STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF013	A. BUILDING _____ B. WING _____	C 06/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOWBOAT RETIREMENT CENTER	150 WYOMING STREET LANDER, WY 82520

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)	[illegible]
S5023	Ch 12 Sec 7 (b)(iv)(A-C) Assisted Living Facility (ALF) Core Services	S5023		

(b) Resident Assessment and Services. The staff/contract Registered Nurse (RN) shall conduct initial and, at a minimum annually, an accurate, standardized, reproducible assessment of each resident's functional capacity, physical assessment and medication review.

(iv) Frequency of assessment. An assessment must be conducted:

(A) No earlier than one (1) week prior to admission;

(B) Immediately upon any significant change in the resident's mental or physical condition, or

(C) No less than once every twelve (12) months.

This State Rule and Regulation is not met as evidenced by:
Based on medical record review and staff interview, the facility failed to ensure change of condition assessments were completed for 3 of 3 sample residents (#1, #8, #9) identified with changes. The findings were:

1. Review of the medical record of resident #8 was transferred to the hospital on 6 occasions. The hospital discharge instructions were in the record and showed these visits included: 5/29/14 for a contusion, 1/9/14 for constipation, 9/7/13 for a fall with complaints of pain, 7/27/13 related to falls, 4/7/13 for back pain, and on 2/13/13 for a lower leg contusion. Review of facility progress notes failed to show any information related to these accidents and incidents. There was no

The facility will ensure that the Manager will work with the RN to ensure Change of Condition Assessments are completed for residents as needed. Change of Condition reports and assessments will be on the agenda for monthly Quality Assurance Management Meetings, attended by the Administrator, Manager and RN, referring to resident #8

The Manager will ensure that Change of Condition Assessments and Service Care Plans are made when needed and appropriate. This will be accomplished by 8.15.14.

1. Manager and RN will ensure all visits to the hospital are recorded in resident progress notes with doctor comments or orders. A Change of Condition Assessment will be completed by the RN as determined by physical or mental changes.

2. Manager and RN will ensure all accidents/incidents are recorded in resident progress notes and when appropriate an incident report will be submitted to the State licensing Division and Ombudsman by the Manager or RN.

3. Manager and RN will ensure all falls/incidents are documented in resident progress notes and in incident records.

FACILITY DIRECTOR'S OR PROVIDER'S/SUPPLIER'S REPRESENTATIVE'S SIGNATURE

Annedell Foote — Administrator — 7.21.14

Stacy Owen — Manager

Accepted by Locale Russo 7/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S5023	Ch 12 Sec 7 (b)(iv)(A-C) Assisted Living Facility (ALF) Core Services (b) Resident Assessment and Services. The staff/contract Registered Nurse (RN) shall conduct initial and, at a minimum annually, an accurate, standardized, reproducible assessment of each resident's functional capacity, physical assessment and medication review. (iv) Frequency of assessment. An assessment must be conducted: (A) No earlier than one (1) week prior to admission; (B) Immediately upon any significant change in the resident's mental or physical condition; or (C) No less than once every twelve (12) months. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure change of condition assessments were completed for 3 of 3 sample residents (#1, #8, #9) identified with changes. The findings were: 1. Review of the medical record showed resident #8 was transferred to the hospital on 6 occasions. The hospital discharge instructions were in the record and showed these visits included: 5/29/14 for a contusion, 1/9/14 for constipation, 9/7/13 for a fall with complaints of pain, 7/27/13 related to falls, 4/7/13 for back pain, and on 2/13/13 for a lower leg contusion. Review of facility progress notes failed to show any information related to these accidents and incidents. There was no	S5023	The facility will ensure that the Manager will work with the RN to ensure Change of Condition Assessments are completed for residents as needed. Change of Condition reports and assessments will be on the agenda for monthly Quality Assurance Management Meetings, attended by the Administrator, Manager and RN, referring to resident #8 The Manager will ensure that Change of Condition Assessments and Service Care Plans are made when needed and appropriate. This will be accomplished by 8.15.14. 1. Manager and RN will ensure all visits to the hospital are recorded in resident progress notes with doctor comments or orders. A Change of Condition Assessment will be completed by the RN as determined by physical or mental changes. 2. Manager and RN will ensure all accidents/incidents are recorded in resident progress notes and when appropriate an incident report will be submitted to the State licensing Division and Ombudsman by the Manager or RN. 3. Manager and RN will ensure all falls/incidents are documented in resident progress notes and in incident records.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Arnedell Foote, Administrator — TITLE: Stori Owen, Manager — (X6) DATE: 7.21.14

STATE FORM 6899 GCVF11 If continuation sheet 1 of 11

Accepted by Coralee Rees 7/30/14

Healthcare Licensing and Surveys

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S5023	Continued From page 1 information in the resident record indicating how the falls happened or why the resident required transfer to the hospital on these occasions. In addition, there was no evidence the resident was re-assessed after these instances by the RN to determine if there were physical or mental changes to the resident that required changes to the resident's plan of care and/or assistance plan. 2. Review of the medical record showed resident #9 moved in on 12/19/11. Interview with the resident on 6/17/14 at 3:20 PM revealed s/he had a fall in his/her apartment about 1 year previous, and went to the hospital. The resident stated the fall resulted in a fracture to his/her leg, surgery was done, and s/he participated in physical therapy. Review of the progress notes failed to show any information related to any fall with fracture or the physical therapy. Interview with RN #1 on 6/18/14 at 11:30 AM revealed she remembered the resident's fall and that s/he had surgery and rehabilitation. However, she was not aware this needed to be documented in the record and could not remember the date. In addition, she stated she had not done a change of condition assessment after the fall, and the resident's service assistance plan was not revised. 3. Review of the medical record showed resident #1 moved in on 8/21/13, and was transferred to the hospital on 12/28/13 where the resident passed away. Review of the 3/26/14 mortality report, obtained through the state Medicaid office, and interview with the consultant RN investigator on 6/18/14 at 9:20 AM revealed the resident had two falls (12/11/13 and 12/23/13) while at the assisted living facility. Review of the obtained 12/11/13, 12/15/13 and 12/23/13 ambulance reports showed the resident had a fall at the	S5023	Manager will schedule Inservice to ensure CNA's, RN and other staff report any accidents, falls or other incidents to management for follow up, investigation and reporting. This will be accomplished by 8.15.14. Monitoring of incidents, reporting and Change of Condition Assessments will be monitored monthly at Quality Assurance Management Meeting, referring to residents #1 and #9. Manager & RN will ensure an investigation is conducted for incidents with the facility. The Incident Report will be submitted to the Licensing Division and Ombudsman within 24 hours and the Manager will submit the follow up report within 5 days afterwards.	

Healthcare Licensing and Surveys

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S5023	Continued From page 2 facility on 12/11/13 which resulted in a fractured left elbow. The 12/15/13 ambulance transfer to the hospital was for complaints of pain, and the 12/23/13 report showed the resident had a second fall "while out back" at the facility. Review of the resident record failed to show documentation of these falls and ambulance transfers. Interview with RN #1 on 6/18/14 at 11:30 AM verified the resident was not re-assessed after the falls nor were there any updates or changes to the resident service assistance plan.	S5023		
S5025	Ch 12 Sec 7 (b)(vi)(A-B) Assisted Living Facility (ALF) Core Services (b) Resident Assessment and Services. The staff/contract Registered Nurse (RN) shall conduct initial and, at a minimum annually, an accurate, standardized, reproducible assessment of each resident's functional capacity, physical assessment and medication review. (vi) Resident assistance plan. (A) An RN shall develop an assistance plan for each resident. (B) Each facility shall construct its own forms for such plans, which at a minimum shall contain documentation of the following: (I) Who will provide the care/services; (II) What care/services will be provided; (III) When will care/services be provided;	S5025		

Healthcare Licensing and Surveys

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S5025	Continued From page 3 (IV) How the care/services will be provided; (V) The expected outcome; (VI) Resident participation in development of the assistance plan to the extent of his ability to do so. A relative or other interested party may also participate; and (VII) Dated signature of the RN, the faiclity manager, and the resident or the resident's responsible party. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure resident assistance plans included details for individualized care/services for 9 of 9 sample residents (#1, #2, #3, #4, #5, #6, #7, #8, #9). The findings were: Review of the records showed the facility utilized a form titled the "Resident Assistance Service Plan." This form was completed for each resident upon admission and annually. The form had a typed list of "services provided" and a column next to the list titled "resident preferences." The following concerns were identified: a. Review of the service assistance plans for residents #1, #2, #3, #4, #5, #6, #7, #8, #9 showed for each item there were simple one word answers or symbols to indicate the resident's preferences. The service plans failed to include details such as who would provide care/services, when the care/services would be provided, how the care/services would be provided and the expected outcomes. b. The care/service areas did not have any	S5025	A. The facility will ensure that Resident Assistance Care Plans will include details for individualized care/services for all residents, referring to residents #1, #2, #3, #4, #5, #6, #7, #8 and #9. B. The Manager and RN will ensure use of more detailed information beyond use of single one word answers or symbols to indicate the residents preferences. The service plans will be more specific as to: 1. who will provide the care/service 2. what care/services will be provided 3. when will care/services be provided 4. how will care/services be provided 5. the expected outcome C. The Manager and RN will ensure Service Assistance Plans are based on each individual resident needs. This will be accomplished by 8.15.14.	

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S5025	Continued From page 4 variation for individual residents. The areas of need were determined based on the prepared list and were not based on the individual resident. c. Interview with the manager and RN #1 on 6/18/14 at 11:30 AM verified the assistance service plans needed more individualized details. Further, the RN was unaware the plan was to be updated with any changes of condition the resident may experience.	S5025		
S5052	Ch 12 Sec 7 (d)(iv)(A) Assisted Living Facility (ALF) Core Services (d) Medications. (iv) Medication assistance. (A) The staff shall be responsible for providing necessary assistance to residents deemed capable of self-medicating, but are unable to do so because of a functional disability, in taking oral medications. Non-licensed staff can only assist with oral medications. Medication assistance may include: (I) Reminding resident to take medications; (II) Removing medication containers from storage; (III) Assisting with removal of cap; (IV) Assisting with the removal of a medication from a container for residents with a disability which prevents independence in this act; (V) Observing the resident take the medication; and	S5052		

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S5052	Continued From page 5 (VI) Documentation of observation. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, and review of facility policy and procedure, the facility failed to ensure licensed staff administered medications to random residents. The findings were: Observation on 6/17/14 at 11:45 AM showed CNA #1 came into the large dining room with multiple resident pill packs and pre-filled medication boxes. The CNA opened medication boxes, pouring the enclosed medications into her hand and then proceeded to give the medications to residents. When the medication was in a push through pack, the CNA pushed the medication into her hand, and then put the medication into the resident's hand. The residents were not offered the opportunity to open the medications or take out the pills by themselves. Interview with RN #1 on 6/17/14 at 3:07 PM verified the residents should be given the medication boxes and ask for assistance if needed. She verified CNAs can not administer medications, they may only provide assistance. Review of the updated 12/6/13 facility policy for assisting residents with medications showed, "The CNA will take the cart to the resident and present the med [medication] minder to them...the CNA will ask the resident to open the med [medication] minder...the CNA will offer assistance to the resident if they request it."	S5052	The facility will ensure adherence to stated facility policies & procedures on resident medications. The RN, Administrator and Manager will be responsible for all supervision and management of all medications. 1. The CNA's will assist all residents with their medication by implementing all facility medication policies & procedures. (CNA #1) 2. Medication assistance will be monitored by the Administrator, Manager and RN with a medication quality monitoring tool. 3. The Manager and RN will conduct routine observations of CNA's while assisting residents with their medications. 4. The Manager and RN will conduct an Inservice to strengthen awareness of medication policies & procedures. This will be accomplished by 8.15.14.	
S5054	Ch 12 Sec 7 (e)(i)(A-K) Assisted Living Facility (ALF) Core Services (e) Resident Records and Reports. Each resident's records shall be current, organized and	S5054	5. The medication monitoring tool will be completed weekly for 3 months. and thereafter monthly. Reports will be reviewed monthly at the Quality Assurance Management Meetings.	

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S5054	Continued From page 6	S5054		

maintained in individual folders which shall be made available to the resident, the Licensing Division, or designated representative upon request.

(i) Each folder shall include the following:

(A) Information from the referring agent, if applicable;

(B) History and physical performed by a physician or physician extender;

(C) Individual admission form. The form shall, at a minimum, contain the following information:

(I) Full name of resident and former address;

(II) Date of admission;

(III) Sex, race, date of birth, social security number, and former occupation;

(IV) Name, home address, and telephone number of relative, friend, Power of Attorney, or guardian;

(V) Name, address, and telephone number of resident's personal physician, dentist, ophthalmologist or optometrist;

(VI) Medicare number of other medical insurance identifying data;

(VII) A written inventory of all personal possessions; however, this inventory need not include personal clothing.

Healthcare Licensing and Surveys

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S5054	Continued From page 7 (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; (E) An accounting of all personal funds deposited with and disbursed by the facility; (I) Upon written authorization of a client, the facility must hold, safeguard, manage and account for the personal funds of the client. (1.) The facility must deposit any personal funds in excess of $100 in an interest bearing account. (2.) The facility must establish and maintain a system that assures a full and complete and separate accounting according to generally accepted accounting principles of each resident's personal funds entrusted to the facility. (3.) Upon the death of a resident with a personal fund deposited with the facility, the	S5054		

Healthcare Licensing and Surveys

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S5054	Continued From page 8 facility must convey, within 30 days, the resident ' s funds a final accounting of those funds, to the individual or probate jurisdiction administering the resident ' s estate. (4.) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare except for applicable deductible and coinsurance amounts. (F) A signed copy of the resident's rights; (G) The resident's assessment and individualized assistance plan; (H) Copies of all applicable resident assistance contracts, signed by both parties; (I) Written acknowledgment of the receipt and explanation of all facility policies including admission/discharge policies; (J) Copy of all ALF 102's; and (K) Copy of outside contractual responsibilities, if applicable. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff and resident interview, the facility failed to ensure accidents and injuries were documented in the resident records and or reported to the Licensing Division for 4 of 9 sample residents (#1, #3, #8, #9). The findings were: 1. Review of the medical record showed resident	S5054	The facility will ensure accidents and injuries are documented in the resident files and will be reported to the Licensing Division and Ombudsman, referring to residents #1, 3, 8 and 9. 1. The facility will use the Incident Report from the Department web page. We submitted our first Incident Report on 7.8.14 after receiving instruction on when and how to use the form. 2. The Manager will ensure reporting of accidents and incidents that affect the health, welfare or safety of residents to the Licensing Division and Ombudsman. 3. The Manager will schedule an Inservice to review documentation of accidents and incidents with all staff. This will be accomplished by 8.15.14. 4. All resident files with any incident or accident will be monitored at the monthly Quality Assurance Management Meeting.	

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S5054	Continued From page 9 #8 was transferred to the hospital on 6 occasions. The hospital discharge instructions were in the record and showed these visits included: 5/29/14 for a contusion, 1/9/14 for constipation, 9/7/13 for a fall with complaints of pain, 7/27/13 related to falls, 4/7/13 for back pain, and on 2/13/13 for a lower leg contusion. Review of facility progress notes failed to show any information related to these accidents and incidents. There was no information in the resident record as to how the falls happened or why the resident required transfer to the hospital on these occasions. In addition, these accidents and incidents were not reported to the Licensing Division. 2. Review of the medical record showed resident #9 moved in on 12/19/11. Interview with the resident on 6/17/14 at 3:20 PM revealed s/he had a fall in his/her apartment about 1 year previous, and went to the hospital. The resident stated the fall resulted in a fracture to his/her leg and surgery was done. Review of the progress notes failed to show any information related to any fall or transfer to the hospital. Interview with RN #1 on 6/18/14 at 11:30 AM revealed she remembered the resident's fall and that s/he had surgery and rehabilitation. However, she was not aware this needed to be documented in the record. In addition, there was no report made to the Licensing Division 3. Review of the medical record showed resident #1 moved in on 8/21/13, and was transferred to the hospital on 12/28/13 where the resident passed away. Review of the obtained 3/26/14 mortality report and interview with the consultant RN investigator on 6/18/14 at 9:20 AM revealed the resident had two falls while at the assisted living facility (ALF): one on 12/11/13 and another 12/23/13. These falls were further verified by	S5054		

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S5054	Continued From page 10 obtaining and reviewing the 12/11/13, and 12/23/13 ambulance reports. The fall on 12/11/13 resulted in a fractured left elbow. Review of the resident record maintained by the facility failed to show either of these falls occurred nor were they reported to the Licensing Division. 4. Review of the medical record showed resident #3 moved in on 4/28/12. Review of the progress note dated 3/14/14 showed the resident had a fall from bed and was transferred by ambulance to the hospital. The resident was moved to a higher level of care and was discharge from the ALF on 6/2/14. Interview with the manager and RN #1 on 6/18/14 at 11:30 AM verified there was no report made to the Licensing Division of the fall and transfer to the hospital. 5. Interview with the manager and RN #1 on 6/18/14 at 11:30 AM verified information related to injuries, accidents, and hospital transfers were not always documented. Further, they were unaware of the requirement to report accidents and incidents that affected the health, welfare or safety of residents to the Licensing Division.	S5054		