PRINTED: 05/12/2022
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
	ALF026	A. BUILDING: _____ B. WING _____	C 04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER TRAIL ASSISTED LIVING	2360 REAGAN AVENUE ROCK SPRINGS, WY 82901

(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 from 4/27/22 to 4/28/22 based on complaint intake LIC-22-018.	S 000		
S5009	Ch 12 Sec 7 (b)(iv) Assisted Living Facility (ALF) Core Services (b) (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, staff interview, facility incident report review, and policy and procedure review, the facility failed to ensure assessments were documented related to falls and other changes in condition for 5 of 5 sample residents (#1, #2, #3, #4, #5) reviewed. The findings were: 1. Review of the resident record showed resident #2 was admitted to the facility on 8/16/19 with	S5009		

307-362-0100

6/13/22 9:15AM Talked with Jess. POC accepted w DOC 6/15/22

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S5009	Continued From page 1 diagnoses that included unspecified dementia without behavioral disturbance. The following concerns were identified: a. Review of facility incident reports showed the resident suffered a fall on 2/1/22. Further review showed vital signs were performed. However, no assessment was documented at that time. Review of the 2/1/22 provider notification showed the resident fell onto his/her back, was complaining of pain to his/her right side, and stated s/he hit his/her head. Further review of the resident record showed no additional documented follow-up assessments or evaluations. The facility placed the resident on alert charting, which included two-hour checks; however, it was noted that for February 2022, 113 of the 336 checks were not documented as performed. b. Review of facility incident reports showed the resident was found on the floor in his/her room on 3/19/22 at 11:30 PM, and was unable to communicate what had caused the fall. Further review showed vital signs were taken at that time, and the resident was again placed on alert charting. However, no assessment was documented at that time. Review of the resident record showed no additional documented follow-up assessments or evaluations after the incident occurred. Review of the 3/20/22 provider notification noted " ... Resident noted to have unsteady gait prior to fall ..." Review of a nursing progress note showed on 3/20/22 at 5:18 PM the resident was transported to the hospital with a " ... possible brain bleed." Review of the resident's hospital documentation showed s/he was diagnosed with a traumatic subdural hemorrhage without loss of consciousness, and was placed on hospice care. Review of the March 2022 two-hour check documentation showed 75 out of 234 checks prior to the resident's hospitalization were	S5009		

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S5009	Continued From page 2 not documented as performed. The resident returned to the facility on 3/22/22 on hospice care until s/he passed on 4/9/22. 2. Review of the resident record showed resident #1 was admitted to the facility on 4/14/20 with diagnoses that included hemiplegia and hemiparesis following non-traumatic subarachnoid hemorrhage affecting left non-dominant side, lack of coordination, history of falling, difficulty walking, and unspecified dementia without behavioral disturbance. The following concerns were identified: a. Review of the provider notification on 2/22/22 showed "[Resident] is increasing [sic] confused ... Possible [urinary tract infection] ..." Review of the resident record showed no documented assessments or evaluations after the changes were noted. b. Review of the 2/23/22 incident report showed the resident was found on the floor at 6:15 PM. Vital signs were taken, and the resident was complaining of left hip pain. The resident was then sent to the hospital for evaluation. Review of the resident record showed no assessment was documented related to this incident. Review of the provider notification from 2/23/22 showed the resident was admitted to the hospital with a fractured pelvis. Review of the resident record failed to show documentation the resident returned to the facility. However, the record showed the resident was discharged to a long term care on 3/23/22. 3. Review of the resident record showed resident #3 was admitted to the facility on 1/8/22 with diagnoses that included hemiplegia and hemiparesis following other cerebrovascular disease affecting left non-dominant side. The following concerns were identified:	S5009		

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S5009	Continued From page 3 a. Review of the incident log showed the resident suffered falls on 7 different occasions since his/her admission. With each fall, vital signs were taken, and the resident was placed on alert charting. Further review showed no documented assessments or evaluations associated with each incident. Review of the incident report documentation for each fall showed 3 of the falls resulted in skin tear/wound injuries. b. Review of the resident record showed no additional documented assessments, evaluations, or monitoring related to each incident. 4. Review of the resident record showed resident #4 had diagnoses that included unspecified dementia without behavioral disturbance. The following concerns were identified: a. Review of the 1/31/22 incident report showed at 10:00 AM, the resident was " ... slurring [his/her] words ... hands looked cramped. These [signs and symptoms] lasted approximately 15-20 minutes." Further review showed vital signs were taken, but no assessment was documented at that time. b. Review of the resident record showed no additional documented assessments, evaluations, or monitoring after the noted change. 5. Review of the resident record showed resident #5 was admitted to the facility 1/28/22 with diagnoses that included venous insufficiency. The following concerns were identified: a. Review of the incident log showed the resident suffered falls on 17 different occasions, one incident of potential stroke, and one incident involving a head laceration of unknown origin. Review of the incident report for each incident showed vital signs were taken and the resident was placed on alert charting. Further review	S5009		

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S5009	Continued From page 4 showed no documented assessments or evaluations associated with each incident. 6. Interview with the director of nursing (DON) on 4/27/22 at 2:41 PM revealed staff were " ... constantly assessing and evaluating residents, but they don't document everything ..." She stated changes in status or condition were communicated during the morning meetings. Interview with the DON on 4/28/22 at 9:22 AM revealed not every resident had two-hour monitoring in place. She stated the task is primarily for CNAs, but nurses can perform them, as well. She stated the checks involve assessing pain, status, safety, bathroom needs, confusion, and oxygen status. She further stated the checks are just signed off, and changes noted are communicated to the nurses; however, there is no specific documentation unless a progress note is created. She added that alert charting is for new admits, falls, and incidents, and involves daily charting and vital signs. If a head injury occurs or is suspected, neurological checks will be initiated, as well. She acknowledged the lack of consistent documentation, and was working on rectifying the situation. 7. Review of facility policy "Level 2 Resident Assessments," last reviewed 2/27/19, showed "1. Purpose: To obtain resident's medical history, level of activity and required needs, current medical status, level of cognition, nutritional needs and requirements, impairments, medication review and psychosocial needs ..." 8. Review of facility policy "Change of Condition and Monitoring," last reviewed 3/25/21, showed "A. Purpose: To define a resident's change of condition as either short-term or significant ... B. Prerequisites: ... 3. If a resident experiences a	S5009		

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S5009	Continued From page 5 significant change of condition ... [the facility] will evaluate the resident ... document the change, and update the service plan as needed ... 4. If a resident experiences a short-term change of condition that is expected to resolve or reverse with minimal intervention, ... [the facility] will determine and document what action or intervention is needed for the resident ... b) The documentation of staff instructions or interventions will be resident specific and made part of the resident record with a minimum of weekly progress noted [sic] until the condition resolves."	S5009		

DEER TRAIL
ASSISTED LIVING
& MEMORY CARE

Response to Survey of April 27 & 28, 2022

ID Prefix Tag S5009

1.
   a. Resident #2 has passed. No additional measures can be taken with this resident.
   b. For current residents, the Wellness Director will conduct an audit to ensure assessments of residents is conducted when they have a significant change in mental or physical condition. The "Assessment – Resident 2A" form will be used as it is for admission and regularly scheduled resident assessments.
   c. An audit of residents currently on two-hour checks will be conducted by the Wellness Director to ensure necessity of those checks and compliance with documentation.
   d. Retraining of the two-hour check policy will occur with all Wellness staff. Training will be documented.
   e. Assessments, audits, and training will be complete by June 15, 2022.

2.
   a. Resident #1 has passed. No additional measures can be taken with this resident.
   b. For current residents, the Wellness Director will conduct an audit to ensure assessments of residents is conducted when they have a significant change in mental or physical condition. The "Assessment – Resident 2A" form will be used as it is for admission and regularly scheduled resident assessments.
   c. Assessments and audits will be complete by June 15, 2022.

3.
   a. A current assessment for Resident #3 is complete.
   b. For Resident #3 and other current residents, the Wellness Director will conduct an audit to ensure assessments of residents is conducted when they have a significant change in mental or physical condition. The "Assessment – Resident 2A" form will be used as it is for admission and regularly scheduled resident assessments.
   c. Assessments and audits will be complete by June 15, 2022.

4.
   a. A current assessment for Resident #4 is complete.
   b. For Resident #4 and other current residents, the Wellness Director will conduct an audit to ensure assessments of residents is conducted when they have a significant change in mental or physical condition. The "Assessment – Resident 2A" form will be used as it is for admission and regularly scheduled resident assessments.
   c. Assessments and audits will be complete by June 15, 2022.

DEER TRAIL
ASSISTED LIVING
& MEMORY CARE

5.
   a. A current assessment for Resident #5 is complete.
   b. For Resident #5 and other current residents, the Wellness Director will conduct an audit to ensure assessments of residents is conducted when they have a significant change in mental or physical condition. The "Assessment - Resident 2A" form will be used as it is for admission and regularly scheduled resident assessments.
   c. Assessments and audits will be complete by June 15, 2022.
6. The Wellness Director will assess the current documentation program in use to convey resident conditions consistently. Training on that program will be accomplished with the Wellness staff. If the program is found to be insufficient, the Wellness Director will develop a new program that will meet the requirements of the community's policy as well as Chapter 12.
7. An audit of Memory Care (Level 2) residents will be conducted by the Wellness Director to ensure information regarding each resident's "medical history, level of activity and required needs, current medical status, level of cognition, nutritional needs and requirements, impairments, medication review, and psychosocial needs" is current and accurate. This audit will be complete by June 15, 2022.
8. An audit of all residents regarding any significant change in condition since their last assessment will be conducted by the Wellness Director. Assessments will be updated, and the resident's service plan will be updated if necessary. If the change in condition is deemed to be short-term, appropriate intervention will be implemented. That intervention will be documented, including instructions for staff that are specific for that resident. Those instructions and interventions will be made part of the resident record and will include resident progress, at least weekly, until the condition resolves.

Respectfully submitted,

Jeffrey Smith
Executive Director
Deer Trail Assisted Living