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 03/21/2023

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 on 3/21/23. The survey was prompted by complaint intake(s) WY-LIC-23-008 and WY-LIC-23-015.	S 000		
S5047	Ch 12 Sec 8 (a) Services Which Cannot Be Provided By Level 1 (a) The following services cannot be provided: (i) Continuous assistance with transfer and mobility; (ii) Care of the resident who is unable to feed himself independently and/or; monitoring of diet is required; (iii) Total assistance with bathing and dressing; (iv) Invasive catheter or ostomy care, such as changing of catheter or irrigation of ostomy; (v) Care of resident who is on continuous oxygen, if; (A) Continuous monitoring is required; or	S5047		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kandace Brooks | TITLE: Executive Director | (X6) DATE: 4/10/2023

Accepted POC as revised with Kandace Brooks, ED 4/17/23 @ 4:38 PM. Date of correction 5/8/23
Copenberg RN

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 03/21/2023

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
S5047	Continued From page 1	S5047		

(B) Oxygen is ordered by the physician of physician extender to be titrated based on oxygen saturation levels;

(vi) Care of resident whose wandering jeopardizes the health and safety of the resident;

(vii) Incontinence care by facility staff;

(viii) Wound care requiring sterile dressing changes;

(ix) Stage II skin care and beyond;

(x) Care of the resident with inappropriate social behavior; e.g. frequent aggressive, abusive, or disruptive behavior; and

(xi) Care of resident demonstrating chemical abuse that puts him and/or other at risk;

(xii) Monitoring of acute medical conditions.

This State Rule and Regulation is not met as evidenced by:

Based on observation, review of resident records, and resident, family and staff interview, the facility failed to ensure care required for 2 of 8 sample residents (#1, #4) did not exceed the Level I Assisted Living Facility (ALF) limitations. The findings were:

1. Review of the resident record showed resident #1 was admitted to the assisted living facility on 4/26/22 with a history of a stroke and was bed bound in a hospital bed. The following concerns were identified:

a. Observation of resident #1 on 3/21/23 at

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 03/21/2023

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
S5047	Continued From page 2	S5047		

9:10 AM showed the resident was alert and oriented, was bed bound in a hospital bed and was dependent on others for hygiene and transfers out of bed. Interview with the resident at that time confirmed she/he was not strong enough to stand and could not get out of bed without assistance.

b. Review of the care plan in the resident record, dated 2/1/23, showed "needs some help with bathing...entering and exiting the shower...needs help with transfers (one person) and assistance with walking.

c. Review of a communication note to the medical provider dated 3/13/23 showed "Resident presents with wheezing throughout on auscultation...Resident has increased weakness, max assist of 2 for ADL's and transfers." Further review showed the resident was admitted to hospice services on 3/14/23 for symptom management and a home health aide (HHA) 1 time a week for bathing.

d. Interview with certified nurse aide (CNA) #1 on 3/21/23 at 9:25 AM revealed the resident was bed bound and she was not sure how the resident would be transferred out of the bed if needed.

e. Interview with CNA #3 on 3/21/23 at 11:10 AM revealed the resident was bed bound and required a full bed bath and bed change, while the resident was in the bed, several times a week and it took 1-1 1/2 hrs each time. She further verified that the care provided to the resident was done by the facility staff and if hospice was involved, it was not enough to keep the resident clean and if the resident was transferred out of bed it would take 2-3 people to transfer him/her.

2. Review of the resident record showed resident #4 was admitted to the ALF on 10/30/21 with a history of coronary artery disease and was losing

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 03/21/2023

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
S5047	Continued From page 3	S5047		

weight. The following concerns were identified:

a. Observation of the resident on 3/21/23 at 9 AM showed the resident was in a wheelchair at the dining room table with breakfast but the resident did not eat. Interview with the resident at that time revealed the resident was able to provide his/her name but otherwise did not communicate. An additional observation of the resident at 12:10 PM during lunch showed the same. The resident's daughter arrived at 12:20 PM and began feeding the resident and assisted the resident with fluids.

b. Review of a trending report in the medical record showed a steady decline in the resident's weight. The weight recorded on 1/3/23 was 124.5 lbs, on 1/5/23 121 lbs and a note entered on 1/23/23 showed the resident's weight ranged from 100-105 lbs.

c. Interview with CNA #3 on 3/21/23 at 11:13 AM revealed the resident has been declining and the resident was a 2 person transfer because of weakness and rigidity. In addition the CNA stated she had not seen anyone feeding the resident at meals and knew they were not allowed to do so.

d. Interview with the resident's daughter on 3/21/23 at 12:30 revealed the resident was not eating without assistance today but ate well with assistance. She further verified that she visits daily but just to get the resident to the breakfast table and then leaves. She did not usually come in for lunch but was concerned and came in to check on her that day.

e. Interview with the executive director and director of clinical services on 3/21/23 at 1:15 PM revealed the resident had declined, was on hospice and could benefit from assistance with feeding at meal time.

Plan of Correction for Meadow Wind Assisted Living, March 21st, 2023, survey date.

Tag #S5047

Resident #1 has had services increased with Caring Edge Hospice at this time. Nursing at Caring Edge saw resident 1 time a week and has increased to 3 times a week. Caring Edge is monitoring wounds and providing catheter care for resident. Caring Edge CNA has increased services from 2 times a week to 3 times a week. This CNA and nurse are providing all bathing care for this resident.

Resident #1 care plan has been updated to reflect these services that are provided.

A Caring Edge nurse and therapy have verified that in the event of an emergency resident #1 would be able to stand and pivot to a wheelchair for evacuation. Staff would use a gait belt for safety with the transfer.

Gait belt training will be provided at the all staff meeting on April 18th, 2023. This training will be done by a Caring Edge physical therapist. The training will include safe transfers, and use of the gait belt during transfers.

(By DON) JJ * KB

Any new admission to the facility will be screened using the nursing screening tool to ensure that it is an appropriate admission and will have a care plan done at 30 days, and annually. The resident will be screened for emergency evacuation status as well as transfer assistance needed. Care plans will be updated with any care changes as well and kept on file in the facility.

Resident #4 at the time of the survey has hospice services increased to assist with feeding needs. Residents daughter also agreed to come into the facility and assist her mother with eating all of her meals. Resident has since passed away on hospice services.

(By DON) JJ * KB

Any new admissions to the facility will be assessed for meal assistance needs. In the future if a resident needs assistance with meals above and beyond cutting up foods or cues hospice services will be approached and/or family will be required to provide this assistance to ensure that nutritional needs are met. The resident will be placed on nutrition protocol and will have weight monitored.

This survey and care plan reviews will be reviewed monthly in the Quality Assurance Meetings.

Completion date: May 8th, 2023