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 07/07/2022

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

(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 05/29/2001. A complaint survey was conducted by Healthcare Licensing and Surveys on 7/7/22. The survey was prompted by complaint intake LIC-22-033.	S 000		
S5024	Ch 12 Sec 7 (i) Assisted Living Facility (ALF) Core Services (i) Adult Protection. (i) The facility must assure that all residents are protected from abuse. This includes the resident's right to be free from verbal, physical, mental, or sexual abuse in accordance with the definition of abuse as stated in Section 4(a) of these rules. (ii) The facility must adhere to written policies and procedures that prohibit the abuse of any resident. These policies and procedures must identify how the facility will screen employees before hiring, ongoing in-servicing of abuse topics with employees, and a protocol that specifies how allegations of abuse will be investigated. Each staff member must be accountable to report any suspicion or knowledge of abuse to the appropriate facility personnel immediately. (iii) The facility is responsible to ensure all allegations of abuse are investigated expediently and that the resident(s) are protected from	S5024		

Accepted POC 9/1/22 @ 2:20PM
Kaitlyn notified. DOC 8/26/22
Hoppenberg RN

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S5024	Continued From page 1 further, potential abuse while the investigation is in progress. (A) Instances of abuse, neglect, or exploitation of disabled adults shall be reported to the sheriff's department, the local police department, or to the department of family services in accordance with W.S. 35-20-103. (B) The facility must ensure that, if necessary, additional authorities are contacted if there is an allegation of abuse, neglect, or exploitation. These additional authorities may include the Wyoming State Board of Nursing, Office of Healthcare Licensing and Survey, and the State Long Term Care Ombudsman. This State Rule and Regulation is not met as evidenced by: Based on review of facility incident reports, resident record review, and staff interview, the facility failed to ensure residents were free from abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) for 2 of 6 sample residents (#2. #3). The findings were: Review of the resident record for resident #2 showed the resident was admitted to the memory care unit on 8/11/2020 with a diagnosis of dementia. Resident's medications included a recent (6/22/22) increase in the doses of divalproex (anticonvulsant) to 250 mg 2 times a day and quetiapine (antipsychotic) 25 mg in the morning and 50 mg in the evening. Review of the resident record for resident #3 showed the resident was admitted to the memory care unit on 10/20/21 with a diagnosis of dementia. Review of a facility incident report submitted to the	S5024		

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S5024	Continued From page 2 Licensing Division on 6/1/22 showed resident #2 was agitated and entering other residents' rooms. The resident was directed back to his/her room, but soon came out of the room again, prompting the facility to remove everything "...from the kitchen counters that the res [resident] could use as weapons that were in easy reach and breakable glass. Resident at one point went to put [his/her] hands on RN when RN was merely talking to [him/her] encouraging [him/her] to go back to bed and RN stopped [him/her] but then [s/he] pushed and pinned this RN to the table. PCA and CNA had to help RN get resident's attention away from RN so I could get out of harms way. Resident was growling at RN and at other aids (sic) as they managed to turn [him/her] and get [him/her] to let go of this RN. [The resident] growled and snarled and then laughed in histaria (sic)." Attempts to interview resident #2 and #3 were unsuccessful. The following concerns were identified: 1. Review of two facility incident reports submitted to the Licensing Division on 6/20/22 showed resident #2 was discovered in the facility dining room standing over resident #3, who was sitting on the floor and had a bloody nose. Resident #3 stated, "He hit me...in this eye and this one, and hit me in the head and all over." Resident #2 admitted to hitting resident #3, and reported s/he had been hit by resident #3 as well. Resident #2 was found to have a bruise forming under the left eye, and had several areas of bruising to his/her left hand. Both residents were sent to the hospital emergency room for evaluation. 2. Interview with the executive director (ED) and the director of nursing (DON) 7/7/22 at 1:40 PM revealed that the injuries to each resident were caused by the other resident. The DON revealed	S5024		

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S5024	Continued From page 3 that resident #2 was found in the dining room, standing over resident #3 and admitted to hitting him/her and being hit. Resident #2 had bruising on the left eye, an enlarged left pupil and injuries to the left hand. At the same time, resident #3 was found on the dining room floor with his/her back to the wall, with a bloody nose and reported being hit by resident #2. Both residents were transported to the emergency room for evaluation. The ED revealed that resident #2 had aggressive behaviors in the past and the agency had tried to find alternative living arrangements but to date, had been unsuccessful.	S5024		

Edgewood – Spring Wind
1072 N. 22nd St.
Laramie, WY 82072

Survey Date: 07/07/2022
Ref: LH-2022-0860

Plan of Correction

Tag: S5024 Ch 12 Sec 7 (i) Assisted Living Facility Core Services

A. Resident 2 and resident 3 were both placed on 72-hour alert charting. Staff instructed to keep close eye on resident 2 and away from resident 3. Resident 3 door locked when he is in there.
B. Resident #2 was moved to closest room to the nurse's station to allow staff to better observe any aggressive behaviors.
C. We have worked close with resident #2 PCP to get correct medication management to assist with residents' aggressive behaviors. On 6/21/2022 Resident's PCP ordered an Increase Divalproex to 250 mg BID Increase Quetiapine to 50 mgs at supper. Since this change we have not experienced the aggressive behaviors we had experienced prior.
D. Clinical Service Director will provide additional training related to dementia and managing aggressive behaviors.
E. If the past experienced aggressive episodes present themselves again, we will proceed with an emergency discharge.

Date of completion: 8/26/2022

Executive Director: _____ Date: 9/1/22