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WY Dept of Health
NOV 16 2012
Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF27	A. BUILDING _____ B. WING _____	10/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONDELL HEIGHTS RETIREMENT COMMUNIT	106 E MAIN STREET NEWCASTLE, WY 82701

(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: The Initial Assisted Living Facility (ALF) Health and Life Safety Code survey was conducted by Healthcare Licensing and Surveys (HLS) on 10/24-25/12. The survey revealed the facility was out of compliance with the Rules and Regulations for Program Administration (Chapter 12) of Assisted Living Facilities. Chapter 12, Section 7. Assisted Living Facility (ALF) Core Services. (b) Resident Assessment and Services. (i) The completion of the ALF 102. (I) The ALF 102 is only valid if completed within forty-five days prior to admission This REGULATION was not met as evidenced by: Based on record review and staff interview, the facility failed to complete the ALF 102 prior to admission for 1 of 3 (#1) residents. The findings were: Review of resident record #1 revealed the resident was admitted to the facility on 6/13/12. Further review revealed the ALF 102 form was not signed as complete until 8/16/12. Interview with the facility nurse on 10/25/12 at 9 AM confirmed the ALF 102 was not signed as complete until after the resident was admitted. (c) Resident Rights. The facility shall adopt and follow a written policy of resident rights. The policy shall be posted in a conspicuous place and there shall be documentation in the resident's	SALF	Chapter 12, Sec 7 Assisted Living Facility Core Services (b) (i)(I) The facility will ensure that form ALF 102 is completed for each resident being admitted within 45 days prior to admission with the following actions: 1. The owners will develop a checklist with dates for each person admitted. 2. The registered nurse will be trained in the use of the checklist. 3. The registered nurse supervisor will be responsible to complete the ALF-102 in a timely manner within 45 days prior to admission and document it on the form. 4. Staff responsible for this activity will report Compliance with this activity to the QA. committee on a quarterly basis.	11/22/12

DIRECTOR
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Diane Laird Hudson — 11-16-12

Approved POC & Manager on 12/4/12 @ 1045 Am.
Addition of Q.A. paragraph on all pages — SL

QA Paragraph 5

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SALF	Continued From page 1 record that the resident read or management explained the policy. This REGULATION was not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to document 3 of 3 (#1, #2, #3) residents were aware of their rights. The findings were: Review of resident records #1, #2 and #3 revealed none of the records contained signed documentation the residents read or were read their rights. The facility manager confirmed no documentation was in any of the resident records indicating they were aware of their rights. In addition, periodic observation during the survey revealed there was no posting of the resident rights throughout the facility. Interview on 10/25/12 at 10 AM with the facility manager confirmed resident rights were not posted in the facility. (d) Medications (ii) Prescription drugs (A) An RN shall destroy all discontinued prescriptions (B) Controlled substances shall be destroyed in the presence of a licensed pharmacist (m)Facility Policies and Procedures (i) Management shall develop policies and procedures that are available to resident and staff including but not limited to: (D) Medication management This REGULATION was not met as evidenced by: Based on review of facility policies and procedures, and staff interview, the facility failed to include requirements for appropriate	SALF	(c) Resident Rights. The facility will ensure that residents are aware of their rights by the following: 1. Resident Rights shall be posted in a public area in the main hallway. 2. Individual residents shall document their awareness of their rights as residents with a signature on a form developed for that purpose and maintained in the resident's file. 3. QA Paragraph (d) Medications (ii)(A)Destruction of discontinued medications. The facility will ensure that prescription medications shall be appropriately disposed of by: 1. The owners will develop a policy to be added to the facility's Policy and Procedures; 2. The owners will train the registered nurse on the added policies; 3. The RN will be responsible for charting the disposition of medications in the resident file. 4. QA Paragraph	11/22/12 11/22/12

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SALF	Continued From page 2 disposition of resident medications within their policies and procedures. The findings were: Review of facility policies and procedures revealed no documentation existed identifying the requirements for appropriate disposition of resident medications upon discontinued prescriptions or resident transfer, discharge or death. Interview on 10/26/12 at 11 AM with the facility manager and nurse confirmed the policies did not address proper disposition of resident medications. (e) Resident Records and Reports. (i) Each folder shall include the following: (I) Written acknowledgment of the receipt and explanation of all facility policies This REGULATION was not met as evidenced by: Based on record review, and staff interview, the facility failed to verify the required documentation that 3 of 3 residents (#1, #2, #3) were made aware of facility policies and procedures during the admission process. The findings were: Review of resident records #1, #2, and #3 revealed none of the records contained signed documentation the residents read or were read an explanation of all facility policies and procedures prior to admission. Interview with the facility manager on 10/26/12 at 11 AM confirmed no documentation was in any of the resident records indicating the residents were aware of facility policies and procedures. (g)Grievance Procedure. (iv) The written grievance procedure shall be posted in a conspicuous place within the facility.	SALF	(e) Resident Records and Reports (i) (I) Written acknowledgment of receipt and explanation of all facility policies. The facility will ensure that there is documentation of each resident's knowledge of the facility policies by: 1. Policies and Procedures shall be posted in a public area in the main hallway. 2. Individual residents shall document their awareness of the operating Policies and Procedures with a signature on a form developed for that purpose and maintained in the resident's file. 3. QA, paragraph	11/22/12

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SALF	Continued From page 3 This REGULATION was not met as evidenced by: Based on observation and staff interview, the facility failed to post the grievance procedure in the facility. The findings were: Periodic observation on 10/24/12 and 10/25/12 revealed the facility grievance procedure was not posted. Interview with the facility manager on 10/24/12 at 11 AM confirmed the finding. (o) Evacuation Capability, Emergency Procedures and Fire Safety. (iii) Fire Safety (D) Resident training for the fire emergency plan shall be in accordance with the Life Safety Code Operating Features sections. (I) each resident shall be instructed in the proper action of the fire emergency plan. This REGULATION was not met as evidenced by: Based on record review, and staff interview, facility staff failed to document 3 of 3 residents were instructed in what action to take in the event of a fire emergency. The findings were: Review of resident records #1, #2, and #3 revealed none of the records contained signed documentation the residents read or were read the facility policy regarding what to do in the event of a fire or some other type of emergency. Interview with the facility manager on 10/25/12 at 9:10 AM confirmed no documentation was in any of the resident records indicating what to do in the event of an emergency. Chapter 4, Section 10, Life Safety and Electrical	SALF	(g) Grievance Procedure. (iv) posting. The facility will ensure that the Grievance Procedure described in the facility's Policies and Procedures will be available to each resident, their families and the public by: 1. Grievance Procedure shall be posted in a public area in the main hallway. 2. QA paragraph (o) Evacuation Capability, Emergency Procedures and Fire Safety (iii)(D)(I) each resident shall be instructed in the proper action in the fire emergency plan The facility will ensure that there is signed documentation of each resident's knowledge of the facility's Evacuation Capability, Emergency Procedures and Fire Safety policies by: 1. Policies and Procedures shall be posted in a public area in the main hallway. 2. Individual residents shall document their awareness of these Policies and Procedures with a signature on a form developed for that purpose and maintained in the resident's file. 3. QA Paragraph	11/22/12 11/22/12

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SALF	Continued From page 4 Safety. The requirements in the Department of Health Chapter III, Construction Rules for Health Facilities apply. (ii)Assisted Living Facilities operating prior to the effective date of these rules, shall meet the Life Safety Code of the National Fire Protection Association that was in effect at the time the facility was licensed as an Assisted Living Facility. This REGULATION was not met as evidence by: 1. Based on observation and staff interview, the facility failed to maintain the installed sprinkler system in accordance with NFPA 13. The findings were: Observation on 10/25/12 between 8:55 AM and 10:22 AM revealed one sprinkler head escutcheon was coming away from the wall in the stair well and two sprinkler head escutcheons were coming away from the ceiling in the dining room. This resulted in a greater than half an inch gap existed between the escutcheons and the wall/ceiling surface. Interview with the facility maintenance manager on 10/25/12 at 9:48 AM confirmed the above observation. Reference NFPA 101 Life Safety Code, 1994 Edition 22-3.3.5.1 All buildings shall be protected throughout by an approved, automatic sprinkler system installed in accordance with section 7-7.... 7-7.1.1 Each automatic sprinkler system required by another section of the Code shall be installed in accordance with NFPA 13, NFPA 13 Standards for the installation of Sprinkler Systems.	SALF	Chapter 4. Section 10 Life Safety and Electrical Safety 1. The facility will ensure the maintenance of the sprinkler system in accordance with NFPA 13 and NFPA 101 by: a) Adding a check for sprinkler head escutcheon positions throughout the building to the Monthly In House Life Safety Inspection list. b) The maintenance supervisor will be responsible to complete these checks and document each month correcting any problems identified. c) QA. paragraph	11/22/12

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SALF	Continued From page 5 5.2.7.2 Escutcheons used with recessed, flush-type, or concealed sprinklers shall be part of a listed sprinkler assembly. 2. Based on observation, and staff interview, the facility failed to maintain the fully sheathed surfaces of the building in 1 of 3 smoke compartments. The findings were: Observation on 10/25/12 at 9:48 AM revealed an approximate 6" x 6" hole present on the bathroom ceiling of resident room #18. Interview with the maintenance manager at the time of the observation confirmed the findings. The manager stated a ceiling fan had been removed from the ceiling and had not yet been replaced. Reference NFPA 101 Life Safety Code, 1988 Edition: 22-3.1.3.1 Construction requirements for large facilities shall be as required by this section. Where noted as "fully sheathed", the interior shall be covered with a lath and plaster or material providing a 15-minute thermal barrier. 3. Based on observation and staff interview, the facility failed to provide an electrical system installed in accordance with NFPA 70. The findings were: Observation on 10/25/12 at 10:03 AM revealed a busted electrical wall cover plate on an electrical outlet in the resident dining room. Interview with the maintenance manager at the time of the observation confirmed the findings. Reference NFPA 101 Life Safety Code, 1988 Edition: NFPA 101, Chapter 32 Referenced Publications: NFPA 70, National Electrical Code, 1999 edition:	SALF	2. The facility will ensure the maintenance of fully sheathed surfaces of smoke compartments in accordance with NFPA 101 by: a) Covering the 6X6 duct (open area) with the original cover. b) The maintenance supervisor will be responsible to complete this project. c) QA paragraph 3. The facility will ensure the maintenance of the electrical system in accordance with NFPA 70 by: a) Replacing the broken electrical wall cover plate in the dining room. b) The maintenance supervisor will be responsible to complete this project and will be responsible for identification and replacement of other cracked or broken cover plates. c) QA. paragraph	11/22/12 11/22/12

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SALF	Continued From page 6 370-28, Pull and Junction Boxes. (3) (c) cover. All pull boxes, junction boxes and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use....	SALF		