LSC-10-006
10-008

PRINTED: 06/15/2010
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 06/09/2010

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: Program administration of Assisted Living Facilities Chapter 12. Section 7. Assisted Living Facility (ALF) Core Services. (a) The assisted living facility core services include the following: (iv) Frequency of assessment. An assessment must be conducted: (B) Immediately upon any significant change in the resident's mental or physical condition; (v) Use of the assessment. (A) The results of the assessment are used to develop, review, and revise the resident's individualized assistance plan. (vii) The assistance plan shall be reviewed and updated by the RN at least annually or when a significant change occurs, with input from direct care-givers, the resident, and others as designated by the resident. This standard is not met as evidenced by: Based on medical record review, and staff and resident interviews, the facility failed to ensure 2 of 2 sample residents (#23, #55) who were identified with changes in condition were assessed related to their new care needs. The findings were: 1. Interview with resident #23 on 6/9/10 at 11:40 AM revealed the resident was confused. The resident was unable to recall facts about her stay at the facility and his/her life. The resident expressed that s/he was confused and often	SALF	Section 7. Assisted Living (ALF) Core Services. The facility will ensure that resident assessments will be conducted immediately upon any significant change in resident's mental or physical condition and the assistance plan shall be reviewed and updated by the RN at least annually or when a significant change occurs, with input form direct caregivers, the resident, and others as designated by the resident. A) The DON, RN will conduct an assessment immediately upon significant change of residents mental or physical condition. Administrator to monitor for compliance. Quality audit review team to meet quarterly to monitor for compliance. B) The DON, RN will follow the communities policy which states level of care assessments will be completed upon admission, 30 days after admission, quarterly, and upon any change of condition. Administrator will monitor for compliance. Quality audit review team to meet quarterly to monitor for compliance.	6/23/10

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Admin — (X6) DATE

RECEIVED
Wyoming Dept of Health
JUN 25 2010
Office of Healthcare Licensing and Surveys

STATE FORM 6899 YTIN11 If continuation sheet 1 of 4

Accepted on 7/9/10 by Loralee Rich
message provided to Donald Green, admin.

Hand Delivered

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SALF	Continued From page 1 didn't understand what was happening. Interview with CNA #1 on 6/9/10 at 11:50 AM revealed the resident had become more confused in the past four days. She stated the resident was trying to get into other resident's apartments, couldn't remember where the dining room was, and had reported dogs and cats were taking over her room. The following concerns were identified: a. A 6/6/10 nursing note showed the resident was put on 15 minute checks due to increased confusion, wandering, wanting to go to Canada, and taking other confused residents outside with him/her. The following note showed the resident's family was notified of the 15 minute checks for the resident's safety. b. Record review failed to show a new elopement risk assessment had been completed. The most current elopement risk assessment in the record was dated 4/26/10 and showed the resident was not at risk. In addition, there was no evidence there had been reassessments of the resident's functional ability and mental status since the change in condition. Furthermore, there were no updates to the resident's care plan. c. Interview with the director of nursing (DON) on 6/9/10 at 3 PM revealed she was aware of the resident's increased confusion. The DON stated the physician had been notified, and new medications were ordered on 6/7/10. The DON stated they were waiting for laboratory results to rule out a urinary tract infection. The DON stated new assessments should have been completed related to the resident's change in condition, and the resident's care plan should have been updated. 2. Interview with resident #55 on 6/9/10 at 11:25 AM revealed s/he was being treated with antibiotics for a urinary tract infection. The resident stated s/he had an indwelling urinary	SALF	1) Resident #23- Family has been given less than (30) days written notice to transfer Resident #23 to a higher level of care as Resident #23 imposes an imminent danger to them self because of the increased confusion, wandering, and is an elopement risk. Resident #23- Family has hired Home Instead to provide 24 hour supervision until they can find placement and transfer Resident #23 to an Alzheimer's care unit. Significant changes should have been addressed. State guidelines and company policies will be complied with. Assistance plan has been updated. 2) Resident # 55- Assistance plan has been updated and Resident #55 has been assessed and is appropriate to provide own catheter care. Catheter care Education has been conducted with Resident #55 and written catheter care instructions have been provided to Resident #55.	6/23/10

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SALF	Continued From page 2 catheter that s/he had been caring for independently for the past month. The resident stated s/he had experienced a few accidents with the catheter bag popping open and spilling its contents. The resident stated s/he did not have any written instructions on how to care for the catheter and stated that having those instructions would be helpful. Medical record review showed there was no assessment done to determine the resident's level of function or his/her ability to take care of the catheter. In addition, the catheter was not mentioned on the resident's care plan, which was dated 4/22/10. Interview with the DON on 6/9/10 at 3 PM revealed the resident came back from the hospital with the catheter, which was required due to urinary retension. The DON further stated the resident should have been assessed to ensure s/he was independent in caring for the catheter. In addition, the DON acknowledged the care plan needed to be updated. Section 7. Assisted Living Facility (ALF) Core Services. (i) Adult Protection. (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) (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. This	SALF	Section 7. Assisted Living Facility (ALF) Core Services. (i) Adult Protection. The facility will adhere to written policies that prohibit the abuse of any resident. The facility will ensure that instances of abuse, neglect, or exploitation of disabled adults will 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. A)DON will conduct in servicing on abuse topics and reporting maltreatment of vulnerable adults with employees during new hire orientation and ongoing. Administrator to monitor for compliance. Quality audit review team to meet quarterly to monitor for compliance. B)Facility policy and procedure related to reporting that was revised on 9/17/08 has been amended to address the reporting requirement pursuant to W.S. 35-20-103.	6/23/10

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SALF	Continued From page 3 standard is not met as evidenced by: Based on review of facility investigation, policy and procedure review, and staff interview, the facility failed to ensure investigations were thorough and that the required authorities were notified for 1 of 1 investigation reviewed. The findings were: Review of the facility's investigation log revealed there had been one investigation conducted in the past four months. Review of this investigation revealed it was related to a reported incident of alleged verbal abuse on 5/6/10 between a resident and a CNA. Review of the documentation revealed the investigation was incomplete. The investigation failed to include an interview with the alleged victim or another resident who witnessed the exchange. Interview with the regional manager on 6/9/10 at 3:40 PM revealed these individuals had been interviewed; however, the questions and responses were not recorded because the residents had dementia and were not considered credible. In addition, the manager stated DFS or local law enforcement was not notified of the allegation of abuse. Review of the policy and procedure related to reporting showed it was revised on 9/17/08 and failed to address the reporting requirement pursuant to W.S. 35-20-103.	SALF		