11/29/11

PRINTED: 11/15/2011
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
	ALF020	A. BUILDING _____ B. WING _____	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOMES ASSISTED LIVING	2391 MUDDY STRING RD THAYNE, WY 83127

(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 6. (a)(i)(H) Pass an open book test on the same. The open book test shall be administered by the Program Division. the passing score will be 85% or greater. Those individuals who successfully completed the examination administered by the Licensing Division shall have their test scores honored; The REQUIREMENT is not met as evidenced by: Based on data review during off-site survey preparation and staff interview, the facility failed to ensure the facility manager took the required test. The findings were: Review of the facility file during off-site preparation on 10/27/11 revealed the facility manager had not taken the required manager test. Interview with the manager on 11/1/11 at 4:20 PM revealed that she had understood she was 'grandfathered' in, and not required to take the test. The manager stated that unfortunately, she did not have written confirmation from the Aging Division exempting her. Section 6. (c) 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	SALF	See attachment * 12-6 previous survivors stated if a new manager were hired they would need to to take this test as of 12-12-07, but Laura feels that is not the case I can get on line and take the now required test. The administator will take qualificaton exam by Jan. 1 2012. ~~This was my failure to have a DCI finger print on employee F~~	

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM If continuation sheet 1 of 17

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NOV 28 2011
Wyoming Dept of Health
Office of Healthcare Licensing and Surveys

Accepted w/ changes. All changes made with approval of Eileen Merritt, Administrator on 11/29/11 at 10:40 Am. DOC = Jan 1, 2012

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SALF	Continued From page 1	SALF	~~which should have been completed, because she is my daughter~~ DCI fing prints will be Completed on Employee F by Jan 1, 2012. All employees will have DFS Required Finger to + background Checks. An orientation Check List will be implemented to ensure this is A meeting with RN complete on 11/7/11 to review this requirement was held and determined approrite change to insure accurate, standardized, reproducible assessements can be achived to accomplish this requirement it was determined to change our documentaition and better placement of RN's signature and initals are clear - This will be completed by the 60 day correction period	1/1/12

Registry Screening before resident contact.
The REQUIREMENT is not met as evidenced by:

Based on record review and staff interview, the facility failed to ensure a DCI fingerprint background check on 1 of 6 employee files (employee F) reviewed. The findings were:

Review of the employee file for employee 'F' showed it contained a Central Registry Screening but no DCI check. Interview with the facility manager by phone on 11/4/11 at 4 PM confirmed the employee did not have the required fingerprint check. The employee's date of hire paperwork was dated 4/19/11.

Section 7. (b) Resident Assessment and Services. The staff/contract Registered Nurse (RN) shall conduct initial and, at a minimum annually, an accurate, standardized, reproducible assessment of each resident's functional capacity, physical assessment and medication review.
The REQUIREMENT is not met as evidenced by:

Based on medical record review and staff interview, the facility failed to ensure an accurate, standardized, reproducible assessment for 3 of 3 resident records (#2, #5, #7) reviewed. The findings were:

1. Review of the assessment for resident #7 showed it was completed on 9/6/07 and this assessment was documented as "reviewed" on 10/13/08, 10/14/09, 10/16/10, and 10/10/11. The following concerns regarding the assessment were found:
a. Review of facility documentation and incident notes showed the resident had falls in April and May of 2010 and then received a pacemaker on

The RN has completed new assessments on Res # 2, #5, #7.
A monthly audit will be conducted by RN of Random records to ensure assessments are updated + Completed.

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SALF	Continued From page 2 5/23/10. Yet, the "reviewed" assessment on 10/16/10 did not document the change in the resident's status. b. Review of facility documentation showed the resident was treated for agitation approximately every two weeks during 2010 and 2011, yet neither assessment on 10/16/10 or 10/10/11 addressed the increase in agitation from the original 9/6/07 assessment. c. Review of a home health order form showed home health was initiated on 4/25/11. Yet the 10/10/11 assessment failed to address the changes in the resident status or the need for home health services. 2. Review of the assessment for resident #2 showed it was completed on 6/26/10. Further review of the medical record failed to show an annual assessment. The review also showed the resident received home health services since 8/5/10, but there was not a re-assessment at that time to address the resident's decline or change which required the services. 3. Review of the assessment for resident #5 showed it was completed on 12/30/09. Further review of the medical record failed to show an annual assessment for December 2010. At the bottom of the original assessment on 12/30/09, the nurse documented "Reviewed 5/23/11 [initials] RN [the medical symbol for "no"] changes". 4. Interview with the facility manager on 11/2/11 at 10:40 AM revealed all available assessments were in each resident's medical record. Section 7. (b)(ii) Admission orders. A resident shall be admitted only if accompanied by a history and physical completed by a physician or	SALF	All significant changes for example skin tears falls - mental status will be reported to family, Doctor, Home Health with in a 24 hour period and appropriate changes will be documented and added to plan of care as indicated by Doctor-Home Health - Nurse. Documentation of change will be acquired. All staff will be trained at ~~next~~ staff meeting the December	

dlf 11/29/11

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SALF	Continued From page 3	SALF		Jan 1, 2012

physician extender within ninety (90) days prior to admission....
The REQUIREMENT is not met as evidenced by:

Based on medical record review and staff interview, the facility failed to ensure 2 of 3 medical records (#2, #5) reviewed had the required history and physical (H&P), and that it was completed prior to admission. The findings were:

1. Review of the medical records for resident #2 showed the resident was admitted on 4/26/10. Review of the medical record showed no H&P. The resident did have a form titled "Medical Assessment and Consent" dated and signed by the physician on 4/30/10. The form documented admission diagnoses, medications, and orders. When asked for the resident's H&P on 11/2/11 at 10:40 AM, the facility manager presented the aforementioned form as the H&P. When asked for the resident's medical history and the physician's office physical, that were done by the physician, the manager stated the only medical history in the record was the one filled out by the resident or family and taken to the office visit by the resident. Review of this form showed no evidence of a physician's H&P.

2. Review of the medical records for resident #5 showed the resident was admitted on 1/1/10. Review of the medical record showed no H&P. The resident did have a form titled "Medical Assessment and Consent" dated and signed by the physician on 1/5/10, four days after admission to the facility. The form documented admission diagnoses, medications, and orders. When asked for the resident's H&P on 11/2/11 at 10:40 AM, the facility manager presented the aforementioned form as the H&P. When asked

Both residents # 2 and # 5 have the same physician. He stated he felt the statement at the top was sufficient having just admitted them as patients. In the future we will obtain a more complete history and physical in 90 days in order to ensure compliance with this requirement

the physician will review the history provided and acknowledge while providing the initial exam & assessment of the Resident prior to exam.

This process will be accomplished for all future admissions.
- The administrator will audit all new admission Records for this requirement and complete ① Recitation Check list.

11/24/11 SF

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SALF	Continued From page 4	SALF		

for the resident's medical history and the physician's office physical, that were done by the physician, the manager stated the only medical history in the record was the one filled out by the resident or family and taken to the office visit by the resident. Review of this form showed no evidence of a physician's H&P.

Section 7. (g)(iii) List of agencies, with address and telephone numbers for residents to contact if grievances are not addressed satisfactorily (e.g. State Long Term Care Ombudsman and the Department of Health, Office of Licensing and Surveys);...
The REQUIREMENT was not met as evidenced by:

Based on observation, policy review, and staff interview, the facility failed to list the address for the state survey agency. The findings were:

Observation on 11/1/11 failed to show the posting of the state survey agency's address. Review of the grievance procedures showed it did not list the survey agency address. Interview on 11/1/11 at 3:46 PM with the facility manager revealed neither the policy nor the posted information had the required information for the state survey agency.

Section 7. (j)(ii) There must be an organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome and sanitary in accordance with the rules. The dietetic service must ensure that food prepared is nutritionally adequate in accordance with the Dietary Reference Intakes (DRI) for adults.
The REQUIREMENT is not met as evidenced by:

Will add the survey agency's address to our posting. All Resident will be educated to this information.

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SALF	Continued From page 5 Based on observation, and staff interview the facility failed to ensure: 1. Food was stored in a safe manner in 1 of 2 refrigerators; monitoring of storage temperatures in 2 of 2 refrigerator-freezers, monitoring of storage temperature for 1 of 1 upright freezers and 1 of 2 refrigerators; safe food storage in an outside shed; safe food storage inside the facility; and, food storage in proper storage containers. 2. The dietetic service was organized. The facility census was 10 residents. The findings were: 1. For failure to ensure food was stored in a safe manner in 1 of 2 refrigerators refer to Section 7. (j)(v) regarding the interior condition of the refrigerator housed in a shed with food spills and food storage under the spills. 2. Observation on 11/1/11 at 2:32 PM of the two facility refrigerators showed the refrigerator in the shed had a thermometer in the refrigerator portion, but the kitchen refrigerator did not. The freezer portion of each refrigerator/freezer lacked a monitoring thermometer. Interview with certified nurse aide #6 on 11/1/11 at 2:32 PM revealed she was unable to find the thermometers. Further interview revealed the daily temperatures were not recorded for either refrigerator nor for the upright freezer housed in the shed. Observation of the upright freezer in the shed on 11/1/11 at 2:32 PM show no monitoring thermometer. The observation was confirmed by CNA #6. 3. For failure to ensure safe food storage in an outside shed, refer to Section 7. (j)(v), item 1.(b) under the deficiency statement regarding food storage on the floor of a shed, which also housed garden supplies, a pet, and litter box.	SALF	Have contacted a dietation to contract for service to meet this requirement. An agreement will be met by Jan 1, 2012. The RD will ensure new adequacy & Sanitation/food Storage Requirements & provide education as needed. Obtain thermometers for Kitchen refigerator and also for freezer portion in each freezer in order to monitor temperatures by a log. Move all food items to appropriate proper storage areas, move other	

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SALF	Continued From page 6	SALF		

4. For failure to ensure safe food storage in the facility, refer to Section 7. (j)(v), item 2, under the deficiency statement regarding food storage in a utility room along with equipment including cleaning supplies, carpet cleaner, and stored equipment such as a bedside commode, and walkers.

5. On 11/1/11 at 2:32 PM observation of the food storage in the facility utility room showed it housed book cases and shelves for food. Multiple gallon mayo jugs and gallon pickle jars were used to store food items such as corn meal (2 jugs total), beans (five jars and jugs total), flour (jars not counted), and muffin mix (2 jugs). Further observation in the kitchen revealed the same practice which included mayo jugs used to store (labeled as) wheat flour, a five quart vanilla ice cream container labeled "corn meal", and a large "Sanka" coffee container, unlabeled, with white powder and a whole in the lid. When interviewed on 11/1/11, the facility manager at 3:46 PM expressed she was unaware that food containers could not be re-used for food storage. According to the 2009 FDA food code 3-201.11 Compliance with Food Law.
(C) Packaged food shall be labeled as specified in law, including 21 CFR 101 Food Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under §§ 3-202.17 and 3-202.18. Pf

6. Interview with the facility manager on 11/1/11 at 3:46 PM revealed the facility staff did not include someone who was a certified dietary manager or equivalent, nor did they employ or contract with a registered dietitian. A second interview with the manager on 11/2/11 at 11:28 AM, she stated that the facility did not have a

items - walker, wheel chairs, bedside commodes to appropriate areas.

Contact ~~Mr Hodette~~ a local food inspector ~~in Etheville~~ ~~for~~ for further information on FDA 2009 Food code and Safety issues. So correct container can be purchased and properly labeled.

8F 11/28/11

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SALF	Continued From page 7	SALF		

FDA Food Code book for reference.

Section 7. (j)(iii)(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 Certified Dietary Manager.
The REQUIREMENT was not met as evidenced by:

Based on staff interview, the facility failed to ensure it had a nutrition and food service manager that was a Certified Dietary Manager or equivalent. The facility census was 10 residents. The findings were:

Interview with the facility manager on 11/1/11 at 3:46 PM revealed the facility staff did not include someone who was a certified dietary manager or equivalent. She stated she was informed of the requirement during the previous survey.

Section 7. (j)(v) Individuals with food preparation responsibilities shall be in good health and shall practice safe food handling techniques in accordance with the current edition of Food Code published by the U.S. Public Health Service, Food and Drug Administration.
The REQUIREMENT was not met as evidenced by:

Based on observation and staff interview, the facility failed to ensure safe food handling/storage within 1 of 2 refrigerators, food stored in a shed, and food storage within the interior of the facility, which had the potential for infestation and contamination. The resident census was 10. The findings were:

Contacted ~~Arlinda~~ ~~Pebbles~~ a registered dietitian in order to ~~comply with this~~ develop management for her services ~~requirement~~

Have ordered a 2009 Food Code instead of printing it online (FDA)

After speaking with local ~~Fire~~ food inspector ~~Mr. Anderson~~ will proceed with his

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SALF	Continued From page 8 1. Observation of the facility's shed on on 11/1/11 at 2:32 PM revealed the following concerns related to food storage: a. The facility had a refrigerator/freezer and an upright freezer in the shed. Interview at the time of the observation with certified nurse aide (CNA) #6 and looking at the interior of the refrigerator revealed red/maroon dried liquid on the bottom shelf of the refrigerator and various other food and liquid spills. The dried red/maroon liquid ran the entire width of the shelf to the bottom drawers. Under the shelf, two draws held broccoli and cauliflower. When asked, the CNA stated the refrigerator was cleaned every Wednesday. b. Observation of the shed also revealed it had a small animal door built within the entrance door, and the pet door was not blocked. Fresh pet food and water was available, the observation also showed a pet bed and a litter box present. Interview with CNA #6 revealed the facility cat used the shed and had resided at the facility a number of years. A sack of potatoes, a sack of onions, and boxes of apples were sitting on the dirt covered cement floor of the shed. A shelf at the back of the shed held canned goods. The CNA stated the apples were to be canned by residents. The shed also held dirt encrusted garden tools, as well as, the holding tanks for the fire system. 2. On 11/1/11 at 2:32 PM observation of the food storage in the facility showed a utility room housed book cases and shelves for food. Bags of noodles and spilled noodles were found on the first book type shelf as one entered the utility room. The bags of noodles partially sat on the floor and the bottom shelf. The utility was crowded and difficult to enter very far as it housed a carpet cleaner, mops, brooms, and a variety of	SALF	Suggestions to ensure the door is secure to avoid potential infestation and contamination to the food storage area. Education Review with Staff on 11/21/11 that when thawing meat proper Container needs to be inplace to avoid leaking blood and spills, also spills need to be cleaned with Soultion as recommeded ~~by the Hydrolic~~, also ~~as stated before~~ have been all items moved and stored in proper Containers with proper labeling for food Saftey and Cleanliness	

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SALF	Continued From page 9 equipment including a portable commode, walkers, and other items and cleaning chemicals. The hot water heater was also in the utility room. 3. Interview with the administrator on 11/2/11 at 11:28 AM revealed the facility did not have a FDA Food Code manual in which to refer to for questions. She stated no other resources were available such as a registered dietitian or a certified dietary manager. 4. According two the 2009 FDA Food Code, Chapter 3, 3-305.12 Food Storage, Prohibited Areas: Food may not be stored: 1. (A) In locker rooms; 2. (B) In toilet rooms; 3. (C) In dressing rooms; 4. (D) In garbage rooms; 5. (E) In mechanical rooms; 6. (F) Under sewer lines that are not shielded to intercept potential drips; 7. (G) Under leaking water lines, including leaking automatic fire sprinkler heads, or under lines on which water has condensed; 8. (H) Under open stairwells; or (I) Under other sources of contamination. Section 7. (j)(viii) Cleaning and sanitizing of dishes and silver ware shall be done by automatic dishwashers. The REQUIREMENT was not met as evidenced by: Based on observation and staff interview, the facility failed to ensure monitoring of dish sanitization. The facility census was 10. The findings were:	SALF	~~As stated previous in process of obtaining a FDA Food Code manual~~ ~~Have contacted Mr Haderlie for~~ Am inservice to be held with staff by the food inspector ~~He suggested~~ by Jan 1, 2012 ~~another possible training which he stated he would contact me with more information when he received it~~	

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys
STATE FORM

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11/2/11 SF

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SALF	Continued From page 10 On 11/2/11 observation at 7:43 AM of meal prep and cleaning showed dishes were pre-washed and placed in the dishwasher which appeared to be a household under cabinet machine. No temperature monitoring logs or chemical monitoring devices were viewed. At the time of the observation, the cook stated, "I just load and push start." She stated if any monitoring was done, maintenance would be doing it. Interview with the administrator on 11/2/11 at 11:28 AM revealed the dishwasher was not monitored for temperature. According to the 2009 FDA Food Code, Chapter 4-703.11 Hot Water and Chemical. After being cleaned, equipment food-contact surfaces and utensils shall be sanitized in: (A) Hot water manual operations by immersion for at least 30 seconds and as specified under § 4-501.111; P (B) Hot water mechanical operations by being cycled through equipment that is set up as specified under §§ 4-501.15, 4-501.112, and 4-501.113 and achieving a utensil surface temperature of 71°C (160°F) as measured by an irreversible registering temperature indicator; P or (C) Chemical manual or mechanical operations, including the application of sanitizing chemicals by immersion, manual swabbing, brushing, or pressure spraying methods, using a solution as specified under § 4-501.114. Contact times shall be consistent with those on EPA-registered label use instructions by providing: 1. (1) Except as specified under Subparagraph (C)(2) of this section, a contact time of at least 10 seconds for a chlorine solution specified under ¶ 4-501.114(A), P 2. (2) A contact time of at least 7 seconds for a chlorine solution of 50 mg/L that has a pH of 10 or less and a temperature of at least 38°C	SALF	Contacted supplier of dishwasher (auto) he states the model we have meets this requirement. He is sending me information regarding this, so follow up information will be provided to insure Compliance. temperature recording device will be used to test the temperature of the dishwasher and logged daily by dietary Staff. The RD &/or Admin will audit the log to ensure Compliance 1/1/2012	

PE 11/09/11

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	ALF020	A. BUILDING _____ B. WING _____	11/02/2011

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SALF	Continued From page 11	SALF		

(100°F) or a pH of 8 or less and a temperature of at least 24°C (75°F), P
3. (3) A contact time of at least 30 seconds for other chemical sanitizing solutions, P or
4. (4) A contact time used in relationship with a combination of temperature, concentration, and pH that, when evaluated for efficacy, yields sanitization as defined in Subparagraph 1-201.10(B). P

Section 7 (I) Quality Improvement. (i) the facility shall have an active quality improvement program to ensure effective utilization and delivery of resident care services....(B) The quality improvement program shall encompass a review of all services and programs provided for all residents. The program shall have: (I) A written description; (II) Problem areas identified; (III) Monitor identification; (IV) Frequency of monitoring; (V) A provision requiring the facility to complete annually a self assessment survey of compliance with the regulations; and (VI) A satisfaction survey shall be provided to the resident, resident's family, or resident's responsible party at least annually. (C) Problems identified during the annual survey or the quality improvement process shall be addressed with appropriate written corrective actions. (D) The quality improvement program shall be re-evaluated at least annually.

The REQUIREMENT is not met as evidences by:

Based on review of the facility's quality assurance book and documentation, and staff interview, the facility failed to ensure: 1. It had an active on-going program and reviewed all services; 2. The program had all six required elements; 3. It addressed the previous survey problems and

Quality Assurance Improvement Program
I need clarification:
I have an annual questionnaire if concerns are noted they are documented on questionnaire (which I ommitted to do on the one Ms Womack refferred to, which I followed up, as to date) Then we hold a quaterly resident council meeting (which is stated on questionnaire #15) which family can attend (and invited to) for follow and on going monitoring

11/29/11

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SALF	Continued From page 12	SALF		

ensured continued compliance with previously addressed problems; 4. The program was re-evaluated at least annually. The facility census was 10. The findings were:

1. Review of the facility's quality assurance (QA) book and documentation was done on 11/2/11. There was no evidence of an on-going program or review of services. Other than resident/family questionnaires dated June 2010, and resident council minutes dated 5/25/11 and 8/9/11 there were no current problems addressed, no on-going monitoring, and the most recent meeting was dated 5/2/05.

2. Review of the documentation within the QA book revealed a facility policy which provided staff with a written description and framework for QA. Further review revealed no problem areas identified, and no monitoring or frequency. Although the facility had forms for a self-assessment, no data was found regarding this.

3. Review of the QA book revealed no documentation regarding the facility's last survey on 3/3/09, the corrective action taken, and evaluation to whether or not the facility was able to sustain the correction or whether it required modification. During the survey on 3/3/09 the facility's plan of correction included action for getting a Certified Dietary Manager. Yet, to date, the facility continued to operate without one. Interview with the facility manager on 11/1/11 at 3:46 PM revealed the facility staff did not include someone who was a certified dietary manager or equivalent. She stated at the previous survey, the surveyor had told her of the requirement. Although the facility did do a resident/family satisfaction survey in June 2010, no more current

Which address these issues. I have provided copies of these forms and those Ms Womack spoke of.

The administrator will review the written policy for Quality assurance program and educate staff who participate in QA.

educate

The QA program will be implemented to allow for monitoring + data collection for: Survey problems, Resident/Family questionnaire, Res Council meeting minutes. Data will be reviewed @ least quarterly to ensure corrective measures are in place + effective.

The QA program will be Review annually.

Jan 1, 2012

BF 11/29/11

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SALF	Continued From page 13	SALF		

satisfaction survey was not found. Negative comments on the 2010 satisfaction survey, such as not being informed of the loved one's change in condition and feeling of not being listened to or responded to in an appropriate manner, were not addressed.

4. As mentioned earlier, the facility had no evidence of re-evaluation.

5. Interview with the facility manager on 11/4/11 at 4 PM by phone revealed satisfaction survey comments, she thought, were addressed. She stated the satisfaction surveys were the facility's current self assessment regarding compliance with the regulations.

Section 7 (o)(iii)(D)(I) On the first day of admission, each resident shall be instructed in the proper action of the fire emergency plan, including the location of all the exits. A record of this instruction shall be in each resident file.

The REQUIREMENT is not met as evidenced by:

Based on medical record review, review of policies, and staff interview, the facility failed to ensure 3 of 3 open medical records (#2, #5, #7) reviewed had the required instruction and it occurred on the first day of admission. The findings were:

Review of the medical records for residents #2, #5, #7 showed no documentation related to fire exit orientation and instruction. When interviewed on 11/2/11 the facility manager at 10:40 AM stated the residents had signed for the orientation when they signed the receipt of policies and

1/1/12

~~This is happening but documentation hasn't been~~ we're developing a orientation check list in order to document that new residents are being instructed to proper action of the fire evacuation and emergency plan prior or upon admition. 1st day of ~~with in 10 day~~ send a copy

* The instruction provided will be included in each Resident files.
* The administrator & RN will audit all new admissions to ensure this Requirement.

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SALF	Continued From page 14	SALF		

procedures. She further stated the orientation was given within the first week. Review of the policies and procedures given to the residents revealed it did not orient residents to fire exits, but instead, informed residents about emergency drills and the frequency. The manager stated no other documentation was available to show residents were instructed regarding emergency exits within the first day of admission.

Section 9. Contractual Services provided Outside Assisted Living Facility Authority.

Residents in an assisted living facility may receive services from and outside entity...These services must be arranged by the appropriate professional and be incorporated into the resident's assistance plan....(a) Components of the outside service(s) contract: (i) Who will provide service(s); (ii) What service(s) will be provided; (iii) When the service(s) will be provided; (vi) Where the service(s) will be provided; (v) How the service(s) will be provided;...A contract between the resident, the ALF, and all outside service providers in the ALF must be in place prior to the time of service delivery. This contract must identify the clear delineation of services.

The REQUIREMENT is not met at evidenced by:

Based on facility documentation, medical record review, and staff interview, the facility failed to ensure an agreement for services provided by outside agencies. In addition, the facility failed to incorporate the services provided into the resident's assistance plan for 2 of 2 residents (#2, #7) reviewed who required outside services. The findings were:

Have contacted agencies Home Health in the area to develop a contract for services that are provided at the facility for P.T.-O.T. under their programs and incorporate these services into residents plans of care (assistance plans) This will be Completed ~~in 60 day to be incompliance~~ by Jan 1, 2012

~~The~~ Res #2 + #7 have had their plans of care updated to incorporate the services provided.

11/28/11 SH

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SALF	Continued From page 15	SALF		

On 11/2/11 at 8:31 AM the facility manager provided a list of all residents with outside services. The list showed resident #2 received home health services and resident #7 received home health services and occupational therapy. Review of the medical records for residents #2 and #7 showed no contract or agreement with the outside service nor was there clear delineation of services. Review of the residents' assistance plans show no documentation related to the services received, such as who was to provide the service, what service was to be provided, etc. Interview with the facility manager on 11/2/11 at 10:40 AM confirmed the facility did not have a contract or agreement with the outside agencies, nor did the residents' assistance plans address the services.

Jun 1, 2012

Section 9. Contractual Services provided Outside Assisted Living Facility Authority.

Residents in an assisted living facility may receive services from an outside entity...These services must be arranged by the appropriate professional and be incorporated into the resident's assistance plan....(c) Additional Contractual Services Provided Outside the Assisted Living Authority....(v) Private Duty Care.

The REQUIREMENT is not met at evidenced by:

Based on staff interview and medical record review, the facility failed to ensure that 1 of 1 resident (#7) who received private duty care, had an agreement for the service and the service was incorporated into the resident's assistance plan. The finding were:

Interview with CNA #4 on 11/2/11 at 7:27 AM

Meeting with family of Resident #7 and private duty care in order to insure there is a copy of the agreement and that it is incorporated into residents plan of care (assistance plan ~~is under to the incompliance within time frame~~

If future private duty care is needed for a Resident the administrator and/or RN will ensure agreement of plan of care.

BK 11/29/11

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SALF	Continued From page 16 revealed she did private duty services for resident #7. Review of the medical record for resident #7 showed no evidence of an agreement for this service, nor was the service incorporated into the resident's assistance plan. Interview with the facility manager on 11/2/11 at 10:40 AM confirmed the CNA provided private duty services. The manager stated the facility did not have a copy of the contract between the CNA and the family, nor did the resident assistance plan specify the services preformed by the private duty CNA or the facility staff as required.	SALF	Completion of these will be today from survey Nov 2, 2011	