PRINTED: 12/16/2009
FORM APPROVED

WDH - Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING _____ B. WING _____	C 11/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE CHEYENNE, WY 82009

(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
SALF	LIC REGS FOR ASSISTED LIVING FACILITIES This State Rules and Regulations is not met as evidenced by: Wyoming Department of Health Aging Division Rules For Program Administration of Assisted Living Facilities. Chapter 12 Section 7. Assisted Living Facility (ALF) Core Services (iv) Frequency of assessment. An assessment must be conducted: (B) Immediately upon any significant change in the resident's condition. This REQUIREMENT was not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to assess significant declines in function for 4 of 9 sample residents (#2, #3, #4, #5). The findings were: Refer to Section 8: Services Which Cannot Be Provided By The Level I Assisted Living Facility Staff, for details related to the failure of the facility to assess significant changes in resident status in the following situations: 1. Record review revealed resident #2 had required routine staff assistance for six months due to increased incontinence and ten and a half months for safety issues regarding falls, confusion, and inappropriate behaviors. Please refer to Section 8 deficiency regarding this resident for further details.	SALF	Section 7. Assisted Living Facility (ALF) Core Services The community will ensure resident assessments are conducted immediately upon any significant change in resident's condition. Corrective actions for residents are listed below. A) Resident #2 is scheduled for transfer to a Long Term Care facility on 12/28/09. For clarification purposes, resident #2's correct admission date was 10/01/2000.	1/25/10

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 12-23-09

STATE FORM 6899 6GLD11 If continuation sheet 1 of 16

Accepted as is. Administration notified on 12/29/09 by LR

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SALF	Continued From page 1 2. Record review and staff interviews revealed that since resident #3 was admitted on 2/4/08, s/he required routine staff assistance regarding incontinence. The resident had also required two staff for assistance with lifts for the last three months. Please refer to Section 8 deficiency regarding this resident for further details. 3. Record review and staff interviews revealed staff were required to provide routine incontinence care for resident #4 for the last six months resident also had frequent falls and inappropriate behaviors for the last three and a half months. Please refer to Section 8 deficiency regarding this resident for further details. 4. Record review and staff interviews revealed that for the last four months, resident #5 required routine staff assistance with incontinence. The resident had safety issues related to increased confusion for at least eleven months, and wandering for the last six months. Please refer to the Section 8 deficiency regarding this resident for further details. Section 8. Services Which Cannot Be Provided By The Level 1 Assisted Living Facility Staff. (a) The following services cannot be provided: (i) Continuous assistance with transfers and mobility; (ii) Care of the resident who is unable to feed himself independently; (vi) Care of resident whose wandering jeopardizes the health and safety of the resident; (vii) Incontinence care by the facility staff; (x) Care of resident with inappropriate social behavior; e.g., frequent aggressive, abusive, or disruptive behavior.	SALF	Resident #3 has been transferred to a Long Term Care facility. Resident #4 has been transferred to a Long Term Care facility. Resident #5 is scheduled to be discharged and transferred to a Long Term Care facility on 12/22/09. B) Director of Assisted Living and RN consulting nurse will audit all remaining resident's charts by 1-11-10 and on an on-going basis to ensure compliance with Wyoming regulations. If resident(s) are identified with significant changes in condition, these residents will be assessed to determine appropriate level of care needed. If resident(s) identified do not meet Assisted Living criteria, appropriate transfer will be coordinated with the resident and/or their responsible party. C) End of shift report is used by care staff and signed off on each shift by the nurse. Nursing and Medication Aide Report is used by used by nursing staff. Director of Assisted Living will review End of Shift Reports and Nursing and Medication Aide Report daily and conduct new assessments for any changes in condition. D) Director of Assisted Living's daily reviews of End of Shift Reports and Nursing and Medication Aide Report will be reviewed monthly during Quality Improvement Program by the DOAL, RN consulting nurse and Executive Director to ensure continual monitoring of resident care needs are being addressed and assessments are being conducted upon changes in condition.	

ff, 12/28/09

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SALF	Continued From page 2 This REQUIREMENT was not met as evidenced by: Based on observation, staff and resident interviews, and medical record review, the facility failed to ensure seven of nine sample residents (#1, #2, #3, #4, #5, #6, #8) who needed a higher level of care had been accurately assessed for appropriate placement. This failure put residents at risk for harm. One resident (#1) was actually harmed due to the facility's failure to comply with this Section 8 requirement. The findings were: 1. Medical record review revealed resident #1 was admitted on 8/31/09 with diagnoses that included Parkinson's disease and dementia. Review of the 8/31/09 Assisted Living Facility (ALF) 102 assessment showed the resident was independent with mobility and had appropriate behavior. However, further review of this resident's record revealed the following concerns: a. Review of the 9/13/09 needs and services plan for elopement showed staff were required to redirect the resident back into the facility with an explanation as to why the resident should not leave the facility without someone else. In addition, the plan required staff to monitor the resident frequently during the day and evening, and check on the resident every two hours during the night. b. Review of a discharge summary from a long term care facility, dated 8/31/09, showed the "pt. remains elopment risk & needs 24 hour supervision." The discharge summary also doucmented that the resident had a history of elopment from both "home & facility." The summary form further documented the resident was easily confused with direction and "Due to	SALF	E) Corporate level staffing will provide monthly on site compliance audits to ensure all resident care, and provide ongoing in-servicing to the Director of Assisted Living on conducting assessments when residents have any significant changes in condition. If audits reveal deficiencies, corporate level staffing will work with Executive Director to ensure appropriate in-servicing and corrections actions are taken. Section 8. Services Which Cannot Be Provided By The Level 1 Assisted Living Facility Staff. Community will ensure accurate assessments are conducted utilizing the ALF 102 Form with emphasis on Section 8 restrictions prior to placement. Corrective actions for the residents are listed below. Internal training on utilization of the ALF Form 102 to ensure potential residents are not admitted if they require care restricted by Chapter 12, Section 8. Services Which Cannot Be Provided By Level 1 Assisted Living Facility Staff has already taken place. If new information arises showing concerns after the admission process occurs, a new ALF Form 102 will be completed to address new concerns.	01/25/10

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SALF	Continued From page 3 this resident needs constant supervision regarding safety." c. Review of narrative charting dated 11/25/09 documented staff were unable to locate the resident. d. Observation and staff interview at the time of the survey showed this resident remained missing from the facility. e. Review of 11/30/09 faxed information from the facility showed the resident was still missing. f. An interview with the administrator on 11/27/09 at 6 PM revealed he did not know why the facility had accepted resident #1 when another facility had made clear the resident had eloped before and was at a high risk for future elopment. The director of nursing (DON) stated the facility admitted the resident because that was the desire of the resident's family. 2. According to the medical record, resident #2 was admitted on 4/10/07 with diagnoses including depression, history of psychosis, and intracranial meningioma. Review of the 6/12/09 ALF 102 showed the resident needed significant assistance or cueing on a regular basis for dressing and personal grooming, was intermittently confused or agitated and required occasional reminders as to person, place, or time, and was occasionally incontinent which required assistance of staff. The following concerns were noted: a. Observation on 11/27/09 at 11:50 AM showed the resident was unaware of being incontinent of urine, and a certified nurses aide (CNA) performed the necessary incontinence care. The CNA then stated incontinence care was routinely done for the resident. b. Review of the 7/17/08 evaluation of fall potential (the only fall evaluation in the record) showed the resident had difficulty with transfers	SALF	Resident #1 was discharged due to death.	

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SALF	Continued From page 4 or needed additional support for ambulation. The evaluation showed the resident was unsafe/unsteady when asked to stand from a chair, walk ten feet, turn and return to the chair. The evaluation also showed the resident was incontinent. The evaluation further showed the resident had dementia which affected his/her balance and mobility. c. Review of the 11/19/08 assessment and service plan showed resident assistants (RA) were required to assist the resident to change incontinent products. Further review showed the RAs were required to assist the resident to undress and put on his/her nightclothing. Review of the 5/11/09 needs and services plan showed caregivers were required to assist the resident with any change in incontinence products when soiled, and were required to encourage/assist the resident to use the bathroom regularly. d. Review of narrative charting showed the resident fell on 1/1/09, 4/7/09, 4/28/09, 6/22/09, 8/28/09, 9/2/09, and 11/16/09. e. During an interview on 11/27/09 at 11:20 AM, the resident was disoriented to time and place. Interviews with facility staff on 11/27/09 at 4:40 PM and on 11/30/09 at 3:10 PM verified that staff had been required to perform incontinence care on a routine basis for this resident for the last five to six months. f. Medical record review showed no documented assessment of the resident's incontinence, falls, or confusion. In addition, there was no evidence the facility had considered a higher level of care for the resident. 3. According to the medical record, resident #3 was admitted to the facility on 2/4/08 with diagnoses including dementia. Review of the ALF 102 assessment dated 6/26/09 showed staff were required to provide significant assistance or	SALF	A.) We will take the following admission steps as our plan of correction: 1) All resident admissions will be reviewed by the RN consulting nurse 2) Prior to the admission of any resident the DOAL will discuss any cognitive concerns with the Corporate Director of Dementia Services 3) A corporate representative will make monthly visits to monitor compliance with admissions. Resident #2 is scheduled for transfer to a Long Term Care facility on 12/28/09. Resident #3 has been transferred to a Long Term Care facility.	

RR 12/29/09

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SALF	Continued From page 5 cueing to the resident on a regular basis for dressing and personal grooming. The ALF 102 assessment also showed staff were required to provide total assistance for the resident with bathing. The ALF 102 assessment also documented that showed staff were required to "occasionally" provide incontinence care to the resident. The following concerns were noted: a. Observation on 11/27/09 at 2:40 PM revealed the resident was being toileted by a CNA. While the resident was not incontinent, the aide stated the resident was often incontinent and staff were routinely required to perform incontinence care for this resident. She further stated that two staff members were needed in order to assist the resident up to his/her walker from the toilet, bed, or chair. b. Review of the 7/17/08 and 10/9/08 evaluations of fall potential showed the resident had issues with confusion, anxiety, disorientation, and wandering. The evaluations also documented the resident had dementia. Review of the 5/11/09 needs and services plan showed staff were required to provide total assistance with wandering, and all staff had to be informed of this resident's wandering behavior. The plan also showed staff were required to supervise the resident and be aware of the resident's whereabouts at all times. Review of the 1/9/09 assessment and service plan showed the resident was incontinent of bladder and staff were required to cue the resident to change incontinence products, then empty the trash can afterward. The assessment further showed staff were required to orient the resident to time and place in the facility daily, and stated the resident would get confused and want to go "home." c. Review of narrative charting showed an elopement concern documented on 8/7/09 at	SALF		

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SALF	Continued From page 6 3:50 PM, which showed the resident was found wandering down the hall carrying hangers of clothes, purse, and pair of pajamas and was "going home for the weekend." Further review of narrative charting showed inappropriate behavior documented on the following dates: On 2/21/09 the resident returned to the dining room very confused. On 8/23/09 at 10:40 AM the resident abruptly fell asleep during breakfast and his/her face fell into the plate. On 8/23/09 at 12 MN the resident was documented to be very confused. The record showed the following documentation concerning safety and staff repositioning assistance: on 1/4/09 at 6:05 PM, staff found the resident sitting on the floor. On 9/5/09 at 5:27 AM the resident fell. On 9/21/09 at 11:45 AM bruising to the resident's left forearm was discovered by staff, the resident was confused, and did not remember where the bruising came from. On 10/15/09 at 10:15 PM the resident was found by staff laying half in and half out of his/her shower. On 11/15/09 at 9:30 AM the resident tried to sit down and missed the chair. On 11/15/09 at 1:15 PM staff were reminded that the resident required assistance with any transfers. Further review showed that on 8/5/09 at 12 AM the resident was incontinent and staff provided incontinence care. d. Interview with a facility staff member on 11/27/09 at 4:40 PM revealed the resident had been intermittently confused and incontinent of urine since admission on 2/4/08. The interview also revealed staff had been required to assist this resident with incontinence care since admission. The staff member also stated two staff were required to lift and reposition the resident. The staff member stated this physical assistance had been necessary for approximately the past three months. Interview with another staff member on 11/30/09 at 3:10 PM verified staff had been required to assist this resident with	SALF		

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SALF	Continued From page 7 incontinence care for at least the last seven months. The staff member also reported two staff were required to lift and reposition this resident for the last three months. e. Medical record review showed no assessment of the resident's wandering behavior, incontinence, falls, or confusion. In addition, there was no evidence the facility had ever considered a higher level of care for this resident. 4. Medical record review revealed the most recent ALF 102 assessment for resident #4 was dated 6/26/09. The assessment indicated the resident required only occasional supervision during meals, was occasionally incontinent and only needed occasional assistance, had appropriate behaviors, and was able to transfer with only stand-by assistance. Interviews with facility staff revealed the resident had not been able to manage his/her own incontinence care for at least the last six months. The staff went on to say the resident fell frequently and needed the assistance of one person to stand. The following concerns were noted: a. Medical record review revealed the following in the narrative charting: 1. The resident fell on the following dates: 7/28/09, 8/1/09, 8/5/09, 9/4/09, 9/21/09, and 11/11/09. 2. The resident required assistance with incontinence care on the following documented dates: 7/10/09, 8/10/09, 8/13/09, 8/24/09, 8/25/09, 9/1/09, 11/20/09, and 11/27/09. 3. The resident displayed inappropriate behaviors on the following days: On 7/18/09, the resident was found crawling on the floor. On 7/24/09, the resident threatened to throw a chair at a staff member. On 7/27/09, after	SALF	Resident #4 has been transferred to a Long Term Care facility.	

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SALF	Continued From page 8 being instructed not to pick or blow his/her nose, the resident continued the behaviors which led to two trips to the emergency room by ambulance for severe nosebleeds. On 8/5/09 the resident attempted to hit a caregiver. On 8/24/09 the resident was combative, and on 8/27/09 the resident attempted to hit a nurse. b. Observation on 11/27/09 at 11:10 AM revealed the resident ambulated very slowly behind a wheelchair that was being used by the resident as a walker. Interview with the resident at that time revealed the resident was oriented to his/her name, but could not state day, time, year, or location. The resident had a pendant around his /her neck that had a button on it that the resident could push if s/he needed assistance. When the resident was asked what the pendant was for, he/she verbalized not knowing what it was for. Further observation at 12:10 PM revealed the resident sitting at a table in the dining room. The resident attempted to lick salad dressing out of a small container. S/he picked up a fork and stabbed at an empty plate then put the fork in his/her mouth. The resident did succeed in getting two bites of salad in his/her mouth with his/her fingers. When the entree of pot pie, beans and bread were served at 12:25 PM, the resident had backed his/her wheelchair away from the table and had his/her head down in his/her lap. At 12:35 PM, the nurse cued the resident to sit up and eat. The resident did not respond, and the nurse left. At 12:55 PM, a CNA cued the resident to eat. When s/he did not respond, the resident was taken from the dining room in the wheelchair and placed in the TV room. The resident had not eaten any of the entree or consumed any fluids. At 1:35 PM, the resident was approached by an activity staff person. The resident remained slumped over in the wheelchair, and the activity staffer left. Upon request of the surveyor, at 1:45	SALF		

BB 12/29/09

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SALF	Continued From page 9 PM, a CNA wheeled the resident from the TV room to the bathroom in the resident's room. The resident was assisted to stand and turn and the CNA pulled the resident's pants and disposable brief down and the resident sat on the toilet. The resident's brief was soaked with urine. The resident was observed to require total assistance with changing his/her brief and performing perineal care. c. Interviews with facility staff on 11/27/09 at 4:40 PM and 11/30/09 at 3:10 PM verified they were required to assist the resident with incontinence care and that this had been necessary for the last six months. d. Medical record review showed no assessment of the resident's behaviors, ability to eat independently, incontinence, or falls. In addition, there was no evidence the facility had considered a higher level of care for this resident. 5. According to the medical record, resident #5 was admitted to the facility on 6/18/08 with diagnoses, including dementia. Review of the 5/29/09 ALF 102 assessment the resident was intermittently confused and staff were occasionally required to reorient the resident to person, place, and time. The ALF 102 assessment also documented the resident was continent of bowel and bladder. However, the following concerns were noted with the current status of this resident: a. Review of the 5/11/09 needs and services plan showed staff were required to provide reassurance and comfort to this resident regarding fears, confusion, or paranoia. The record also showed staff were required to remind/assist the resident with completion of activities of daily living and other daily activities if the resident became forgetful or became	SALF	Resident #5 has been transferred to a Long Term Care facility.	

8b 12/29/09

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SALF	Continued From page 10 distracted Review of the 8/21/09 service plan meeting summary showed staff were required to monitor the resident for incontinence and dressing. b. Review of the narrative charting showed elopement concerns documented on the following dates: On 6/6/09 at 12:25 PM the resident was agitated, confused, and tried to leave the building twice "looking for daughter." On 6/23/09 at 12:35 PM a staff member that was driving by the facility found the resident on the corner of a major intersection and brought the resident back to the facility. On 7/29/09 the resident was "a little confused" and wandered throughout the building, requiring staff to redirect the resident frequently. On 8/8/09 at 11 AM the resident told staff that his/her parents lived up the street and "I might walk over to see them." Staff were required to redirect and monitor the resident frequently at that time. On 8/16/09 at 2:45 PM the resident was found in another resident's room. On 9/11/09 at 8:30 PM the pharmacy delivery person reported the resident tried to get into his truck, and two CNAs redirected the resident back into the building. On 10/3/09 at 5:30 PM the resident was found by staff leaving the front door, and staff redirected the resident and explained that it was "cold outside." On 10/4/09 at 8 PM the resident was found walking toward a major roadway "where there was traffic." Further review showed inappropriate behavior documented on the following dates: The resident was involved in an altercation with another resident on 1/5/09 at 11:30 AM, which required staff intervention. On 3/4/09 at 9:30 PM the documentation showed the resident remained confused. On 3/9/09 at 7 PM the resident was "very agitated most of the shift-wanting to leave." On 5/28/09 at 7:30 PM the resident was in the dining area, unscrewing salt shaker tops and pouring salt on tables. When	SALF		

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	ALF008	A. BUILDING _____ B. WING _____	C 11/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE CHEYENNE, WY 82009

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SALF	Continued From page 11 staff intervened, the resident grabbed a staff member's arm and started yelling at her. The staff member required assistance from other staff to free her arm. On 7/27/09 at 10:15 AM the resident was observed by staff as "half dressed". When staff redirected the resident to her room, the resident stated s/he wanted to look for his/her deceased spouse. On 8/30/09 the resident attempted to leave for breakfast with no pants on. The resident then became aggressive with staff when asked to return to his/her room. The resident became aggressive on 9/18/09 at 9:31 PM and threatened to slap staff when they attempted to toilet the resident. On 9/18/09 at 9:50 PM the resident impeded the hair stylist from leaving the hallway. The resident then became more agitated and stated, "I will slap you, slap, slap." The resident also stated, "I need to go home to my small children." On 9/22/09 at 8:08 PM the resident was "destructive and disturbing during dinner." On 9/28/09 at 10:05 PM the resident pushed another resident and was convinced that resident was a relative. On 9/30/09 at 7:40 PM the resident pushed a CNA and hit her arm while the CNA attempted to take the resident's wet clothing off. On 10/21/09 the resident was involved in a verbal altercation with two other residents in the dining area. Record review revealed the following documentation concerning incontinence: On 8/22/09 at 1:30 PM the resident was visibly incontinent of urine walking down the hallway, and staff were required to provide incontinence care. On 9/5/09 the resident was incontinent of urine "despite toileting by CNAs" and staff were required to provide incontinence care. On 9/6/09 at 6:15 PM, 9/30/09 at 7:40 PM, 10/21/09 at 12 Noon, and 11/15/09 at 1:50 PM, the resident was incontinent of urine and required staff to provide incontinence care. Continued review showed the resident fell or was	SALF		

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SALF	Continued From page 12 found on the floor on 2/10/09 at 10:15 AM, 7/27/09 at 10:15 AM, 11/1/09 at 2 AM, 11/4/09 at 10:10 PM, and 11/27/09 at 12:40 PM. c. Interview with facility staff members on 11/27/09 at 4:40 PM and on 11/30/09 at 3:10 PM revealed they had been required to perform routine incontinence care for this resident for the last four months. d. Medical record review showed no assessment of the resident's elopement behavior, inappropriate behavior, incontinence, or falls. In addition, there was no evidence the facility had considered a higher level of care for the resident. 6. Medical record review for resident #6 revealed an admission date of 10/31/09 and an ALF 102 assessment dated 11/6/09, which indicated the resident required only occasional assistance during meals, was continent of bowel and bladder, and was intermittently confused. Interviews with facility staff revealed the resident currently wandered the facility, did not recognize staff, could not find his/her room, the dining room or bathrooms, and seemed demented. The staff had to dress the resident and take the resident to the bathroom. In addition, the following specific concerns were noted: a. Medical record review revealed the following documentation in the narrative charting: 1. The resident displayed inappropriate behavior on the following dates: On 10/31/09, the resident was wandering in the halls looking for babies. Later that day, the resident poured a whole cup of coffee on the table. On 11/1/09, the resident was wandering the halls at 5:45 AM. Later s/he attempted to put a sock on his/her head and was found talking to his/her reflection in a mirror. The resident also mistakenly thought the elevator was the	SALF	Resident #6 has been transferred to a Long Term Care facility.	

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SALF	Continued From page 13 bathroom and started to pull down his/her pants. The resident was unable to stay seated during the evening meal and, " ...unable to complete any simple task without extensive cueing and physical guiding." On 11/2/09 and 11/3/09, the resident remained confused and lost and continued to wander throughout the facility. On 11/5/09, the resident became angry and spit out his/her medications. On 11/6/09, the resident was very confused, unable to do tasks without physical assistance and continued to talk to his/her reflection in a mirror or window. On 11/16/09, the resident was seen disrobing at the end of a hall and needed constant supervision. On 11/25/09, the resident again was found wandering around the facility, lost. A CNA documented the resident was found playing with her/his own feces and feces was found on the counter in the resident's bathroom. 2. According to medical record review, it was documented the resident needed repeated cueing during meals on 10/31/09, 11/1/09, 11/2/09, and 11/19/09. b. Observation on 11/27/09 at 11:15 AM revealed the resident sitting in the TV room. Interview at that time with the resident revealed the resident was orientated to name only. When the resident was asked what the pendant around his/her neck was for, the resident could not say what it was for. During the interview, someone down the hall knocked on a door. The resident yelled, "Come in." jumped up and walked down the hall where the knock came from. Over the next several minutes, the resident wandered down the hall and into the dining room talking to his/herself, and at one point, stopped to talk to his/her reflection from a mirror hanging in a hall. At 11:45 AM, the resident was directed by staff into the dining room and instructed to sit at a table. There was another resident at the table.	SALF		

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SALF	Continued From page 14 When salad was served, resident #6 just sat and looked at the salad. The other resident at the table got up, walked around to where resident #6 was sitting, put a napkin in resident #6's lap and put a fork in his/her hand. At that point, resident #6 started to eat the salad. Further observation revealed resident #6 often missed his/her mouth and there was spillage on the table and floor. Several times during the meal, resident#6 reached to pick up food off the floor, but stopped when the tablemate said, "No." After the dessert was served, the tablemate left the dining room. Resident #6 again reached for spilled food on the floor and put it in his/her mouth. At 12:50 PM, the resident stood up and started walking around the dining room. Interview with the resident at that time revealed the resident could not remember what s/he ate at the meal. c. Interview with facility staff members on 11/27/09 at 4:40 PM and 11/30/09 at 3:10 PM established that they had been required to assist the resident with incontinence care since his/her admission on 10/31/09. d. Medical record review showed no assessment of the resident's wandering behavior, inappropriate behavior, or inability to eat independently. 7. Medical record review on 11/27/09 for resident #8 revealed an ALF 102 assessment dated 11/3/09 that documented the resident was occasionally incontinent and was able to transfer self with stand-by assistance. Interviews with facility staff revealed the resident had required assistance with incontinence care since admission on 11/4/09 and could not stand up without physical assistance. The following concerns were noted: a. Medical record review revealed a narrative	SALF	Resident #8 was transferred to a hospice facility. B) Director of Assisted Living will audit all remaining resident's charts. If resident(s) are identified that do not meet Level 1 Assisted Living criteria, appropriate transfer will be coordinated with the resident and/or their responsible party. C) ALF Form 102 and Level of Care Assessments on all new residents will be reviewed monthly during Quality Improvement Program review to ensure continual monitoring and accuracy of assessment process on all new residents. D) Executive Director will ensure through Quality Improvement Program oversight that ALF Form 102's and Level of Care Assessments are accurately completed prior to placement to ensure new admits are appropriate for Level 1 Assisted Living. Additionally, Executive Director will ensure that if previously un-known care beyond Level 1 Assisted Living abilities arises after the admit, a new ALF 102 will be completed and proper resident transfer is initiated and completed.	

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SALF	Continued From page 15 dated 11/25/09 that showed the resident had been incontinent of urine in bed and had required assistance with changing clothes and perineal care. Observation on 11/27/09 at 2:25 PM showed facility staff cued and assisted resident to the bathroom. The resident's disposable brief was dry, but the resident needed assistance in wiping properly after voiding in the toilet. b. Further observation of the resident on 11/27/09 at 2:25 PM confirmed the resident could not go from a sitting to a standing position independently. Facility staff had to physically assist the resident to a standing position. c. Interview with facility staff members on 11/27/09 at 4:40 PM and on 11/30/09 at 3:10 PM revealed they had been required to assist the resident with incontinence care since his/her admission on 11/4/09. d. Medical record review showed no assessment of the resident's incontinence or lack of independence with positioning. During an interview with the administrator, the corporate nurse, and the DON on 11/27/09 at 6 PM, the DON stated the facility had not completed an assessment for significant change for residents #2, #3, #4, or #5. During the interview the surveyors presented information to show that residents #1, #2, #3, #4, #5, #6, and #8 required services from staff that a Level I assisted living facility was not licensed to provide. The administrator and DON did not disagree with the information and did not provide any other information when given the opportunity.	SALF		