POC accepted 5/16/11 jc

PRINTED: 04/13/2011
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
	ALF011	A. BUILDING _____ B. WING _____	04/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING FACILITY	624 TWIN RIDGE AVENUE 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: Section 7. Assisted Living Facility (ALF) Core Services. (e) Resident Records and Reports (i) Each folder shall include the following: (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. Based on staff interview, and review of medical records, policies, incident reports, and police reports, the facility failed to ensure incidents involving the health, welfare, or safety of residents were reported to the Licensing Division (Office of Healthcare Licensing and Surveys) for 2 of 4 sample residents (#11, #15) and 2 non-sample residents (#6, #14). In addition, based on a review of 2 of 2 death records (#15, #16), the facility failed to ensure events surrounding the deaths of residents were documented in the medical record. The findings	SALF	The facility will ensure that all resident records and reports include the following: All accidents, injuries, incidents, illnesses, and allegations of abuse, neglect or exploitations 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 by fax or phone. This will be completed by: A) The facility staff will complete an incident/accident form on any situation that occurs that is out of the daily routine. This form shall be reviewed by the nursing staff for any follow-up and then placed in the residents chart. B) The facility staff will notify the Licensing Division via phone or fax within one day of any incident/accident affecting the health, welfare, or safety of a resident. C) In the event of a resident death the paperwork for death/discharge of a	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Changes made per phone call with Cheri Willard manager, and Janeele Cook, ONL 5/16/11 @ 2pm.

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SALF	Continued From page 1 were: 1. Review of incident reports and police reports revealed the following: a. On 1/22/11, resident #14 was found on the ground with blood coming from a head wound. An ambulance took the resident to the hospital. b. Resident #6 fell out of bed on 1/17/11, and his/her family took the resident to the emergency room with a possible broken hip. c. On 10/26/10, resident #11 fell and an ambulance was called to take him/her to the hospital. d. Review of the medical record showed resident #15 was deceased on 8/24/10. Review of the police report showed the resident was found dead in the bathroom. The emergency necklace (whistle) was caught on the commode, and the resident accidently hung him/herself. There was no documentation to show that any of the aforementioned incidents were reported to the Office of Healthcare Licensing and Surveys (OHLS). During an interview on 4/6/11 at 10:45 AM, the owner confirmed the incidents had not been reported to OHLS. She stated she quit reporting incidents about one year ago. Review of the facility's policies regarding incidents showed no procedure to call OHLS for incidents involving the health, welfare, or safety of residents. 2. Review of the closed medical records for residents #15 and #16 revealed they were deceased. However, both records showed no documentation surrounding the deaths of the residents. There were no progress notes for the day of death for either resident. Review of incident reports showed no incident reports for the residents related to their deaths. Interview on 4/5/11 at 5:30 PM with the owner confirmed the	SALF	resident will be completed and filed in the resident chart. If the death is an unanticipated death, the Licensing Division shall be notified via phone or fax within one day. These actions will be monitored by the facility manager on a monthly basis by a random chart review. as part of QA process. jc In-service education was provided to staff. jc	~~04/06/2011~~ 6/1/11

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SALF	Continued From page 2 lack of documentation related to the deaths. Review of the facility's policy "Death of a Resident" (2/06) showed all pertinent information concerning the resident's death must be documented in the resident record. Further review of the facility's policy "Serious illness, serious injury, or death of the resident" (2/06) revealed an incident report was to be completed and filed that included details of the situation, action taken, responses noted, and signature of appropriate personnel. Section 8. Services Which Cannot Be Provided By The Level I Assisted Living Facility Staff. (a) The following services cannot be provided: (i) Continuous assistance with transfer and mobility Based on observation, medical record review, and staff interview, the facility failed to ensure 3 of 3 sample residents (#1, #5, #11) required continuous assistance with transfers and mobility. The findings were: 1. Observation on 4/5/11 at 2:48 PM revealed resident #5 required physical assistance by certified nurse aide (CNA) #1 to transfer from the recliner into the wheelchair. Observation on 4/5/11 at 3:55 PM revealed the resident required the physical assistance of the manager to transfer to the toilet. Further observation on 4/6/11 at 9:35 AM revealed CNA #2 pushed the resident in the wheelchair to his/her room. The	SALF	The facility will ensure that services that cannot be provided by a Level I Assisted Living Facility (i) continuous assistance with transfer and mobility are not provided. This will be accomplished by: A) The facility staff will complete a resident concern form on any resident who requires continuous assistance with transfers and mobility. This form shall be reviewed by the nursing staff and follow-up on the concern will be conducted. This form will be placed in the residents chart.	

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SALF	Continued From page 3 resident required physical assistance by the CNA to transfer from the wheelchair to the recliner. 2. Observation on 4/5/11 at 5:05 PM revealed CNA #3 assisted resident #11 to stand from the recliner. Once standing, the resident required hands-on assistance to ambulate. Observation on 4/6/11 at 10:01 AM revealed CNA #2 pulled the dining room chair out for the resident. The resident required physical assistance to stand from the chair. The CNA then assisted the resident with ambulation by holding onto the resident's back and one of his/her hands. 3. Observation on 4/5/11 at 4:56 PM revealed resident #1 required the physical assistance of CNA #3 to transfer from the recliner to the wheelchair. Once in the wheelchair, the CNA pushed the resident to his/her room. 4. During an interview on 4/6/11 at 9:38 AM, CNA #2 stated residents #1, #5, and #11 all required staff assistance for transfers. 5. Review of the facility's policy "Admission of Resident (Retention of Residents)" (2/06) revealed "The facility will not admit nor keep any resident requiring a level of care or type of service which the facility does not provide or is unable to provide with outside services. These include but are not limited to: continuous assistance with transfers and mobility...."	SALF	B) The facility manager will request a repeat LT 101 be completed as well as a physical therapy evaluation from the home health provider of the patient's choice, including Res #1, #5, #11 jc C) Based on the outcome of the repeat LT 101 and the physical therapy evaluation, the resident will be either enrolled in Physical Therapy services to increase mobility and self transfers or the family will be notified of the resident's status. D) If the physical therapy evaluation determines that the resident does not qualify for rehabilitative services the resident's family will be notified that the resident no longer qualifies for Assisted Living placement. The family will then have 30 days to find new placement for the resident, including Res #1, #5, #11 jc E) If the resident's family chooses to provide assistance (private paid help) to assist the resident, the resident may stay in the facility with the provision that the facility staff is not responsible for the transfer and mobility assistance for the resident. These actions will be monitored by the facility manager on a monthly basis by a random chart review and observation of the care within the facility. as part of QA process. jc	06/01/2011