POC accepted 4/16/13 JC



PRINTED: 03/13/2013
FORM APPROVED

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF009 | A. BUILDING: _____ B. WING _____ | C 02/28/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EMERITUS CORP DBA/EMERITUS AT ABSARC | 2401 COUGAR AVENUE CODY, WY 82414 |

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| SALF | LIC REGS FOR ASSISTED LIVING FACILITIES | SALF | The following is Emeritus at Absaroka Plan of Correction to the Department of Health Services regarding Statement of Deficiencies dated 2.28.13 and received at the community via e: mail on 2.28.13. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions outlined in the Statement of Deficiencies, or proposed administrative penalty (with the right to correct) on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or findings. We have not presented all contrary factual or legal arguments, nor any mitigating factors. | |

Wyoming Department of Health Aging Division Rules for Program Administration of Assisted Living Facilities
Chapter 12

Section 6. Personnel and Staffing Requirements.
(c) Background checks.
All staff of the assisted living facility shall successfully complete, at a minimum, a State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check and a Department of Family Services Central Registry Screening before direct resident contact.

This Rule is not met as evidenced by:

Based on review of personnel files and staff interview, the facility failed to ensure the DCI background check and Department of Family Services (DFS) central registry screening was completed prior to direct resident contact for 4 of 4 employees. The findings were:

Review of personnel files revealed the following concerns:
a. The DCI background check was not completed until 7/25/12 for the resident care director, who was hired 4/30/12. In addition, there lacked evidence of a DFS central registry screening.
b. There lacked evidence of a DCI background check or DFS central registry screening for a certified nurse aide (CNA) hired 2/20/13.
c. The DFS central registry screen was not

April 28

**Chapter 12, Section 6**

1. **Corrective Action:**
A complete review of employee files will be done by the Business Office Manager (BOD) or Designee this will be completed by ~~June 30~~, 2013. Issues identified appropriate action will be taken.

2. **Systemic Change:**
An in-service has been scheduled on April 10, 2013. The in-service will be for the Business Office Director/Designee, and to be done by the Executive Director (ED) The ED will review the required Wyoming Regulation on background checks to include:



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
Kathleen Schultz | 4-1-13

STATE FORM 6899 JZ0511 If continuation sheet 1 of 6

Changes made per phone call with Kathleen Schultz, Director on 4/16/13 @ 12:36pm.
Janelle Colin, DHL

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Healthcare Licensing and Surveys

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| SALF | Continued From page 1<br>completed until 3/28/12 for the dining service director who was hired 2/8/12. In addition, there lacked evidence of a DCI background check.<br>d. A CNA was hired 11/15/12, but the DFS screen was not completed until 1/8/13. In addition, the DCI background check was not completed until 1/31/13.<br><br>During an interview on 2/28/13 at 2:22 PM, the Business Office Director stated the DFS screen for the resident care director "must have been missed." She stated the DCI background check was not completed for the dining service director because he had not turned in the paperwork yet. Furthermore, she stated the facility did not wait for the DFS screenings or DCI background checks to be completed before allowing employees to have resident contact.<br><br>Section 7. Assisted Living Facility (ALF) Core Services<br><br>(a) The assisted living facility core services include the following:<br>(ix) Assessments completed by the Registered Nurse;<br>(A) Registered Nurse medication review every two (2) months or sixty-two (62) days or whenever new medication is prescribed or the resident's medication is changed.<br><br>This Rule is not met as evidenced by:<br><br>Based on review of medical records and staff interview, the facility failed to ensure the registered nurse (RN) reviewed the medications every two months for 4 of 4 residents (#10, #17, #23, #37). The findings were.<br><br>Review of the medical records for residents #10, | SALF | a. The Division of Criminal Investigation (DCI)<br>b. The Department of Family Services (DFS).<br><br>3. **Monitoring:**<br>Results of the review and new employees will be reviewed weekly by the ED/Designee, to make sure the required background check information is sent in timely for processing. Identified issues action will be taken. will monitor in QA Committee.<br>4. **Date of Completion:**<br>April 28, 2013<br><br>**Chapter 12, Section 7 (a)**<br><br>1. **Corrective Action:**<br>The Resident Care Director (RCD) will review the Medication Administration Records every 62 days beginning with March 2013.<br><br>2. **Systemic Change:**<br>An in-service has been scheduled for the Resident Care Director (RCD)/Designee on, March 15, 2013 by the Executive Director (ED)/Designee to review the Wyoming Regulation CHPT 12, Section 7 (Core Services).<br>a. The Executive Director/Designee will review the Medication Administration Records to make sure the RCD signature is done timely and according to the regulation. | |

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| SALF | Continued From page 2<br>#17, #23 and #37 showed no evidence the medications were reviewed by the RN every two months. During an interview on 2/28/13 at 8:38 AM, the resident care director, an RN, stated she reviewed the medication sheets every month, but did not document.<br><br>(e) Resident Records and Reports<br>(i) Each folder shall include the following:<br>(D) All accidents, injuries, incidents, illnesses, and allegations of abuse, neglect or exploitation shall be reported to the resident's family or responsible party and be documented in the individual resident records. All such occurrences shall also be reported to the appropriate entity for follow up and resolution. Reports of all incidents affecting the health, welfare, or safety of a resident shall be provided to the Licensing Division immediately (within one business day). Reporting shall be done by telephone or fax. The facility's investigation of the incident shall be reported to the Licensing Division and the Long Term Care Ombudsman within five (5) working days. Documentation to support the facility reporting the situation and follow up must also be present in the resident records.<br><br>This Rule is not met as evidenced by:<br><br>Based on medical record review and review of the Healthcare Licensing and Surveys (HLS) incident log, the facility failed to report incidents which affected the health, safety and welfare of the resident for 1 of 4 sample residents (#23). The findings were:<br><br>Review of the HLS incident log from 10/1/12 through 2/26/13 showed the facility had not reported any incidents. However, review of | SALF | b. Resident #10, #17, #37 the March Medication Administration Records (MAR's) have been reviewed the Registered Nurse and signed.<br>c. Resident #23 no longer resides at the community.<br><br>3. **Monitoring:**<br>Reviews of the Medication Administration Records will be completed every other month by the Executive Director/Designee and issues identified appropriate action will be taken. will monitor in QA committee.<br>4. **Date of Completion:**<br>March 15, 2013<br><br>**Chapter 12, Section 7 (e), (i), (D)**<br><br>1. **Corrective Action:**<br>Resident #23 no longer resides at the community. .<br><br>2. **Systemic Change:**<br>The Executive Director (ED)/Designee will in-service the Resident Care Director (RCD) on March 15, 2013 in regards to the following:<br><br>a. Wyoming state reporting requirements to include reporting incidents that affect the health, safety, and welfare of the residents.<br>b. Events in the community will be reviewed at the clinical meeting by the RCD and ED the following elements will be reviewed for compliance: | |

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| SALF | Continued From page 3<br>progress notes showed resident #23 eloped (left the facility without staff knowledge) on 2/10/13, 2/11/13, 2/15/13, 2/24/13, and 2/27/13. None of the elopements were reported to HLS.<br><br>(j) Food Service and Nutrition.<br>(iii) Food service supervision:<br>(A) Day to day responsibilities for food production and management of the dietary services shall be assigned to a person with nutrition and food service management experience equivalent to that of a Cerified Dietary Manager.<br><br>This Rule is not met as evidenced by:<br><br>Based on staff interview, the facility failed to ensure dietary services was supervised by a certified dietary manager (CDM) or the equivalent. The findings were:<br><br>During an interview on 2/27/13 at 10:41 AM, the dining service director stated he was not a certified dietary manager, but was currently enrolled in an on-line course.<br><br>Section 8. Services Which Cannot Be Provided By The Level 1 Assisted Living Facility Staff.<br>(a) The following services cannot be provided:<br>(vi) Care of resident whose wandering jeopardizes the health and safety of the resident;<br><br>This Rule is not met as evidenced by:<br><br>Based on observation, medical record review and staff interview, the facility failed to ensure a resident did not require more care than was allowed according to ALF rules and regulations | SALF | i. Notification of family timely<br>ii. Notification of the state agency timely<br>iii. Comprehensive investigation<br>iv. Documentation, intervention and implementation<br><br>3. **Monitoring:**<br>The Executive Director/Designee will review the event log monthly to make sure that the events having the following elements:<br>a. Notification of the family<br>b. Notification of the state agency if necessary to include timely reporting, comprehensive investigation, complete documentation, and action taken. Issues identified appropriate action will be taken.<br>will monitor in QA committee.<br>4. **Date of Completion:**<br>April 15, 2013<br><br>**Chapter 12, Section (j), (iii), (A)**<br><br>1. **Corrective Action:**<br>The Dietary Manager will complete the courses for a Certified Dietary Manager (CDM) program and be tested in October 2013.<br><br>3. **Monitoring:**<br>The Executive Director (ED will monitor the progress monthly of the Dietary Manager completing the CDM program.<br>will monitor in QA committee.<br>4. **Date of Compliance: October 2013** | |

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| SALF | Continued From page 4<br>for 1 of 4 sample residents (#23). The findings were:<br><br>Observation during the survey on 2/27/13 and 2/28/12 revealed whenever a door was opened, including the front door, an alarm was sent to the walkie talkies that staff carried with them. Staff then observed the door, to see who entered or exited. In addition, staff were giving resident #23 tasks to keep busy.<br><br>Review of the 11/14/12 service plan revealed resident #23 had dementia and periods of confusion. Review of progress notes revealed the following:<br>a. On 10/15/12 the resident was observed leaving the facility twice.<br>b. On 2/10/13 the resident left the facility. Somebody driving in a car said the resident was seen outside.<br>c. The resident left the facility (eloped) on 2/11/13.<br>d. On 2/15/13 at 6:30 PM a nurse found the resident outside. Later, at 8:30 PM, a CNA found the resident outside.<br>e. On 2/17/13 the resident attempted to elope out the back door.<br>f. On 2/19/13 the physician ordered Seroquel 25 milligrams, one to two tabs, at bedtime for dementia related behavior, i.e. wandering.<br>g. On 2/24/13 the resident left at 1:30 PM, and then came back in, using the kitchen exit. At 2:30 PM, a citizen called and said the resident was downtown at the Holiday Inn. (On 2/28/13, the surveyor drove from the facility to the Holiday Inn, which was 0.9 mile)<br>h. On 2/27/13 at 2:15 PM the resident left the facility and was found by a family friend a few blocks away. | SALF | **Chapter 12, Section 8**<br><br>1. **Corrective Action:**<br>Resident #23 no longer resides at the community.<br><br>2. **Systemic Change:**<br>a. The Resident Care Director (RCD)/ Designee will do a complete review of the residents for risk of elopement using the (unsupervised absence form). Issues identified appropriate action will be taken.<br><br>b. Residents will be evaluated pre-move in, every 6 months and on change of condition for risk of elopement (unsupervised absence)<br><br>c. Staff will be in-serviced on the process for missing residents to include the following:<br>i. Who to notify timely<br>ii. Documentation<br>iii. Interventions and implementation<br><br>3. **Monitoring:**<br>Event reports will be reviewed monthly by the quality assurance committee for completion and compliance; identified issues appropriate action will be taken.<br><br>4. **Date of Completion:**<br>April 15, 2013 | |

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| SALF | Continued From page 5<br><br>Confidential interviews with three staff members on 2/28/13 at 2:55 PM, 3:30 PM and 4 PM revealed resident #23 had been eloping from the facility. In addition, the staff stated other residents had started locking their doors at night because s/he came into their rooms. Furthermore, they stated the doors now had alarms (which went to their walkie talkies) because of the resident's elopements.<br><br>During an interview on 2/27/13 at 4:46 PM, the executive director stated she had not issued a discharge notice to the family of resident #23. She stated she was "on the fence" with regards to the resident, and wanted more time to see if the recent medication changes would help. During the exit conference on 2/28/13 at 4:16 PM, however, the executive director stated she spoke to the resident's family that day, after the resident eloped again. She stated the family was told the resident was no longer appropriate to remain at the facility. | SALF | | |