2/26/14

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WY Dept of Health
FEB 26 2014
Healthcare Licensing and Surveys

PRINTED: 02/14/2014
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF022	A. BUILDING _____ B. WING _____	02/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE MANOR INC	830 NORTH MAIN STREET BUFFALO, WY 82834

(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
S5049	Ch 12 Sec 7 (d)(i)(A-K) Assisted Living Facility (ALF) Core Services (d) Medications. (i) An individual record shall be kept for each resident, recording any prescription drugs administered by the facility. This record shall include: (A) Name of resident; (B) Name and telephone number of primary physician; (C) Name and telephone number of the primary pharmacy; (D) Name and description of the medication, including prescribed dosage; (E) Dosage administered; (F) Quantity; (G) Times and dates administered; (H) Method of administration; (I) Any adverse reactions to the medication; (J) Signature of licensed staff administering medication; and (K) RN review date and signature. This State Rule and Regulation is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the	S6049	**S5049** Effective 02/24/14 all resident's, including #4, #10, #19, #23, MARs have been edited to include all information required in Chap 12 Sec 7 (d)(i)(A-K), including but not limited to the physician phone number, name of pharmacy and phone number of pharmacy. As of 03/01/14 the procedure for filling out the MAR has been updated to require the initials of the individual who has administered the medication. Formal training and discussion regarding this procedure took place on 02/20/14. The Resident Care Director, LPN, and RN will all be periodically checking the MARs for adherence to the current procedure. Review of the MAR form and the procedure will be reviewed annually during the Quality Assurance review. **S5067** Effective 02/20/14 a copy of the updated Grievance Procedure has been posted in the entry way of Agape Manor, Inc. The Grievance Procedure includes current contact information for the Department of Health Licensing and Surveys and the WY Ombudsman local representative.	3/1/14 02/17/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Exec. Director — TITLE — (X6) DATE: 2/26/14

Accept w/ date of completion as 3/1/14
Spoke w/ Renee, ED
on 2/27/14
3/1/14

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S5049	Continued From page 1 medication administration records (MARs) contained the required information. Information was lacking in the individual records for 4 of 4 sample residents (#4, #10, # 19, #23) who's medications were administered by the facility. The findings were: Observation during a medication pass on 2/11/14 at 7:45 AM showed certified medication aide (C-MA) #1 administered a pre-labeled package of medications to resident #10. The resident's name, the medication names and doses, and the pharmacy information was labeled on the package. After administering the medications, the C-MA documented in the medication log book that she had given the residents "A.M." medications. Review of the medication log book showed it had a list for the day of all the residents' names and a place to initial for "A.M., Noon, P.M., NOC [night], PRN [as necessary], and other." This document did not include the specific medications for the residents. Review of the individual records for resident #10, #4, #19, and #23 showed the MARs for January and February 2014 had specific medications listed with the doses; however, there were no initials to show who had administered the medications. Instead there was an "x" in each box. Additionally, the individual resident MARs failed to include the physician phone number, and the name of the pharmacy and the pharmacy phone number. Interview with the C-MA, who was also the resident care director on 2/11/14 at 3 PM verified the system they were using failed to document all the required information on the MARs in the individual records.	S5049	~~The Grievance Procedure along with any~~ changes in state requirements will be reviewed annually by the Resident Care Director and the Executive Director during the annual Quality Assurance review. **S5072** Effective 02/27/14, a Registered Dietician will begin visits to Agape Manor, Inc. each month. New residents or residents with dietary changes requiring special needs, including #4, #12, #17 #19, will be reviewed by the RD each month. The RD will be contracted to visit Agape Manor, Inc. at a minimum of once monthly to review residents' dietary needs and the competency of the dietary staff. The RD will oversee all therapeutic and/or modified diets and provide guidance related to dietary services. The RD will review all new residents' dietary requirements. There will be formal training for necessary kitchen and nursing staff members after the RD visit. The RD will meet with the Kitchen Manager each month to review	02/20/14 2/27/14

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S5067	Continued From page 2	S5087	**S5049** Effective 02/24/14 all resident's, including #4, #10, #19, #23, MARs have been edited to include all information required in Chap 12 Sec 7 (d)(i)(A-K), including but not limited to the physician phone number, name of pharmacy and phone number of pharmacy. As of 03/01/14 the procedure for filling out the MAR has been updated to require the initials of the individual who has administered the medication. Formal training and discussion regarding this procedure took place on 02/20/14. The Resident Care Director, LPN, and RN will all be periodically checking the MARs for adherence to the current procedure. Review of the MAR form and the procedure will be reviewed annually during the Quality Assurance review.	2/24/14 02/17/14
S5067	Ch 12 Sec 7 (g) Assisted Living Facility (ALF) Core Services (g) Grievance Procedure. The written grievance procedure shall be posted in a conspicuous place within the facility. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to post the written grievance procedure in a conspicuous place within the facility. The findings were: Review of the undated resident policy and procedures manual showed if a resident had a grievance or complaint they should speak with the administrator and together they would complete the report. The information contained in the written policy and procedure included contact information for the State agency to be contacted if problems were not resolved through the facility administration. However, the State agency contact information address was outdated and not correct. In addition, the written grievance procedures were not posted in the facility other than in the medication/nurses area, where resident's were not allowed. Interview with the resident care director on 2/11/14 at 3:25 PM verified the procedures were not posted in an area where residents could see it.	S5067	**S5067** Effective 02/20/14 a copy of the updated Grievance Procedure has been posted in the entry way of Agape Manor, Inc. The Grievance Procedure includes current contact information for the Department of Health Licensing and Surveys and the WY Ombudsman local representative.	
S5072	Ch 12 Sec 7 (j)(i) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (i) Assisted Living Facilities that choose to admit residents who need therapeutic or	S5072		

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S5072	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 State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to employ a contract Registered Dietitian (RD) to oversee therapeutic and/or modified diets, and to provide guidance related to dietary services. There were 5 of 23 residents (#4, #12, #13, #17, #19) the facility identified with orders for diabetic or low sodium diets. The findings were: Review of the physician orders showed the following residents had diabetic diets: #4 had orders dated 6/14/10 #12 had orders dated 8/1/13 #17 with orders dated 8/1/13 #19 had orders dated 6/12/13 In addition, resident #13 had physician orders dated 3/29/13 for a "No added salt, Low Sodium" diet. Interview with the administrator on 2/11/14 at 12:10 PM verified there was not an RD that worked with the facility related to the therapeutic diets or to provide a monthly onsite review of the dietary services.	S5072	given timeframe they've been assigned. The CDM will be checking the kitchen area weekly to ensure all weekly/monthly cleaning checklist items are items are completed in addition to ensuring safe food storage requirements. All cleaning schedules will be evaluated during the annual Quality Assurance review. **S5088** On 02/21/14 we developed a Quality Assurance program to identify areas of concern. The QA program will utilize monthly resident council meeting minutes, resident satisfaction surveys, any grievances/complaints, etc. The Executive Director is responsible for coordinating the program. An annual review of the WY Assisted Living Rules and Regulations will clarify future requirements or changes to the current requirements.	02/22/14
S5076	Ch 12 Sec 7 (j)(v) Assisted Living Facility (ALF) Core Services	S5076	The Executive Director and the Resident Care Director have added the QA program to their annual calendars.	

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S5076	Continued From page 4 (j) Food Service and Nutrition. (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 the Food Code published by the U.S. Public Health Service, Food and Drug Administration. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a sanitary environment in the kitchen related to food storage and cleanliness. The findings were: 1. Observation on 2/11/14 at 7:30 AM showed raw chicken, raw pork roast, and a "fully cooked" ready-to-eat ham were all placed on the same tray thawing in the refrigerator. Each type of meat was packaged; however, they were not separated as required. Interview with cook #1 at that time verified the foods should be separated. According to Food Code 2013, U.S. Public Health Service, 3-302.11 "(A) FOOD shall be protected from cross contamination by: (1) Separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables, and (b) Cooked READY-TO-EAT FOOD;..." 2. Observation on 2/11/14 at 7:30 AM showed the following items/equipment were identified as	S5076	~~The QA program's final step is to~~ review the QA process annually and see if it can be improved upon. 02/21/14 **S5089** As of 02/21/14 Agape Manor has amended their policies and procedures to include a. Disciplinary procedures regarding substantiated cases of resident abuse. b. Notification of change in condition of resident c. Identification of change in resident's condition d. Notification of change in established per diem/rate/charges/fees e. Outside contractual responsibilities. Annually the Rules and Regulations will be reviewed to insure we have all the required written policies and procedures in place. All policies and procedures will be evaluated during the annual Quality Assurance review. 02/22/14	

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S5076	Continued From page 5 needing to be cleaned: a. Three ceiling vents and the surrounding ceiling tiles located in the production area of the kitchen. These vents and tiles had accumulation of dust. b. The hood vents located above the range had a thick accumulation of dust and grease. c. The range top burners were crusted with burned and spilled food d. The interior of the refrigerator and freezer units had food crumbs and debris on the shelves and the floors of the units. e. The convection oven and the standard oven interiors were unclean with burned black food accumulation in the bottoms and on the sides of the ovens. Interview with cook #1 on 2/11/14 at 8:40 AM verified there was not a cleaning schedule for the kitchen. She stated the kitchen staff cleaned as needed. At 12:10 PM that day, the administrator verified there was not a cleaning schedule for the kitchen; further, the ceiling vents would need to be scheduled with maintenance to be cleaned. According to Food Code 2013, U.S. Public Health Service 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. "...(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris."	S5076		
S5088	Ch 12 Sec 7 (I)(i)(A-D) Assisted Living Facility (ALF) Core Services (I) Quality Improvement. (i) The facility shall have an active quality	S5088		

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S5088	Continued From page 6 improvement program to ensure effective utilization and delivery of resident care services. (A) A member of the facility's staff shall be designated to coordinate the quality improvement program. (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 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. This State Rule and Regulation is not met as evidenced by:	S5088		

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S5088	Continued From page 7 Based on review of quality program information and staff interview, the facility failed to develop a quality program to identify and monitor areas of resident services and programs. The findings were: Review of the facility quality program information showed it was not comprehensive. The 2012 and 2013 information consisted of annual satisfaction surveys of residents and families. Interview with the administrator and the resident care director on 2/11/14 at 3:25 PM verified the program did not have specific areas identified to monitor. The administrator stated the facility was small and there was frequent informal monitoring of resident services. She verified the process needed to be developed into a formal written process.	S5088		
S5089	Ch 12 Sec 7 (m)(i)(A-R) Assisted Living Facility (ALF) Core Services (m) Facility Policies and Procedures. (i) Management shall develop policies and procedures that are available to residents and staff, including but not limited to: (A) Resident rights; (B) Disciplinary procedures surrounding substantiated cases of resident abuse; (C) Admission, transfer, bed hold days, and discharge of residents; (D) Medication management; (E) Emergency are of residents (including missing resident, blizzard, water outage, etc.)	S5089		

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S5089	Continued From page 8 (F) Fire/disaster plan; (G) Departure and return; (H) Smoking; (I) Visiting hours; (J) Activities; (K) Management of resident trust accounts; (L) Personnel policies (M) Grievance procedures; (N) Per Diem rate/charges/fees, to include a listing of what is included in the established charges; (O) Incident reports; (P) Notification of change in established per diem rates/charges/fees; (Q) Outside contractual responsibilities; and (R) Identification and notification of change in resident's condition. This State Rule and Regulation is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure all required policy and procedures were developed. The findings were: Review of facility policies and procedures, and	S5089		

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S5089	Continued From page 9 Interview with the administrator and resident care director on 2/11/14 at 3:25 PM verified the following required policy and procedures were not available, and had not been developed: a. Disciplinary procedures regarding substantiated cases of resident abuse. b. Notification of change in condition of resident. c. Identification of change in resident's condition. d. Notification of change in established per diem rate/charges/fees. e. Outside contractual responsibilities.	S5089		