the thermometers the facility used were not reliable.

2. Review of the 10/1/21 through 11/2/21 employee symptom monitoring worksheets showed employees were to record their body temperature when arriving for duty and contact a licensed nurse if "yes" was marked to any symptoms listed on the form. The following concerns were identified:

a. Review of the employee symptom monitoring worksheets showed the executive director/designee had failed to review and sign the documents every 24 hours as directed.

b. Random review of 7 of the worksheets showed 34 of the 64 entries failed to include a body temperature. An additional 12 entries showed employees documented a temperature of "Lo" or a body temperature of 90.6 degrees Fahrenheit or less.

c. Review of the employee monitoring worksheets showed 8 entries where employees had marked yes to one or more symptoms of cough, fatigue, headache, congestion/runny nose, sore throat, shortness of breath, muscle/body aches, loss of taste/smell, and nausea/vomiting. There was no documentation of any additional screening from a licensed nurse.

d. Interview with the ED on 11/3/21 at 3:25 PM revealed staff presenting with symptoms would be testing with a rapid COVID-19 antigen test prior to being allowed to provide resident care, however the facility did not document the testing results. In addition, the ED confirmed he had not reviewed and signed the employee monitoring worksheets.

3. Review of the CDC guidance, last updated 9/10/21, showed a process should be established

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to identify anyone entering the facility, regardless of their vaccination status, who has any of the following so that they can be properly managed: 1) a positive viral test for SARS-CoV-2, 2) symptoms of COVID-19, or 3) who meets criteria for quarantine or exclusion from work. Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility. Healthcare personnel (HCP), even if fully vaccinated, should report any of the 3 above criteria to occupational health or another point of contact designated by the facility. Recommendations for evaluation and work restriction of these HCP are in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2. Visitors meeting any of the 3 criteria should generally be restricted from entering the facility until they have met criteria to end isolation or quarantine, respectively..."

Related to visitation:

1. Review of the facility's documentation showed CNA #1 had worked the 6 AM to 6 PM shift on 10/19/21 and had tested positive for COVID-19 at the end of the shift. Two additional memory care employees tested positive on 10/21 and 10/22. The following concerns were identified:

a. Review of the facility's documentation showed visitation to the memory care unit was suspended on 10/25/21.

b. Review of the visitor screening worksheets showed the memory care unit had 9 visitors from 10/20/21 to 10/25/21.

c. Interview with the ED on 11/3/21 at 3:25 PM confirmed visitation to the memory care unit had not been suspended until 10/25/21.

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S5003	Continued From page 4 2. Review of the Wyoming Department of Health Nursing and Assisted Living Facility Guidance last updated on 5/7/21 showed "Long-term care facilities (nursing homes and assisted living facilities) should follow the guidance for indoor, outdoor, and compassionate care visitation outlined in the CMS memorandum that was originally issued on September 17, 2020, and revised on April 27, 2021, and the updated CDC guidance on healthcare infection prevention and control recommendations in response to COVID-19 vaccination...During a COVID-19 outbreak in the facility, defined as any new COVID-19 infection in a staff or nursing-home onset of COVID-19 infection in a resident, facilities should immediately suspend all visitation except compassionate care visits and visits required under federal disability rights until at least one round of facility-wide outbreak testing is completed..."	S5003		
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;	S5020		

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S5020	Continued From page 5 (C) Individual admission form. This 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 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	S5020		

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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 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;

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S5020	Continued From page 7 (G) The resident's assessment and 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		

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This State Rule and Regulation is not met as evidenced by:
Based on observation, staff and family interview, review of facility documentation, and resident record review, the facility failed to ensure a family member was updated on the health status of 4 of 5 memory care residents (#1, #2, #3, #4) diagnosed with COVID-19 which were reviewed for family notification. The findings were:

1. Review of the facility's documentation showed resident #3 had been diagnosed with COVID-19 on 10/28/21, and the resident's daughter had been notified. The following concerns were identified:

a. Review of the COVID assessments dated 10/28, 10/29, and 10/30 showed the resident had symptoms of a loose nonproductive cough, clear drainage from the nose, fever, diminished lung sounds, and complained of chest pain with cough and fatigue. There was no documentation the resident's daughter had been notified until 10/31 of the resident's condition.

b. Interview with the resident's daughter on 11/4/21 at 10:36 AM revealed she had been told on 10/28 by facility staff that the facility would update her daily on the resident's condition, however that had not occurred and she called the facility twice daily to get an update.

2. Review of the facility's documentation showed resident #4 had been diagnosed with COVID-19 on 10/28/21, and the resident's daughter had been notified. The following concerns were identified:

a. Review of the COVID assessment dated 10/29/21 and timed 1:59 AM showed the resident had diminished bilateral lower lung sounds and

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appeared to be at baseline.

b. Review of the COVID assessment dated 10/29/21 and timed 1:49 PM showed the resident had a temperature of 99.6 degrees Fahrenheit, felt dizzy and continued to have diminished lung sounds.

c. Review of the COVID assessment dated 10/30/21 and timed 12:53 AM showed the resident had slightly diminished lung sounds in the right medial and bilateral lower bases. The resident was alert with a fair appetite and no cough was noted.

d. Review of the COVID assessment dated 10/31/21 and timed 1:19 AM showed the resident had a cough, was more fatigued, "gait is weak", and had multiple episodes of diarrhea.

e. Review of the COVID assessment dated 10/31/21 at 7:57 PM showed the resident's daughter had a window visit in the early afternoon and was updated on the resident's status at that time. In addition, the resident was able to ambulate short distances, however a wheelchair was used for longer distances due to "still weak".

f. There was no documentation the resident's daughter had been notified of the resident's status until she received an update on 10/31 during the window visit.

3. Review of the facility's documentation showed resident #2 had been diagnosed with COVID-19 on 11/1/21, and the resident's daughter had been notified. The following concerns were identified:

a. Review of the COVID assessment dated 11/1/21 and timed 8:47 PM showed the resident had a moist unproductive cough and a hoarse voice. The next COVID assessment was documented on 11/3/21 at 2:55 AM with no significant changes identified.

b. Interview with the resident's daughter on 11/4/21 at 10:18 AM stated the facility had not

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contacted her to inform her of the resident's status, however she called the facility once or twice a day.

c. Review of the resident's record showed no documentation the family had been updated on the resident's health status.

4. Review of the facility's documentation showed resident #1 had been diagnosed with COVID-19 on 10/31/21, and the resident's son had been notified. The following concerns were identified:

a. Review of the COVID assessment dated 11/1/21 and timed 8:11 PM showed the resident had a moist unproductive cough, was not short of breath, was fatigued, and had a decrease in appetite, but had eaten 100% of the evening meal. There was not a COVID assessment documented on 11/2/21.

b. Review of the COVID assessment dated 11/3/21 and timed 2:17 AM showed the resident was lethargic, had a cough, was more irritable, and was less cooperative with cares.

c. Review of the resident's record showed no documentation the family had been updated on the resident's health status.

5. Interview with the ED on 11/3/21 at 3:25 PM revealed the initial intent was for the business office manager (BOM) to call and update the families of the memory care residents on a daily basis, however the BOM was out of the facility due to an illness. In addition, the ED stated due to the temporary staffing shortage the amount of telephone calls for the memory care unit was challenging.

Edgewood Spring Wind

Survey Date 11/4/22

Ref: LH-2021-1352

Plan of Correction:

Tag: S5003 – Ch 12, sec 6 (d) personnel and staffing

1. New thermometers for the employee and guest areas were purchased as well as an extra one for backup. They were placed in the respective areas.

   The ED or a designated staff member will audit these areas to assure thermometers, hand sanitizer, and masks are readily available upon entry into the building. A thorough audit will be completed daily for two weeks then weekly for six weeks then monthly for three months. This audit will be kept in the state audit specific binder.

   The staff will be educated on the importance of reporting any of the above-mentioned items that are not available immediately.

   QA will review and discuss the process quarterly to assure the issue is being managed properly.

   Completion Date: 2/18/2022

2. ED, BOD or designated employee will review symptom monitoring worksheets for completion and any symptoms marked yes. Worksheets will be signed off at a minimum of every 24 hours.

   Education will be provided to the staff immediately on the importance of thoroughly filling out the screening worksheets completely as well as testing and reporting to a licensed nurse immediately with any yes answer on the worksheet.

   The licensed nurse will assess the employee and test results to determine if they are well enough to work. The nurse will document the test results and that the assessment had been completed in the state binder.

   ED will audit this process to assure that it is completed daily for two weeks then weekly for six weeks then monthly for three months. This audit will be kept in the state audit specific binder.

   QA will review and discuss the process quarterly to assure the issue is being managed properly.

   Completion Date: 2/18/2022

3. When the building is in outbreak there will be a notice posted upon entrance of the building. The notice will include notice of outbreak as well as education on the risks to them if they choose to follow through with visitation. The facility policies will be reviewed and updated regarding the current guidelines set forth by the Wyoming Department of Health.

2/11/22 - This POC was accepted with agreed to changes between Rob [illegible], ED and [illegible] - State Health [illegible] 2/[illegible]

Edgewood Spring Wind

Survey Date 11/4/22

Ref: LH-2021-1352

S5020

When a resident test positive for Covid-19 the staff will contact family by phone. This call will be documented by the nurse in the resident's electronic chart. It will be confirmed and documented in the state binder by the ED. If there is a change in the resident condition this process will be followed again. When the building is in outbreak, they will send a letter out to all the families of the residents informing them of building status.

The DON will provide education to Skilled nurses on the process. (1)

The ED will monitor for positive test whenever testing is being done.

QA this will be discussed quarterly to assure the process is being managed.

Completion Date: 2/14/2022

Executive Director: _____ Date: 2/9/22

2/10/22