Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF007	A. BUILDING _____ B. WING _____	C 05/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POINTE FRONTIER RETIREMENT COMMUNITY	1406 PRAIRIE AVENUE CHEYENNE, WY 82009

(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	SALF		

WYOMING DEPARTMENT OF HEALTH AGING DIVISION RULES FOR PROGRAM ADMINISTRATION OF ASSISTED LIVING FACILITIES

Chapter 12

Section 7 Assisted Living Facility (ALF) Core Services
(iv) Frequency of assessment. An assessment must be conducted:
(B) Immediately upon any significant change in the resident's condition.

This REQUIREMENT was not met as evidenced by

Based on observation, medical record review, resident interview, and staff interview, the facility failed to accurately and timely assess significant declines in function for 2 of 5 sample residents (#1, #2). The findings were

1. Medical record review for resident #1 showed s/he was admitted to the facility on 2/23/12 with diagnoses which included dementia. Review of the resident's 2/21/12 ALF 102 assessment showed s/he exhibited appropriate behavior. Further review showed the area under behavior for wandering and surveillance was not marked. Review of the resident's 2/23/12 Individual Assistance Plan showed the resident had a history of hallucinations with mild dementia. The following concerns were noted
a. Review of the resident's Internal

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

6/11/12

A. With Respect to the Specific Residents Cited: Comprehensive review of resident #1 ALF 102 assessment has been reviewed and updated with additional services provided. Comprehensive review of resident #2 ALF 102 assessment has been reviewed and updated.

B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: An audit of ALF 102 assessments was conducted. An ALF 102 assessment schedule was established and implemented. Resident Care Director (RCD) will review the schedule weekly and ensure follow up compliance.

C. With Respect to What Systemic Measures have been put in place to address the Stated Concern: An In-service training has been scheduled for 07/06/2012 to review use of the 24-hour report to communicate resident follow up needs and changes for our resident care staff. The Resident Care Director will communicate follow up resolution to the General Manager. The Resident Care Director will ensure review and update of the ALF 102 assessments appropriately

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: GENERAL MANAGER — (X6) DATE: 06/16/2012

STATE FORM 6XWR11 If continuation sheet Page 1 of

This POC accepted with agreed to changes between James Oliver, Administrator and Tony Medina, Surveyor on 6/21/12.

6/21/12

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SALF	Continued From page 1	SALF		

Communication Nurses and CNA's note dated 3/25/12 for 7 AM to 7 PM revealed the resident was "very confused" and going into other rooms. Review of a Resident Care Note dated 3/3/12 at 3 PM revealed the resident was agitated and confused, and was "banging" on the door across the hall from his/her room. The note also revealed the resident wanted to leave the building. Review of the resident's Internal Communication Nurse and CNA's note dated 4/1/12 at 3:15 AM showed the resident eloped from the facility, was found outside of the northeast door, and did not know where s/he was going.

b. During observation and interview on 5/25/12 at 12 Noon, the resident would not answer questions about person, time, or place. Instead, s/he rambled about the past and appeared unaware of his/her surroundings.

c. During an interview with the administrator and DON on 5/25/12 at 3:40 PM, the DON confirmed the facility failed to complete a comprehensive assessment after the resident eloped on 4/1/12.

2. Medical record review for resident #2 showed s/he was admitted to the facility on 11/11/10 with diagnoses which included memory loss. Review of the resident's 11/13/11 ALF 102 assessment showed s/he was intermittently confused and required occasional reminders as to person, place, or time. Review of the 12/27/11 Individual Assistance Plan showed the resident had very short term memory and would get up at night and come to the nurses station briefly. The plan also showed the resident required reminders for meals, activities, etc. The following concerns were noted:

a. Review of the Resident Care Notes revealed the following issues: On 4/8/12 the

D. With Respect to How the Plan of Corrective Measures will be monitored: The Resident Care Director will report change of condition ALF 102 assessments to the General Manager weekly.

6/21/12

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SALF Continued From page 2 SALF

resident was found outside and kept wanting to go outside. On 4/13/12 the resident was going into other resident's rooms and was "very confused". On 4/16/12 the resident was "very confused".

b. During observation and interview on 5/25/12 at 1:40 PM, the resident did not know where s/he was, the date or time, and did not know any staff or residents when asked.

c. During an interview with the administrator and DON on 5/25/12 at 3:40 PM, the DON confirmed that the facility failed to complete a comprehensive assessment after the resident eloped on 4/8/12.

Section 8. Services Which Cannot Be Provided By The Level I Assisted Living Facility Staff

(a) The following services cannot be provided:

(vi) Care of the resident whose wandering jeopardizes the health and safety of the resident;

This REQUIREMENT was not met as evidenced by

Based on observation, medical record review, resident interview, family interview and staff interview, the facility failed to ensure 2 of 5 sample residents (#1, #2) who required a higher level of care had been accurately assessed for appropriate placement. This failure put residents at a safety risk. The findings were:

1. Medical record review for resident #1 showed s/he was admitted to the facility on 2/23/12 with diagnoses which included dementia. Review of the resident's 2/21/12 ALF 102 assessment showed s/he exhibited appropriate behavior. Further review showed the area under behavior for wandering and surveillance was not marked

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

6/11/12
6/30/12

A. With Respect to the Specific Residents Cited: Resident #1, ALF 102 assessment has been updated the area under behavior for wandering and surveillance has been marked and includes additional observation and services provided daily until the discharge date of 06/30/2012 to Mountain Towers Nursing Home Secured Unit. Spouse, family members, and staff are providing 24 hour observation. Resident #2, ALF 102 assessment has been updated and assessed for a higher level of care which include. Resident #2 scheduled discharge date is 06/17/2012 to Aspen Wind Memory Care Level 2. The Community staff will provide 24 hour observation until discharge date.

B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: Prior to admission Resident Care director will complete an use ALF 102 assessment prior to resident approval for admission. The Resident Care Director and the General Manager will review the care and service needs prior to admission approval. The community move-in and admission process was reviewed and modified to ensure review of the care and service needs prior to admission approval.

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SALF	Continued From page 3	SALF		

Review of the resident's 2/23/12 Individual Assistance Plan showed the resident had a history of hallucinations with mild dementia. Further review showed the resident needed no assistance in this area. The following concerns were noted.

a. Review of the resident's Internal Communication Nurses and CNA's note dated 3/25/12 for 7 AM to 7 PM revealed the resident was "very confused" and going into other rooms. Review of a Resident Care Note dated 3/3/12 at 3 PM revealed the resident was agitated and confused, and was "banging" on the door across the hall from his/her room. The note also revealed the resident wanted to leave the building. Review of the resident's Internal Communication Nurse and CNA's note dated 4/1/12 at 3:15 AM showed the resident eloped from the facility, was found outside of the northeast door, and did not know where s/he was going.

b. During observation and interview on 5/25/12 at 12 Noon, the resident would not answer questions about person, time, or place. Instead, s/he rambled about the past and appeared unaware of his/her surroundings. Interview with the resident's spouse at that time revealed s/he was worried that the resident would wander off and get lost or injured. The spouse referred to the 4/1/12 incident and stated that it was likely the resident would elope again. The spouse further stated that when the resident was found outside the building on 4/1/12, staff did not know how long the resident had been outside of the building.

c. During an interview with the administrator and DON on 5/25/12 at 3:40 PM, the administrator and DON confirmed the facility was aware the resident had been confused and had eloped. However, the facility had failed to

The Century Park Resident Weekly Retention process will be utilized to review resident care and service needs weekly. Facility Elopement Missing Resident Policy and Procedure was reviewed.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:
An in-service training will be scheduled to review the community Elopement Policy with emphasis on communication and follow up. The Resident Care Director will review resident Incident and Accident follow up with the General Manager daily to include Elopement follow up.

D. With Respect to How the Plan of Corrective Measures will be monitored: The Resident Care Director will submit and review assessment schedule with the General Manager weekly.

6/21/12

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SALF	Continued From page 4	SALF		

consider the resident for a higher level of care

2. Medical record review for resident #2 showed s/he was admitted to the facility on 11/11/10 with diagnoses which included memory loss. Review of the resident's 11/13/11 ALF 102 assessment showed s/he was intermittently confused and required occasional reminders as to person, place, or time. Review of the 12/27/11 Individual Assistance Plan showed the resident had very short term memory and would get up at night and come to the nurses' station briefly. The plan also showed the resident required reminders for meals, activities, etc. The following concerns were noted.

a. Review of the Resident Care Notes revealed the following issues. On 4/8/12 the resident was found outside and kept wanting to go outside. On 4/13/12 the resident was going into other resident's rooms and was "very confused". On 4/16/12 the resident was "very confused"

b. Observation and interview on 5/25/12 at 1:40 PM showed the resident did not know where s/he was, the date or time, and did not know any staff or residents when asked. At that time, CNA #1 had to show the resident where his/her room was in order for the resident to be reminded to use the toilet. When interviewed at that time, CNA #1 confirmed the resident was always confused.

c. During an interview with the administrator and DON on 5/25/12 at 3:40 PM, the administrator and DON confirmed the facility was aware the resident had been confused and had eloped. However, the facility had failed to consider the resident for a higher level of care.

6/12/12