POC accepted 11/16/12 JC

PRINTED: 09/27/2012
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF010	A. BUILDING _____ B. WING _____	C 09/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF EVANSTON	1949 WEST UINTA STREET EVANSTON, WY 82930

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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. (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(e) 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 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. (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,	SALF	The facility will adhere to our written Abuse and Neglect Policy and Procedures: Bee Hive Homes of Evanston is committed to providing a safe environment for clients, employees, and other individuals who visit or are associated with the facility. It is the responsibility of all employees to provide an environment where individuals feel they can trust the safety of their environment. Psychological, sexual, financial, verbal, and physical abuse and /or neglect or exploitation of any individual who receives services from this facility or is associated with this facility will not be tolerated. All employees, contract personnel, and volunteers must report any allegations or observations of possible abuse, neglect, and/or exploitation. Failure to do so will result in disciplinary action against the employee, contract personnel, and/or volunteer who had knowledge of an incident and failed to make such a report. Any actual or suspected acts of physical and/or verbal abuse and/or exploitation will be reported to the appropriate authorities and a thorough investigation will take place. Procedure: 1. Contact the Facility Director. 2. Contact Department of Family Services/Police Department. 3. Contact WY Healthcare Licensing and Survey 4. Contact Ombudsman. 5. Write up the Incident/Accident Report.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Owner — (X6) DATE: 11/15/12

Charge to POC per email from Kevin Dearing received on 11/16/12 Janice Cole 10 MRC

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SALF	Continued From page 1 Office of Healthcare Licensing and Survey, and the State Long Term Care Ombudsman. This REQUIREMENT was not met as evidenced by: Based on review of incidents, staff interview, and policy and procedure review, the facility failed to ensure 2 of 2 allegations of abuse or neglect were thoroughly investigated and reported to Healthcare Licensing and Surveys (HLS). The findings were: Review of the facility's "Abuse and Neglect Policy and Procedure" (April 2012) revealed "Any actual or suspected acts of physical and/or verbal abuse and/or exploitation will be reported to the appropriate authorities and a thorough investigation will take place." The following concerns were identified: a. Review of an incident report dated 7/29/12 revealed resident #3 was found on the floor with a cut above his/her eye. The resident stated that resident #1 knocked him/her down and hit him/her. The incident report also documented that resident #4 said that resident #1 had exposed his private parts to the residents. Further review showed the police were notified, but HLS was not. In addition, there lacked evidence a thorough investigation was completed. During an interview on 9/12/12 at 5:15 PM, the assistant manager stated she was not sure why the incident was not reported to HLS. On 9/13/12 at 9:25 AM licensed practical nurse (LPN) #1 stated she was in the office when the incident occurred. She stated she did not see resident #1 hit resident #3, but stated the resident did expose himself to the other residents. She stated the police were notified of the allegation, but HLS was not.	SALF	6. Director will do the following: a. Notify Resident's Family. b. Director would suspend employee immediately and employee would be on suspension during the investigation. c. Director would gather information from involved resident, from the suspended employee, and witnesses. A summary report would be written by the Director on findings. d. Send Report to State of Wyoming Board of Nursing and Wyoming Office of Healthcare Licensing and Surveys. e. The Director would coordinate action to be taken against suspended employee with Department of Family Services, Police Department and Ombudsman. f. Actions taken will depend upon the investigation results which could be having the employee terminated or the employee could be brought back to work under supervision for a set period of time. g. A final report would be written and sent to appropriate authorities.	11/16/20

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SALF	Continued From page 2 5. Review of an incident report dated 8/27/12 revealed resident #1 was found on the floor. The resident was taken to the emergency room by ambulance. Review of a "complaint form" dated 8/28/12 revealed the emergency room (ER) staff called certified nurse aide (CNA) #1 and stated the resident had been "badly taken care of." During an interview on 9/12/12 at 4:25 PM, the assistant manager stated CNA #1 told her about the complaint from the ER. She stated the next day, the Department of Family Services (DFS) was involved and was investigating an allegation of neglect for resident #1. She stated she did not notify HLS of the allegation. She further stated the manager was out, and she wasn't aware that HLS needed to be notified of allegations. Further review of documentation showed no evidence the facility had completed a thorough investigation into the allegation of neglect. Section 8. Services Which Cannot Be Provided by The Level I Assisted Living Facility Staff (a) The following services cannot be provided: (vii) Incontinence care by facility staff; (x) Care of the resident with inappropriate social behavior, e.g., frequent aggressive, abusive, or disruptive behavior. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff and resident interviews, and review of incident reports, the facility failed to ensure that 2 of 2 sample residents (#1, #2) did not require more assistance than staff were allowed to provide in accordance with the regulations. The findings were: Review of the ALF 102 dated 4/9/12 showed	SALF	The staff has also been notified that if they observe any problems between residents that they need to separate the residents and again report this concern to the Director. The Director will take appropriate actions at that time by following the Abuse and Neglect Policy and Procedures. An In Service on Abuse and Neglect was held with facility staff in June 2012 and another In Service is scheduled for November 18, 2012. The Director will review all incidents from September 14, 2012 to November 15, 2012 for any suspected abuse. If there are any incidents of alleged abuse, the director will follow the above policy. Compliance with the Abuse and Neglect Policy will be monitored by the facility's Quality Assurance program. The Director will be Responsible for compliance with this standard. Bee Hive Policy and Procedure Manual, Section H, #7 & #8 states: 7. [Director will] complete an investigation whenever there is reason to believe that a resident has been subject to abuse, neglect, or exploitation. 8. [Director will] report all suspected abuse, neglect, or exploitation in accordance with Section 62A-3-3-2, and document appropriate action if the alleged violation is verified. Resident #1 is no longer living in the facility	12/5/20 12/9/201 12/10/20 11/30/12 11/7/201

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SALF	Continued From page 3 resident #2 was occasionally incontinent and needed occasional help to clean him/herself. Observation on 9/12/12 at 2:10 PM the resident was on the toilet. At 2:12 PM CNA #2 came into the bathroom and the resident stated she needed help. The CNA checked the pad in the resident's underwear and stated it was wet. She removed it, and got another pad for the resident. The resident then stood up, and the CNA wiped and cleaned the resident. The CNA then pulled up the resident's pants. During an interview on 9/12/12 at 2:20 PM, the resident stated staff helped him/her in the bathroom, including wiping. During an interview on 9/12/12 at 3:25 PM, CNA #1 stated the resident required assistance with incontinence care. Observation on 9/13/12 at 8:45 AM revealed CNA #3 wiped the resident when s/he stood from the toilet and then pulled his/her pants up. On 9/13/12 at 9:25 AM, LPN #1 stated the resident needed assistance with changing her incontinence pad and wiping. Review of the day shift CNA duties sheet showed the following instructions for the resident "...barrier cream on [his/her] bottom whenever you change [his/her] Attends. Use wet wipes- no toilet paper." Review of the 2567 for a previous survey dated 2/27/12 showed this same resident was written for requiring care beyond what staff were supposed to provide. Review of the medical record showed resident #1 was no longer in the facility. Notes showed on 9/3/12 he was in the hospital, and then a note dated 9/7/12 showed he was now in a nursing home. However, review of the medical showed the following documention which indicated the resident required more care than was allowed in the month leading up to his discharge: a. Review of an incident report dated 7/29/12 showed resident #1 exposed himself to some	SALF	The staff has been notified that Resident #2 has to do more for herself when it comes to her incontinence care. A Procedure has been written in regards to what our staff can do in regards to incontinence care, and the staff is implementing these changes with Resident #2. Staff will be regularly monitoring Resident #2 to ensure compliance with the standard. Policy of Hive Homes: Those residents who require incontinence care must adhere to the following regulations: • The resident must be able to get themselves to the bathroom by themselves (they can use their walker or wheelchair). Resident must be able to pull their pants and incontinence brief down by themselves and remove them, if they are soiled. Resident must be able to clean themselves and apply any creams that have been ordered for them to apply to certain personal areas. • The resident must be able to put on their incontinence brief and pad, if needed, by themselves and redress themselves. • The resident must be able to get out of the bathroom by themselves. • Stand-by assistance by staff is allowed. The staff will conduct an assessment of all current residents to ensure they are able to comply with the above standard. Compliance with the Incontinent Care Policy y will be monitored by the facility's Quality Assurance program.	11/30/12 11/12/20

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SALF	Continued From page 4 female residents. A communication sheet dated 7/31/12 showed the facility was going to try suspenders with the resident to keep him from exposing himself. The note also said "you will have to help him go to the bathroom. Watch so he doesn't pee on his floor in his room." b. 8/4/12-" pulled pants down and played with himself. Then this morning wandered the halls naked." c. 8/13/12-"urinated all over himself...I changed him and cleaned him up and he is wearing an Attend." d. 8/21/12- "has been urinating on himself and has to be changed and cleaned up." e. A note dated 8/27/12 showed the CNA put two Attends on the resident on 8/26/12 because he was having issues with diarrhea. During an interview on 9/12/12 at 4:25 PM, the assistant manager stated the resident had declined and exhibited sexually inappropriate behaviors and started urinating on himself. She stated the facility had "struggled" with him and had been trying to work with the sister on finding another placement. However, when asked if the facility had issued a notice of discharge because the resident was no longer appropriate, she replied "no."	SALF	In regards to complaints or allegations of abuse or residents by other residents, the stated Abuse and Neglect Policy and Procedures are in place. If residents are unable to comply or it has been verified that they have abused or sexually harassed other residents, the resident will be immediately issued a notice of discharge. The Director will be Responsible for compliance with this standard.	11/16/20