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 03/02/2023

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 by Healthcare Licensing and Surveys on 3/1/23 to 3/2/23. The survey was prompted by complaint intakes LIC-23-012 and LIC-23-014.	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 shall, at a minimum, contain the following information: (I) Full name of resident and former address; (II) Date of admission;	S5020		

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	24 MAR '23

5/5/23 - 2:46 pm. I spoke with the administrator, Jeff Smith, and the Plan was accepted with agreed upon changes. The new date of compliance is 5/31/23. EPW 5/5/23

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S5020	Continued From page 1 (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 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	S5020		

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S5020	Continued From page 2 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 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	S5020		

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S5020	Continued From page 3 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. This State Rule and Regulation is not met as evidenced by: Based on review of incident reports and resident records, staff interview, and review of the Healthcare Licensing and Surveys (HLS) incident database, the facility failed to ensure family was notified of accidents or incidents for 1 of 4 sample residents (#1) with incidents. In addition, the	S5020		

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S5020	Continued From page 4 facility failed to ensure the Licensing Division was notified of incidents affecting the the health, welfare and safety of the resident for 2 of 2 incidents reviewed that should have been reported (residents #3, #4). The findings were: 1. Review of facility incident reports showed on 1/18/23 resident #1 had an unwitnessed fall which resulted in 2 small abrasions to the resident's back. The incident report was blank for the section "family member notified:" Review of the resident record showed no evidence the family was notified of the fall. 2. Review of facility incident reports showed on 1/18/23 resident #4 had an unwitnessed fall which resulted in a fracture to the hip. Further review of incident reports showed on 1/13/23 resident #3 had an unwitnessed fall which resulted in surgery on the right hip. The following concerns were identified: a. Review of the HLS incident database on 3/1/23 at 7:13 PM showed neither of the falls with major injury were reported. b. During the exit conference on 3/2/23 at 1:15 PM the administrator confirmed the incidents were not reported.	S5020		
S5054	Ch 12 Sec 10 (a)(iii) Secure Dementia Units *(a) (iii)* Level 2 Direct Care Staff. In addition to meeting all other requirements for direct care staff stated in this Chapter, assisted living Level 2 direct care staff must receive additional documented training in: (A) The facility or units philosophy and approaches to providing care and supervision or persons with severe cognitive impairments;	S5054		

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S5054	Continued From page 5 (B) The skills necessary to care for, intervene, and direct residents who are unable to independently perform activities of daily living; (C) Techniques for minimizing challenging behaviors; (I) Wandering; (II) Hallucinations, illusions, and delusions; and (III) Impairments of senses; (D) Therapeutic programming to support the highest level of residents function including: (I) Large motor activity; (II) Small motor activity; (III) Appropriate level cognitive tasks; and (IV) Social/emotional stimulation; (E) Promoting residents dignity, independence, individuality, privacy, and choice; (F) Identifying and alleviating safety risks to residents; (G) Recognizing common side effects and reactions to medications; (H) Techniques for dealing with bowel and bladder aberrant behavior.	S5054		

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S5054	Continued From page 6 (I) At least one staff member with this specialized training must be available on the unit at all times to provide supervision and care to the residents, as well as to assist the residents in evacuation of the facility. (J) Staff must have at least twelve (12) hours of continuing education annually related to care of persons with dementia. This State Rule and Regulation is not met as evidenced by: Based on review of the staffing schedule and staff interview, the facility failed to ensure that level 2 direct care staff received additional training as required in the regulations and failed to ensure 12 hours of continuing education annually for 6 of 6 employees reviewed (certified nurse aides (CNAs) #1, #2, #3, #4, #5, #6). The findings were: 1. Six employees (CNAs #1 through #6) who were scheduled for memory care (level 2) on the February 2023 staffing schedule were selected for review. Documentation of the additional training required for level 2 staff was requested on 3/1/23. During an interview on 3/2/23 at 8:54 AM the administrator stated he was unable to provide any documentation of training. He stated he thought staff were assigned to complete training, but "it didn't get done." He also confirmed that the 12 hours of continuing education had "fallen off." He stated he would look again for any documentation of training for the 6 employees. On 3/2/23 at 1:12 PM the administrator stated he was not able to find documentation that the six selected employees had received the additional training required for level 2.	S5054		

DEER TRAIL
ASSISTED LIVING
& MEMORY CARE

Response to Survey of March 2, 2023

Version 3 submitted April 28, 2023

ID Prefix Tag S5020

1.
    a. Resident #1 passed in January 2023 and is no longer a resident.
    b. An audit of resident incidents reported in 2023 is complete.
    c. Retraining of the incident reporting policy is complete (see attached).
    d. Deer Trail proposes compliance as of March 31, 2023.
2.
    a. The Wellness Director will meet with the reporting nurse regarding resident incidents within one business day of the incident.
    b. The aspects of the incident will be discussed together, allowing for clarity and a decision regarding the requirement to report to state.
    c. The Wellness Director will report all incidents affecting the health, welfare, and safety of a resident to the Licensing Division within the required timeframe, including for residents #3 and ~~$4~~. #4.
    d. This was implemented March 20, 2023 and will be reviewed during regular Quality Assurance meetings.
    e. Deer Trail proposes compliance with this requirement as of March 31,2023.

ID Prefix Tag S5054

3.
    a. Upon hire, Level 2 Direct Care Staff is provided with "Creating Moments of Joy", the Deer Trail philosophy of providing care for residents with cognitive impairment. This will be documented starting March 20, 2023.
    b. An ongoing training program for Level 2 Direct Care Staff is now in use.
    c. An audit of training is complete. All Level 2 Direct Care Staff are assigned the following courses with a completion date no later than ~~April 28, 2023.~~ 5/31/23.
        - A Day in the Life of Henry: A Dementia Experience
        - About Alzheimer's Disease and Dementia
        - Alzheimer's Disease and Related Disorders: Activities
        - Alzheimer's Disease and Related Disorders: ADL Care
        - Alzheimer's Disease and Related Disorders: Behavior Management
        - Alzheimer's Disease and Related Disorders: Communication
    d. CNAs #1 through #6, as well as all staff not fully trained, are included in this training and will complete the above courses by ~~April 28, 2023~~. 5/31/23.
    e. Further courses will be assigned and completed throughout the year to ensure at least 12 hours of continuing education is accomplished annually.
    f. A monthly report will track progress on these courses and will be reviewed at regular Quality Assurance meetings.
    g. Deer Trail anticipates compliance with this requirement by ~~April 28, 2023.~~ 5/31/23

Respectfully submitted,

Jeffrey Smith
Executive Director
Deer Trail Assisted Living