PRINTED: 04/22/2011
FORM APPROVED

WDH - Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF008	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 04/19/2011
NAME OF PROVIDER OR SUPPLIER: SIERRA HILLS ASSISTED LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE: 4606 NORTH COLLEGE DRIVE 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 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 7. (b)(i)(A)(1) The ALF 102 is only valid if completed within forty-five (45) days prior to admission and there is no change in the resident's condition. The RULE was not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 3 of 16 medical records (#7, #9, #10) contained a completed ALF 102 within 45 days of admission. The findings were: During survey on 4/19/11 at 11:21 AM, interview with licensed practical nurse (LPN #2) revealed some residents had transferred from another facility owned by the same corporation, and located in the same city. Review of the medical records showed some lacked the required ALF 102 within 45 days prior to admission. The following were found: a. Resident #7 was admitted to the facility on 1/19/11, but the ALF 102 assessment was dated 9/8/10. b. Resident #9 was admitted to the facility on 3/4/11, but the ALF 102 assessment was dated 1/7/11.	SALF	ALF 102 completed for residents #7, #9 and #10. An audit was completed of the remaining medical records to ensure completion of ALF 102 within 45 days of move-in. RN will ensure ALF 102 is completed for all move-ins and any issues will be noted in the quality assurance program.	5/3/2011 5/3/2011

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

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

Sarah [signature] 05/04/2011

STATE FORM 6899 490Q11 If continuation sheet 1 of 5

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Wyoming Dept of Health
MAY 05 2011
Office of Healthcare Licensing and Surveys

The POC was accepted as written on 5/4/11 @ 1030 by: Elizabeth Mangeluf, DON + Karen [illegible] HFS Health Surveyor

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SALF	Continued From page 1 c. Resident #10 was admitted to the facility on 3/3/11, but the ALF 102 assessment was dated 9/18/10. Section 7. (b)(ii) Admission orders. A resident shall be admitted only if accompanied by a history and physical completed by a physician or physician extender within ninety (90) days prior to admission. The facility shall confirm the resident's medication regimen and special treatment orders at the time of admission. The RULE was not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 6 of 13 open medical records (#7, #8, #9, #10, #11, and #12) contained the required admission documentation. The findings were: Interview on 4/19/11 at 11:21 AM with licensed practical nurse (LPN #2) revealed some residents had transferred from another facility owned by the same corporation. Review of the medical records for residents #7, #8, #9, #10, #11, and #12 showed the records were co-mingled with the records from the other facility. None of the residents had been "discharged" from the other facility and "admitted" as a new admissions for this facility. Interview with the administrator on 4/19/11 at 11:49 AM confirmed the aforementioned residents as having transferred from the other facility. The administrator stated since she was in charge at both facilities, and each was owned by the same company, the idea that the two facilities were actually separate entities had not been considered. She confirmed	SALF	Admission orders will be obtained for residents #7, #8, #9, #10, #11 and #12. An audit was completed of the remaining medical records to ensure admission orders were obtained. RN will ensure admission orders are obtained prior to move-in and any issues will be noted in the quality assurance program.	5/30/2011 5/30/2011

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	ALF008	A. BUILDING _____ B. WING _____	04/19/2011

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SALF	Continued From page 2 the transfers did not include a formal admission in accordance with these rules. She stated the practice had been occurring since mid-January 2011. Interview with the nursing director on 4/19/11 at 11:58 AM confirmed that upon transfer between facilities, this facility did not treat the residents as new admissions. She stated none of the records would have the required elements such as seperate nurses' notes, history & physicals, and admission orders. Section 7. (e) Resident Records and Reports. Each resident's records shall be current, organized and maintained in individual folders which shall be made available to the resident, the licensing Division, or designated representative upon request. The RULE was not met as evidenced by: Based on medical record review and staff interview, the facility failed to keep resident records organized and maintained in individual folders for 1 of 3 closed records (#15) and 6 of 14 open records (#7, #8, #9, #10, #11, and #12). The facility co-mingled resident records with the records of a seperately licensed facility when residents transferred between these particular facilities. The findings were: Review of the closed record for resident #15 revealed the record contained current information about the resident's life in another facility where he was currently living. Interview with LPN #2 on 4/19/11 at 11:21 AM revealed when a resident transferred between this facility and the other facility located down the street, the medical	SALF	Medical records for residents #7, #8, #9, #10, #11, #12 and #15 will split and the records returned to the other assisted living facility. An audit of remaining medical records was completed to ensure there were no co-mingled records. RN will ensure medical records will not be co-mingled between assisted living communities and any issues will be noted in the quality assurance program.	5/13/2011 5/13/2011

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SALF	Continued From page 3 record followed the resident. The LPN identified five other residents, residents #7, #8, #10, #11, and #12, who were admitted to this facility from the facility down the street. Review of these medical records showed documentation was co-mingled including nurses' notes, history & physicals, admission/discharge orders, and the required ALF 102 assessments. Interview with the administrator on 4/19/11 at 11:49 AM confirmed the aforementioned residents and an additional resident, resident #8, transferred between the facilities. The administrator stated since she was in charge at both facilities, and each was owned by the same company they hadn't thought of these as two seperate facilities. She confirmed the transfers did not include doing a formal discharge from one facility or admission to the accepting facility. She stated the practice had been occurring since mid-January 2011, due to a construction project at the other facility. Interview with the nursing director on 4/19/11 at 11:58 AM confirmed that upon transfer between facilities, the only items not co-mingled at the accepting facility was the admission assessment and new admission service plan. Section 7. (e)(ii) The resident shall be assured of confidential treatment of all information in the record, and the resident's written consent (or the consent of the guardian) shall be required for the release of information to persons not otherwise authorized to receive it. The RULE was not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure written	SALF	A signed release of information will be obtained for residents #7, #8, #9, #10, #11, #12 and #15. An audit of remaining residents was completed and a signed release will be obtained as needed. RN will ensure medical release is obtained prior to the sharing of information with another community and any issues will be noted in the quality assurance program.	5/30/2011 5/30/2011

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SALF	Continued From page 4 authorization by the resident/guardian when transferring a resident's medical record between this facility and another facility for 1 of 3 closed records (#15) and 6 of 14 open records (#7, #8, #9, #10, #11, and #12). The findings were: Review of the medical records for residents #7, #8, #9, #10, #11, #12, and #15 revealed the records were co-mingled between this facility and another facility at a separate address. Each contained all the information and documentation of each resident's life at both facilities. Interview with LPN #2 on 4/19/11 at 11:21 AM confirmed when residents transferred between the two facilities, the accepting facility received the entire medical record from the discharging facility. Interview with the administrator on 4/19/11 at 11:49 AM confirmed the practice and stated the facility had been doing this since mid-January. She identified resident #15 as a discharge to the other facility and residents #7, #8, #9, #10, #11, and #12 as admissions from the other facility. When asked about resident authorization for transfer of their entire medical record, the administrator confirmed neither facility had obtained written authorization. The administrator confirmed she was aware that each facility had a separate state licensure number and were considered separate healthcare facilities.	SALF		