POC accepted 4/16/12 JL

Healthcare Licensing and Surveys

PRINTED: 03/15/2012
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 _____	02/28/2012

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

(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. 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 REQUIREMENT is not met as evidenced by: Based on review of personnel records and employee contracts, and staff interview, the facility failed to ensure 3 of 4 employees (#1, #2, #3) reviewed successfully completed a DCI fingerprint background check before resident contact. In addition, the results of the DFS Central Registry screening were not received prior to direct resident contact for 4 of 4 employees (#1, #2, #3, #4) reviewed. Furthermore, the facility failed to complete the DCI background check or DFS Central Registry screening for 4 of 4 contract nurses (LPN #1, LPN #2, LPN #3, RN #1). The findings were: Review of the personnel files for the following four employees revealed the following concerns: a. Employee #1 was a certified nurse aide (CNA) hired 12/5/11. There lacked evidence a DCI fingerprint background check was	SALF	**The facility will ensure that all employees must have completed a Department of Family Services Central Registry Screening before having direct resident contact.** **The DFS Central Registry Screening will be sent at the time the employee fills out an application. The employee will not be able to start Working until the completed DFS Central Registry screening has been completed & received from DFS.** **A DFS Central Registry Screening Has now been received for Employee #3.** **This information will be added to the Employee Information Review Sheet that is maintained by the Director of the facility.** **The Director will be Responsible for compliance with this standard.** **Date of Completion. April 27, 2012**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Florence J Parker	Director	3-28-12

Changes made per phone call with Flo Parker, manager on 4/16/12 @ 1:45pm.
Jamala Collins, ODGM

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S/ALF	Continued From page 1	S/ALF	**All DFS screenings have now been completed for LPN #1,LPN #2, LPN #3, and RN #1.**	

completed. In addition, the results of the DFS Central Registry screening were not received until 1/11/12.

b. There lacked evidence a DCI criminal background check was completed for employee #2, a CNA hired 8/24/10. Additionally, the DFS Central Registry screening was not dated until 9/22/10. The screening indicated the facility should consider completing a complete background check.

c. Employee #3 was a housekeeper hired on 2/6/12. The file indicated the DFS Central Registry screening was not sent until 2/21/12. The results had not been received yet. Furthermore, there lacked evidence a DCI background check was completed.

d. The DFS Central Registry screening was received on 6/8/09 for employee #4, a CNA hired 6/1/09.

During an interview on 2/28/12 at 11:40 AM, the manager stated she did not wait for the results of the DFS Central Registry screening before allowing employees to start working. She stated when she hired somebody, she usually needed them to start right away. Furthermore, she stated she did not think the DCI background checks were required. She stated she sent the employee's fingerprints to her boss, who would turn them in to DCI. She stated she never received the results.

On 2/28/12 at 11:15 AM, the surveyor requested the background check information for the four nurses (LPN #1, LPN #2, LPN #3, RN #1) who worked in the facility. The manager stated she did not have DFS screenings or DCI background checks for any of the nurses. She stated the nurses were "contract" nurses. Review of the contracts for the nurses revealed the contract

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The Director will be responsible for Compliance with this standard.

Facility will continue to monitor compliance with QA program. JC

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8ALF	Continued From page 2 was between the nurse and the facility, and failed to include any requirement for background checks. 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. This REQUIREMENT is not met as evidenced by: Based on policy and procedure review and staff interview, the facility failed to develop an abuse policy which addressed screening, training, and investigation. The findings were: Review of the facility's abuse policy (dated 11/08) revealed it did not address screening or training of employees. In addition, it did not specify how allegations of abuse would be investigated. On 2/28/12 at 11:45 AM the manager stated that was the policy she received from corporate, so that is what she used. She confirmed it did not address the required elements. (j) Food Service and Nutrition. (i) Assisted Living Facilities that choose to admit residents who need therapeutic or	8ALF	**The facility will ensure that all employees and nursing staff have DCI background checks completed before having direct resident contact.** DCI checks were submitted for employees #1, #2, #3 and WPs #1, #2, #3 and PRN #1. **The Director will be responsible for receiving the finger print forms at the time the employee fills out an application. The Director will then send the finger print forms to the Owner of Bee Hive Homes and make sure that the DCI background checks are received from the Owner of Bee Hive Homes and placed in the employees' files. This information will be added to the Employee Informaton Review Sheet that is maintained by the Director of the Facility.** **The Director will be responsible for Compliance with this standard.** Facility will continue to maintain compliance in all programs. **Date of Completion: April 27, 2012**	

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SALF	Continued From page 3 mechanically modified diets must employ or contract with a Registered Dietitian who shall approve written menus and dietary modifications, approve special diet needs, plan individual diets, and provide guidance to dietary staff in areas of preparation, service, and monitoring. The frequency of visits is determined by the residents' needs and the competency of the dietary staff but must include at least a monthly onsite review of dietary services. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and staff interview, the facility failed to employ or contract with a registered dietitian (RD). The facility had 3 residents (#2, #4, #10) who required a therapeutic diet. The findings were: Review of a list provided by the facility showed residents #2, #4, and #10 required a diabetic diet. On 2/27/12 at 5 PM the manager stated the RD quit the first of February. During another interview on 2/28/12 at 3:30 PM, the manager stated the facility did not currently have an RD. She stated she was a certified dietary manager (CDM), therefore she didn't think the facility needed to contract with an RD.	SALF	**The facility will update the existing Abuse and Neglect Policy and Procedures. Screening of employees is completed by the DCI background check. This UpdatedAbuse And Neglect Policy and Procedures will be added to the Employees' File. An in-service on the topic of Abuse and Neglect will be given every six months. Procedures for investigation will be added to this Updated Abuse and Neglect Policy and Procedures.** **Date of Completion: April 27, 2012** **The Director will be responsible for compliance with this standard.** **The facility is in the process of hiring a new Registered Dietician.** **The Director will be responsible for Compliance with this standard.** Facility will continue to monitor compliance in QA program. K **Date of Completion: April 27, 2012**	
	(i) Quality Improvement. (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			

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SALF	Continued From page 4 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. This REQUIREMENT is not met as evidenced by: Based on review of quality improvement (QI) documentation and staff interview, the facility failed to complete an annual self assessment of compliance with the regulations. In addition, the facility failed to provide evidence of annual satisfaction surveys. The findings were: Review of the facility's written description of the QI program (dated 7/08) revealed the facility would perform a self assessment of compliance with the regulations yearly. In addition, the facility would send out satisfaction surveys yearly. However, review of the QI book revealed no evidence of an annual self assessment of compliance nor evidence of satisfaction surveys. During an interview on 2/28/12 at 3:30 PM the manager stated the facility did satisfaction surveys every year, but she was unable to locate them. In addition, she stated she was not able to provide evidence that a self assessment of all regulations was performed. (m) Facility Policies and Procedures. (I) Management shall develop policies and procedures that are available to residents and staff, including but not limited to: (G) Departure and return; (J) Activities; (R) Identification and notification of change in resident's condition.	SALF	**The facility can provide a Policy & Procedure stating that an annual self assessment of compliance with regulations has to be done on an annual basis but I don't think this is necessary since the facility already uses numerous check off lists to make sure that all compliance with regulations are recorded. These check off lists are kept in numerous binders, some are posted throughout the facility, posted in the staff office, posted on the bulletin board and posted in the director's office. These forms can be provided as evidence.** ~~**(See Attachment A)**~~ delete At least annually will review check off lists to determine compliance with Regulations jc **The Director did find the annual satisfaction surveys which have been sent out since 2008. The surveys for 2011 were sent out the 1st part of January 2012 and we are still receiving them.** The Director will be responsible for **compliance with this standard.** Facility will continue to monitor compliance with QA program. **Date of Completion: March 28, 2012** jc	

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SALF	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on review of policies and procedures and staff interview, the facility failed to develop policies related to departure and return, activities, and identification and notification of change in resident's condition. The findings were: Review of the facility's policies and procedures revealed no policies related to departure and return, activities, or identification and notification of change in resident's condition. On 2/28/12 at 11:45 AM the manager confirmed a lack of the aforementioned policies. (n) Furnishings, Buildings, Physical Plant. (Z) Portable space heaters shall not be used (e.g. electric or kerosene). This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure space heaters were not used. The findings were: Review of an incident report dated 11/30/11 revealed a resident fell while trying to move a space heater. During an interview on 2/28/12 at 9:30 PM, the manager stated the facility tried not to use space heaters, but stated occasionally they were used because the resident rooms were so cold. Section 8. Services Which Cannot Be Provided By The Level I Assisted Living Facility Staff. (a) The following services cannot be provided: (iii) Total assistance with bathing and	SALF	**The facility will develop policies related to departure and return of a resident, activities and identification and notification of change in a resident's condition.** **The Director and RN will be responsible for compliance with these standards.** **Date of Completion: April 27, 2012** **The director has now removed all space heaters from the building and will ensure that no space heaters are not used.** **The Director will be responsible for compliance with this standard.** **Date of Completion. March 5, 2012** Facility will continue to maintain compliance with QA program	

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SALF	Continued From page 6 dressing; (iv) Provision of catheter or ostomy care; e.g.; changing of catheter or irrigation of ostomy; total assist with appliance care/changing. (vii) Incontinence care by facility staff. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure residents did not require services the facility staff were not allowed to perform in accordance with the ALF regulations for 2 of 4 sample residents (#2, #11). The findings were: Review of the ALF 102 completed 4/25/11 revealed resident #2 had frequent to total incontinence and was unable to manage the condition independently, required significant assistance for dressing/grooming, and was unable to bathe without total assistance. The 10/24/11 plan of care showed the resident required extensive assistance with toileting, including perineal care. Observation on 2/28/12 at 9:10 AM revealed certified nurse aide (CNA) #1 assisted the resident with toileting. The CNA pulled the brief and pants down, wiped the resident, and then pulled the brief and pants up. Interview with the CNA at that time revealed staff did not want the resident to wipe him/herself. The CNA further stated when the resident was incontinent, s/he was not able to change the brief by him/herself. On 2/28/12 at 10:10 AM, CNA #1 stated the resident required total assistance for dressing. During an interview on 2/28/12 at 3:15 PM, CNA #2 stated the resident required total assistance for bathing. She stated the resident "helped some" with dressing, but that staff performed about 75% or more of the task. Furthermore, she stated the resident was	SALF	**I have attached a copy of the Services Provided (Attachment B) that states what Personal Care is provided by Bee Hive Homes of Evanston. We are also in the process of re-training residents #2 and #11 to become more independent. They are both capable of doing more for themselves. We will provide stand-by assistance as needed. We also provide stand-by assistance with bathing with the resident doing as much as they can.** Resident #11 passed away. Staff will report any increased assistance required with ADLs so the manager or RN can determine if beyond the care allowed. jc	

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SALF	Continued From page 7 incontinent, and was unable to do perlcare or change the brief by him/herself. According to the 11/12/11 ALF 102, resident #11 required total assistance with bathing and had frequent to total incontinence, and required facility maintenance of the colostomy. The 11/12/11 plan of care indicated the resident required moderate assistance with toileting, including assistance for ostomy care. In addition, the resident required moderate assistance for dressing, bathing, and transfers/mobility. On 2/28/12 at 10:10 AM, CNA #1 stated the resident had a colostomy. She stated facility staff had to assist the resident with the care of the colostomy, including helping her irrigate it. On 2/28/12 at 3:15 PM CNA #2 stated the resident required total assistance for bathing and dressing. She stated facility staff helped the resident care for the colostomy. During an interview on 2/28/12 at 3:30 PM the manager was told about the concerns with the level of care residents #2 and #11 required. The manager replied that the facility couldn't afford to lose any residents.	SALF	**Resident #11does have a colostomy bag and can clean her bag and burp her bag. The only help she needs is when she is cleaning the bag. The CNA assists with providing water so that the resident can use her syringe to flush out her bag.** Res #11 passed away. JL **Both residents can operate their wheelchairs and can evacuate the building in case of an Emergency.** **The Director will be responsible for compliance with this standard.** **Date of Completion. April 27, 2012** Facility will continue to maintain compliance in QA program. JL	