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 _____	03/12/2025

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 by Healthcare Licensing and Surveys was conducted on 3/12/25 prompted by complaints LIC-25-012, LIC-25-021 and LIC-25-032. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency.	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	S5024		

5/6/25 - 8:18AM - I spoke with the administrator, Kandus Brooks, and let her know the Plan was accepted with an alleged date of compliance of 4/30/25.

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S5024	Continued From page 1 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 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 resident record review, and staff interview, the facility failed to ensure residents were protected from abuse for 1 of 4 sample residents (#1). The findings were: 1. Review of the medical record for resident #1 showed s/he was admitted to the assisted living facility on 10/26/23 and had diagnoses including vascular dementia and bipolar disorder. Review of the medical record for resident #2 showed s/he was admitted to the assisted living facility on 10/3/24 and had diagnoses of Alzheimer's	S5024		

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S5024	Continued From page 2 disease, depression, and anxiety. The following concerns were identified: a. Review of the resident record dated 3/2/25 showed resident #1 was in a manic episode, had a verbal argument, and threatened to hit resident #2. Resident #1 had been locked out of the room earlier in the day by resident #2 which further escalated the situation. Resident #2 then pushed resident #1 to the floor. Resident #1 obtained a dime-sized abrasion to his/her right elbow and multiple bruises to both forearms. b. Review of the care plan for resident #2 showed "At risk for aggression both to and from others during periods of high stress." c. Interview with CNA #1 on 3/12/25 at 2:56 PM revealed resident #1 had been up late the night prior to the incident and resident #2 had not slept well. Resident #2 had taken resident #1's walker, and the CNA went to get assistance to find an activity for resident #2. Resident #1 then stomped on his/her own glasses and resident #2 pushed resident #1 down. Resident #1 received a scratch and bruises on his/her arm. Further interview revealed Resident #2 was taken to his/her room, and resident #1 was moved to Memory Care Unit #1 "for a while." d. Interview with the administrator and clinical services director on 3/12/25 at 11:55 AM revealed resident #1 and resident #2 were roommates, and usually got along with each other. They revealed resident #1 had been manic for several days and had been yodeling, and resident #2 pushed him/her over due to being frustrated. Further interview revealed resident #1's family had been given a 30-day notice to move him/her to a long term care facility due to increased behaviors. 2. Review of the facility policy titled "Abuse	S5024		

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S5024	Continued From page 3 Prevention, Intervention, Reporting and Investigation" dated January 2025 showed "Residents are to be free from verbal, sexual, physical, emotional/mental abuse, neglect, self-abuse/self-neglect, medical neglect, misappropriation of resident property, exploitation, and involuntary seclusion at all times."	S5024		

Plan of Correction for Meadow Wind Assisted Living, March 12th, 2025, survey date.

Tag #S5024

Resident #2 has been moved to another room. Resident #1 does not currently have a roommate in her room. Resident #1 was not issued a 30-day notice however another resident was given a notice opening up a room allowing us to move resident #2 and separate resident #1 and resident #2.

Staff are instructed to redirect resident #2 from other residents in the unit when she is becoming anxious and agitated. Staff to provide residents with alternative activities.

Resident #2 received a medication review and Seroquel was changed to 25mg in morning and noon and Seroquel 50mg at bedtime for increased agitation and aggression. Ativan also started 0.5mg twice a day as needed, and Celexa was increased to 15mg daily.

Staff instructed to redirect residents with aggressive behaviors prior to incident occurring.

Education to be provided to all staff regarding signs of agitation in dementia residents and redirection tactics that can be used to prevent aggressive behavior by 4/30/2025.

In the future residents will be screened further for any previous or current aggression prior to admission and at each care plan annually and as needed.

Any resident with physical aggression will be placed on behavior monitoring which will be reviewed by the Clinical Services Director or Assistant Clinical Services Director weekly for 4 weeks and then bi-weekly thereafter.

Any changes in policy or instances of resident aggression will be reviewed and addressed in the morning manager meeting and monthly during the quality assurance meeting.

Completion Date: April 30th, 2025