Healthcare Licensing and Surveys

PRINTED: 01/07/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF014	A. BUILDING: _____ B. WING _____	C 12/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING WIND ASSISTED LIVING COMMUNITY	1072 NORTH 22ND STREET LARAMIE, WY 82072

(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
S5008	Ch 12 Sec 8 (d)(II)(A-F) Personnel and Staffing Requirements (d) Infection Control. Written policies shall be in effect to ensure that newly hired and current employees do not spread a communicable disease that could be transmitted through usual job duties. These shall not be limited to: (II) Tuberculin Testing. (A) Tuberculin testing must be accomplished for each employee prior to employment and annually thereafter. (B) Employees having known positive skin tests shall provide a certificate of noninfectiousness, recommendations, if any, for treatment, and evidence they have complied with such recommendations. (C) Individuals provide documentation of negative skin test administered within the last twelve (12) months do not require a follow-up (D) Individuals who have not had a skin test or who do not have written proof of skin test results, shall have an intradermal Mantoux using 5TU PPD. This shall be accomplished via the two (2) step procedure. If the first test is negative and the employee is asymptomatic, the employee may engage in resident contact prior to the results of the second skin test. (I) A negative reaction requires no follow-up. (II) A positive reaction (10mm in duration using 5TU PPD) requires a referral to a physician for x-ray and certification of noninfectiousness and appropriate treatment if	S5008	**S5008** **Personnel and Staffing Requirements** The Clinical Services Director (CSD) or designee has observed CNA #1 performing direct resident care. The CSD has educated CNA #1 on universal precautions while performing direct resident care. The CSD or designee has observed the current nursing staff performing direct resident care to ensure the staff is following universal precautions. The CSD has educated current nursing staff on universal precautions while performing direct resident care. 1/31/15 Newly hired staff will be educated and show competency on the use of universal precautions while performing direct resident care during their orientation and training by the CSD or designee. The CSD or designee will randomly observe current staff while performing direct resident care to ensure the staff is following universal precautions 3 x per week for 1 month then twice monthly until resolved. The Edgewood Dressing Competency Form will be used as a monitoring tool. The results of the monitoring tool will be calculated monthly and reported to the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Exec. Dir. (X6) DATE 1/31/15

STATE FORM 6899 QAUH11 If continuation sheet 1 of 20

POC accepted. Called Tony Janusz, E.D., on 1/15/15 @ 10:49 a.m. Janice Colby, OSHL
DOC = 1/31/15

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S5008	Continued From page 1 needed. Follow up shall comply with the recommendations of the attending physician. (E) If symptoms occur, a new certificate of noninfectiousness is required. (F) No person with an airborne, contagious or infectious disease shall be employed until a work release is obtained. (I) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents and their food, if direct contact will transmit a disease. (II) The facility shall require staff to follow universal precautions when performing direct resident care. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview and policy review, the facility failed to ensure the staff followed universal precautions when performing resident care during two random observations. The findings were: Observation on 12/22/14 at 8:20 PM showed CNA #1 assisted resident #11 to the restroom and removed the resident's wet brief. The CNA did not remove her gloves before assisting the resident with sitting on the toilet, putting on a new brief and pants, retrieving a wash cloth for the resident to use to clean his/her face, and retrieving the oxygen cannula that had fallen on the floor. While still wearing the soiled gloves, the CNA placed the resident's drink in the refrigerator, placed the cleaned oxygen cannula on the resident's face,	S5008	Quality Management Committee quarterly for review; and corrective action if necessary until resolved.	

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S5008	Continued From page 2 touched the resident's abdomen to inspect the skin, retrieved a clean towel, performed perineal for the resident, and then removed her gloves and performed hand hygiene. Interview at that time with CNA #1 revealed she "should have removed my gloves" before putting the drink in the fridge, and that she did not receive "a lot of training when [she] returned [to work at the facility]." Observation on 12/22/14 at 8:45 PM showed CNA #1 assisted resident #12 to the restroom and removed the resident's wet underwear pad. The CNA did not remove her gloves before assisting the resident with putting on a new brief. The resident wiped his/herself, and the CNA assisted the resident to bed. The CNA washed her hands, but did not offer to assist the resident to wash his/her hands. Interview at that time with CNA #1 revealed the CNA "probably should have offered to have [the resident] wash [his/her] hands." Interview with the DON on 12/23/14 at 4 PM confirmed the CNA should have removed her gloves and washed her hands after removing a wet brief or underwear pad and before touching anything else. Review of the facility policy titled "Infectious Disease Guidelines" dated November 2014 revealed the expectation the staff are to follow the Center for Disease Control (CDC) guidelines. Review of the CDC guidelines titled "Guideline for Hand Hygiene in Health-Care Settings" published October 2002, page 34, showed "...wash hands with an antimicrobial soap and water...Decontaminate hands after removing gloves." (www.cdc.gov)	S5008	**S5049** **Assisted Living Facility (ALF) Core Services** Residents # 2, #4, #10, #15, and #16, their families and physicians have been notified regarding missing medication administration documentation. An audit of the MAR's has been completed to determine if there is any missing medication administration documentation. Any residents who had missing medication administration were notified as well as families and physician. 1/31/15 Current LN staff will have a Medication Administration Audit completed by the CSD or RN designee by 1/31/2015 and then annually prior to their yearly performance evaluation. Newly hired LN will have a Medication Administration Audit completed within 1 week after their orientation and training (to include completion of the Medication Administration Training Manual) and then annually prior to their yearly performance evaluation. The CSD or RN Designee will review the Medication Administration Training Manual with the current LN staff by 1/31/2015.	

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S5049	Continued From page 3	S5049	The CSD or designee will audit the MAR's for completeness and compliance 2 x per week for 1 month then weekly thereafter for 3 months then monthly thereafter. The results of the audits will be presented to the Executive Director at the Quality Management meetings quarterly for review and corrective actions if necessary until resolved.	
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:	S5049		

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S5049	Continued From page 4	S5049		

Based on medical record review and staff interview, the facility failed to ensure a complete medical record was maintained for 5 of 21 sample residents (#2, #4, #10, #15, #16) with medication orders. The findings were:

Review of the December 2014 Medication Administration Record (MAR) for resident #4 showed documentation was missing on 12/2 for metoprolol 12.5 mg scheduled to be given at 8 AM; 12/5 for the following prescribed medications: omeprazole 20 mg scheduled to be given at 8 AM, calcium with vitamin D 600/200 mg scheduled to be given at 8 AM and 5 PM, Namenda 10 mg scheduled to be given at 8 AM and 5 PM, Meclizine 12.5 mg scheduled to be given at 8 AM, 12 PM, and 5 PM; the blood pressure recordings to be taken every Wednesday and Saturday were missing on 12/3, 12/10, 12/13, and 12/17.

Review of the December 2014 MAR for resident #10 showed documentation was missing for fasting blood sugar to be taken every Wednesday on 12/10 and 12/17; and was missing for an ordered blood sugar check "every week on Thursday a few hours after meal" on 12/11 and 12/18.

Review of the December 2014 MAR for resident #15 showed documentation was missing on 12/7 for the following prescribed medications: doxycycline 100 mg scheduled to be given at 5 PM, and omeprazole 20 mg scheduled to be given at 5 PM; documentation was missing on 12/8 for Mapap (acetaminophen) 500 mg scheduled to be given at 8 AM and at 12 PM.

Review of the December 2014 MAR for resident #16 showed documentation for blood pressure

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S5049	Continued From page 5 recordings to be taken every day was missing on the following days: 12/1, 12/4, 12/7, 12/9, 12/13, and 12/17. Review of the November 2014 MAR for resident #2 showed documentation was missing for ordered blood sugar checks 1 hour after meals for the following dates: 9:30 AM on 11/8, 11/12, 11/21, and 11/30; 6:30 PM on 11/29 and 11/30. documentation was missing on 11/25 and 11/28 for fentanyl 25 mcg/hr patch to be applied every 72 hours. Interview with the DON on 12/22/14 at 3:30 PM confirmed the above documentation was missing, and it was unknown if the residents had received their medication as ordered, or if the blood sugars and blood pressures were taken. According to Nursing Interventions & Clinical Skills, Perry, Potter and Elkin, 5th Edition, 2012, page 493: Record the administration of each medication on the MAR as soon as you give it.	S5049		
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 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;	S5054	**S5054** **Assisted Living Facility (ALF) Core Services.** The incident report involving resident # 4 has been reported to the Licensing Division along with the final investigative report. The resident's family and physician have been notified of the incident. 1/31/15	

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S5054	Continued From page 6 (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. (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	S5054	The CSD has reviewed incidents which were initially reported as injury of unknown origin for the last two quarters of 2014 for any that were not reported to the Licensing Division in a timely manner. Any that were not in compliance were reported to the Licensing Division and family and physicians notified. The CSD reviewed the facility policy titled "Incident and Risk Management Reporting". Current LN staff was educated on the "Incident and Risk Management Reporting" policy regarding injury of unknown origin documentation by the CSD. Newly hired LN staff will be educated on the "Incident and Risk Management Reporting" policy by the CSD or designee during their orientation and training. Future incidences where there is a potential injury of unknown origin will be investigated by the CSD and/or ED and the report reviewed for compliance with the facility policy titled "Incidence and Risk Management Reporting". Incidence of unknown origin will be reported to the proper entities per ALF Chapter 12 section 7 time requirements. The CSD or designee will compile a report monthly and the results presented	

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S6064	Continued From page 7 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 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.	S6054	to the Quality Management Committee quarterly for review and corrective actions taken when necessary.	

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S5054	Continued From page 8 (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, staff interview, policy review, and State Survey Agency record review, the facility failed to report incidents involving the health, welfare or safety of a resident to the Licensing Division in a timely manner for 1 of 21 sample residents (#4) selected for review of incidents. The findings were: Review of nursing notes for resident #4 dated 6/18/14 timed 2:40 AM showed three quarter sized bruises were found on the resident's lower abdomen, the resident had a diagnosis of dementia, and the family member who was notified was not aware of a possible reason for the bruising. Review of the Licensing Division records revealed the incident had not been reported to the agency.	S5054		

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S5054	Continued From page 9 Interview with the DON on 12/22/14 at 8 PM confirmed the incident had not been reported to the Licensing Division because her investigation had shown the bruises were obtained from using heparin while the resident was in the hospital, and that incidents of unknown origin were not reported to the Licensing Division if the investigation shows a possible cause for the injury. Review of the facility policy titled "Incident and Risk Management Reporting" dated November 2014 showed resident incident reports should be completed in the event of any resident incident, but did not specify the resident's family should be notified, or that occurrences should be reported to the appropriate entity for follow up and resolution, or that all incidents affecting the health, welfare or safety of a resident shall be provided to the Licensing Division within 24 hours, and the investigation shall be reported within 5 business days.	S5054		
S5085	Ch 12 Sec 7 (k)(iv)(A-F) Assisted Living Facility (ALF) Core Servicse (k) Transfer and Discharge. (iv) Residents transferred to another health care facility shall be given written transfer/discharge notice which includes: (A) The name of the resident; (B) The reason for the transfer/discharge; (C) The effective date of the transfer/discharge;	S5086	**S5085** **Assisted Living Facility (ALF) Core Services.** Resident #21 has already been discharged and admitted to another facility therefore the 30 day written notice cannot be corrected. 1/8/15 There are no current resident in which a facility initiated transfer or discharge has been issued to audit for compliance at this time.	

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S5086	Continued From page 10 (D) The location to which resident is transferred/discharged; (E) The name, address, and telephone number of the Ombudsman; and (F) A listing of all outside contracted services. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure discharged residents received a complete 30 day written notice prior to any facility initiated transfer or discharge for 1 of 3 sample residents (#21) reviewed as a closed record. The findings were: Review of the medical record for resident #21 showed a discharge letter was given to the family. However, the letter failed to specify the following: the location to which resident was transferred/discharged; the name, address, and telephone number of the Ombudsman; and a listing of all outside contracted services. Interview with the DON on 12/23/14 at 2:30 PM confirmed the letter was missing the information because she was unaware it was required.	S5086	A revised Resident Complaint Grievance Resolution Policy which contains updated Names, addresses, and phone numbers of the Ombudsman and the Licensing Division has been delivered to current residents and their families. The ED, CSD, and BOM have reviewed the ALF Core Services Chapter 12 Section 7 regarding the requirements for a thirty day written notice prior to any facility initiated transfer or discharge. Future 30 day written notices for facility initiated transfer and discharge will be reviewed prior to delivery for completeness (including Name, Address, Telephone Number of the Ombudsman and a listing of any outside services). Any Non-compliance will be corrected immediately and the results will be reported to the Quality Management Committee at the quarterly meeting for review and corrective action if necessary until resolved.	
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	**S5088** **Assisted Living Facility (ALF) Core Services.** 1/31/15	

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S5088	Continued From page 11 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	The Healthcare Licensing and Survey Division's 2567 submitted from the survey conducted on Oct. 16, 2013 and ensuing Plan of Correction put in compliance Dec. 12, 2013 was presented to the Quality Management Committee on 1/21/2015 for review and corrective actions for citations which are non-compliant will be developed (including falls). The ED has reviewed Chapter 12 Section 7 Assisted Living Facilities Core Services regarding Quality Improvement and then presented to the Quality Management Committee on 1/21/2015. The Quality Management Committee will meet no less then quarterly to review the effective utilization and delivery of resident care services, the audits and Plans of Corrections of previous surveys and plans to integrate the results into the daily resident care services in accordance with ALF Core Services regulations. Incident Reports (including falls) will be investigated by the CSD and/or Designee and then reviewed by the ED. Residents with frequent falls will be evaluated by the CSD and ED and interventions put in place and documented in the resident's MR and individualized care plan. A monthly report of incidents will be	

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(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
S5088	Continued From page 12 Based on incident tracking log review, staff interview and policy review, the facility failed to ensure an active quality improvement program was in place that encompassed a review of all services and programs provided for all residents. The facility census was 68. The findings were: The following concerns were identified related to the quality improvement program: 1. Review of the facility incident tracking log showed 235 falls for 2014. 2. Interview with the Administrator on 12/23/14 at 2:45 PM revealed the quality improvement program was not fully developed in the following areas: there was no written description, there were no audits from the previous survey and no plan to integrate the results, and the only quality improvement committee meeting was the monthly safety meeting. For the issue of falls, the administrator also verified there was no documentation of interventions and evaluations. Review of the policy titled "Risk Quality Management" dated November 2014 showed "The QA/RM [Quality Assessment/Risk Management] Committee shall monitor compliance with corrective action plans developed in response to events."	S5088	presented to the monthly Safety Committee meeting for review. Trends and concerns will be addressed and corrective actions and interventions will be put in place and reported back to the Safety Committee meeting monthly. Results and minutes of the Safety Committee will be presented to the Quality Management Committee for review and corrective actions where necessary.	
S5091	Ch 12 Sec 7 (n)(ii)(A-AA) Assisted Living Facility (ALF) Core Services (n) Furnishings, Buildings, Physical Plant. (ii) Sleeping rooms shall be homelike, well lighted, ventilated and equipped in compliance with the requirements below:	S5091	**S5091** **Assisted Living Facility (ALF) Core Services.** Residents #11 and #13 have had their	1/21/15

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	ALF014	A. BUILDING: _____ B. WING _____	C 12/23/2014

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S6091	Continued From page 13 (A) All windows shall have drapes, curtains, shades or blinds to assurance privacy; (B) Beds (If provided by the facility) shall be at least standard size in width (39"), and shall be equipped with comfortable, clean mattresses and pillows. Mattresses shall be professionally renovated or replaced as needed. Extra long beds shall be used to accommodate tall residents. Rollaway-type beds, cots, and folding beds shall not be used unless the resident brings these items from home for personal use; (I) Two residents may, by consent of both parties; or by approval of the appropriate responsible party, be permitted to use one bed no smaller than double size, and occupy a single-bed sleeping room. (C) Cabinet or bedside table; (D) Non-combustible wastebasket; (E) Chair; and (F) If common closets are utilized by two (2) or more residents, dividers shall be provided for separation of each resident's clothing. All closets shall be equipped with doors. Free-standing closets shall be deducted from the square footage in the sleeping room. (G) The size and arrangement of the residents' beds, furnishings, possessions or equipment shall allow the resident to gain fire emergency access to windows and doors, and access to toilet room. Multiple-bed rooms shall have at least three (3) feet between beds.	S5091	oxygen canisters secured per NFPA 93 regulations. The Environmental Services Director (ESD) has completed an audit of resident's rooms currently using oxygen for compliance. Non-compliant rooms were corrected immediately. The ESD has contacted current oxygen suppliers to educate them on the NFPA regulations in regards to oxygen canister containment. The ED has sent out a letter containing the NFPA 93 regulations to these suppliers. Current residents have been educated on the NFPA 93 regulations regarding oxygen storage and containment. Current staff has been educated on the facility policy "Oxygen Assistance and Administration" as well as the NFPA 93 regulations concerning oxygen storage. Newly hired nursing staff will be educated and show competency on Oxygen Assistance and Administration concerning oxygen storage. The ESD has developed a monitoring tool to randomly check resident's rooms who utilize oxygen canisters for proper storage. Any non-compliant rooms will be corrected immediately. The results of these checks will be presented to the	

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S5091	Continued From page 14 (H) Residents shall be encouraged to bring personal items and furniture to their rooms, (e.g., beds, chairs, and pictures); (I) There shall be at least one (1) bedside screen per double room available to provide resident privacy when needed; (J) There shall be an adequate supply of hot and cold water available at each lavatory, bathtub/shower, kitchen sink, dishwasher, and laundry equipment. Hot water for bathing, and resident handwashing, and laundry should be no hotter than one hundred and twenty (120°) degrees Fahrenheit. (K) All plumbing shall be maintained in good repair and according to the requirements of the Uniform Plumbing Code; (I) Private water systems shall be safe, potable, and have an adequate supply. Testing shall be done monthly and records of tests shall be retained at the facility. (II) Private water systems shall be tested and found safe and potable before Licensure is granted. (L) Fireplaces shall be securely screened and glassed in; (M) The facility shall be maintained so that it is free of hazards, such as loose or broken window glass, loose or cracked floors or floor coverings, or cracked or loose plaster on wall or ceilings; (N) At least one primary grade level entrance to the building shall be freely accessible for wheelchairs; (O) Each resident shall have his individual comb, toothbrush, towels, and wash cloths; (P) Clean drinking glasses shall be	S5091	monthly Safety Committee for review and corrective actions taken when necessary. The monthly Safety Committee meeting minutes will be presented to the quarterly Quality Management meeting for further review and/or corrective action until resolved.	

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S5091	Continued From page 15	S5091		

available for the residents. Common drinking cups are prohibited;

(Q) Bathrooms shall have soap and toilet paper. The facility shall provide paper towels or a blow dryer for hands, or rack space adequate for each resident using the bathroom to hang his/her personal towel. Use of a common towel is prohibited.

(R) Provisions shall be made for privacy in all bath and toilet rooms;

(S) Automatic deodorizers or aerosol fresheners shall not be used except in bathrooms; and

(T) Residents shall not use a common bar of soap. The facility shall provide either soap dispensers or individual bars of soap for each resident.

(U) Housekeeping.

(I) Housekeeping practices and procedures shall be employed to keep the home free from offensive odors, accumulations of dirt, and dust.

(II) Floors shall be maintained and clean.

(III) Polish of floors shall provide a non-slip finish.

(IV) Throw or scatter rugs shall not be used. Non-slip mats may be used.

(V) Covered containers with tight lids shall be used for garbage storage.

(W) The facility shall be maintained free of insects and rodents. All windows shall be screened. All exit doors opening inward shall have a screen door.

(X) Linens and laundry.

(I) Laundry service for linen and residents' personal clothing shall be provided. The manager shall take measures to ensure that residents' clothing is not lost or misplaced while

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S5091	Continued From page 16	S5091		

laundering.

(II) All linen shall be bagged or placed in a hamper before being transported to the laundry area.

(III) Bed linen shall be changed as necessary but at least weekly. Additional blankets or pillows shall be provided. Rubber or water protective sheets shall be used if indicated.

(IV) Two (2) complete changes of clean bed linen shall be on hand for each licensed bed.

(1.) Torn, worn, or unclean bed linen shall not be used.

(V) All bleaches, detergents, disinfectants, and other cleaning agents shall be separated from medicines and foods.

(VI) Soiled linen shall not be transported through, sorted, processed, or stored, in kitchens, food preparation areas, or food storage areas.

(Y) The heating system shall be inspected yearly, before the heating season, and maintained according to manufacturer's instructions.

(Z) Portable space heaters shall not be used (e.g. electric or kerosene)

(AA) Equipment Maintenance and Testing.

(i) The devices, equipment, systems, conditions, arrangements, levels of protection, or any other features that are required for compliance with the provisions of the Life Safety Code shall be permanently maintained for the building housing the facility.

This State Rule and Regulation is not met as evidenced by:
Based on observation, staff interview and policy review, the facility failed to ensure oxygen

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S5091	Continued From page 17 canisters were maintained in a safe manner during three random observations, which affected residents #7, #11, and #13. The findings were: Observation on 12/22/14 at 4:30 PM showed six unsecured "B" size oxygen canisters on the floor in the room of resident #7. Interview at that time with CNA #1 showed the oxygen tanks were "not supposed to be there." Observation on 12/22/14 at 4:45 PM showed one unsecured "B" size oxygen canister in the room of resident #11. Interview at that time with the Administer and DON verified the unsecured oxygen canisters should be in a container. Observation on 12/22/14 at 9 PM showed one unsecured "B" size oxygen canister in the room of resident #13. Interview at that time with CNA #2 verified the unsecured oxygen canister should be in a container, but the CNAs were confused about what to do with empty oxygen canisters. Review of the facility policy titled "Oxygen Assistance & Administration" dated November 2014 showed "3. Oxygen tanks will be secured and stored upright at all times." According to National Fire Protection Association (NFPA) 99 (1993 edition): 4-3.1.1.1 Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over.	S5091		
S5107	Ch 12 Sec 9 (a)(i-v) Contractual Svcs Provided Outside ALF Auth Contractual Services Provided Outside Assisted Living Facility Authority. Residents in an	S5107	**S5107** **Contractual Services Provided Outside ALF Authority.**	1/31/15

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S5107	Continued From page 18 assisted living facility may receive services from an outside entity for care beyond that provided for or specified in the Assisted Living Program Administration Rules. These services must be arranged by the appropriate professional and be incorporated into the resident's assistance plan. The resident's choice of providers must be honored. (a) Components of the outside service(s) contract: (i) Who will provide service(s); (ii) What service(s) will be provided; (iii) When the service(s) will be provided; (iv) Where the service(s) will be provided; (v) How the service(s) will be provided, and This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure an outside service contract was in place for 1 of 1 sample resident (#7) reviewed for outside services. The findings were: Review of the medical record for resident #7 revealed services were being provided to the resident by a hospice company. Interview with the DON on 12/23/14 at 4 PM revealed there were no written contracts with outside services because the resident and/or families contract with hospice and home health, not the facility. Additionally, all communication	S5107	An audit of current residents was conducted and an Outside Services Contract completed for those who were non-compliant. A copy of the ALF Chapter 12 Section 9 regulations concerning outside services was delivered to current service providers along with a copy of the facility Outside Services Contract Form and will be given to any Outside Services providers who are new to the facility. The LN staff was educated on the ALF Chapter 12 Section 9 regulations concerning outside services by the CSD. Newly hired LN staff will be educated on the Outside Services Contract form during their orientation and training. A report will be prepared and presented quarterly to the Quality Management Committee for review and corrective action if necessary until resolved.	

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S5107	Continued From page 19 with outside facilities was verbal, not written. Interview with the Administrator on 12/23/14 at 6:30 PM verified there were no written contracts with outside services.	S5107		