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Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF024	A. BUILDING: _____ B. WING _____	C 03/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOME OF BUFFALO	1 NORTH KLONDIKE BUFFALO, WY 82834

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S 000	Opening Comments Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 12/12/2007 Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001 A complaint survey was conducted by Healthcare Licensing and Surveys on 3/11/15 - 3/12/15. The survey was prompted by complaint intakes LIC-15-020 and LIC-15-021.	S 000		
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;	S5049		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shannon L. Lawrence | TITLE: President | (X6) DATE: 6/27/2015

STATE FORM 6899 CUB611 If continuation sheet 1 of 19

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WY Dept of Health
JUN 29 2015
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Plan of correction accepted with agreed upon changes as of 6/30/15.

Tim [illegible] 6/30/15

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S5049	Continued From page 1 (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 staff interview and medical record review the facility failed to ensure a licensed staff administered medications for 4 of 4 sample (#1, #2, #3, #4) residents who required the facility to administer medications. The findings were: 1. Review of the December 2014 Medication Administration Record (MAR) revealed resident #1 had no documentation to show 2 scheduled medications were given on 12/4/14. Review of the January 2015 MAR showed the resident had no documentation that 11 scheduled medications were given on 1/7/15. Further review showed a CNA had initialed administration of 10 medications on 1/19/15, 9 medications on 1/26/15, and 11 medications on 1/29/15. Review of the service plan for medication assistance started on 11/01/14 showed the resident required total assistance with medications. 2. Review of the January 2015 MAR showed resident #2 had no documentation to show 2 scheduled medications were given on 1/7/15. Further review showed a CNA had initialed administration of 2 medications on 1/19/15, 1/26/15, and 1/29/15. Review of the service plan	S5049	A. Do to our current electronic records system consistently having problems saving our data, as well as issues with login verification, we will determine on or before April 25, 2015, whether we are going to abandon the electronic system and revert back to a manual paper system. We will implement the manual paper system by May 1, 2015, if attempts with software support staff do not meet our needs. B. CNA's do not perform med passes and will be reviewed during a staff in-service scheduled for April 10, 2015. C. All current resident files will be audited by April 30, 2015 to review state requirements for documentation and to verify that all active files are complete, up-to-date and in full compliance with the licensing requirements. D. Facility standard operating procedures will be simultaneously implemented to assure full compliance on a go forward basis.	5/1/15

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S5049	Continued From page 2 for medication assistance started on 10/9/14 showed the resident required moderate assistance with medications and nurses were to perform all medication passes. 3. Review of the January 2015 MAR showed resident #3 had no documentation to show 4 scheduled medications were given on 1/7/15. Further review showed a CNA had initialed administration for 5 medications on 1/19/15, 7 medications on 1/26/15, and 6 medications on 1/29/15. Review of the service plan for medication assistance started on 4/27/14 showed the resident required total assistance with medications. 4. Review of the January 2015 MAR showed resident #4 had no documentation to show 1 scheduled medication was given on 1/7/15. Further review showed a CNA initialed administration of 1 medication on 1/19/15, 1/26/15, and 1/29/15. Review of the service plan for medication assistance started on 10/30/14 showed the resident required moderate assistance with medications. 5. Interview with CNA manager on 3/11/15 at 2:48 PM revealed the facility contracted with nurses and they are not at the facility 24 hours per day.	S5049	E. The manager will be performing audits of the resident files monthly and as needed. The manager will report findings to QA Quarterly meeting.	
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.	S5054		

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S5054	Continued From page 3 (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. (D) All accidents, injuries, incidents, illnesses, and allegations of abuse, neglect or exploitation shall be reported to the resident's	S5054		

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S5054	Continued From page 4	S5054		

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 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.

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S5054	Continued From page 5 (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, incident report review, staff interview, and policy review the facility failed to record and/or report incidents or accidents to the appropriate individuals and/or agencies for 2 of 2 (#1,#2) residents with occurrences affecting their health, welfare, or safety. The findings were: 1. Medical record review showed resident #1 was unstable and required a walker for ambulation, had a diagnosis that included dementia and poor vision, and had verbal and physical behaviors	S5054	A. Protocol for reporting and documenting incidences that occur in the facility has been updated and an in-service staff meeting is set for April 20, 2015, to review these procedures. B. A posting of the procedural requirements is posted in the office/staff room and strict compliance, including full and proper documentation, has immediately been implemented. C. If an incident takes place, the staff on shift will immediately notify the home manager and document the details of the incident. All witnesses will be required to complete a report detailing the facts and circumstances	3/24/15

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S5054	Continued From page 6 including combativeness and agitation requiring Ativan two times per day. Further review showed the resident had a decline in activities of daily living function resulting in a change of condition assessment on 12/9/14. Additionally, the resident had a decline in mentation and vision which resulted in a change of condition assessment dated 3/4/15. The following concerns were identified with documenting, reporting, and investigating incidents: a. Review of an incident report dated 12/12/14 and timed 12 PM showed the resident was yelling because she had something stuck in her rectum. The nurse assisted the resident back to her room where a brush was discovered to be covered in feces. The nurse assisted the resident to remove a "large impaction of stool." The incident report also showed the nurse noted blood due to trauma, hemorrhoids, or digital removal of stool. Further review of the incident report and nurse's notes for that time failed to show evidence that the facility had notified the physician and family. b. Review of nurse's note dated 2/21/15 and timed 1:23 PM showed the resident was at the dining room table eating lunch when staff observed his/her face turn "deep red." Further review showed the resident did not cough or respond to the staff member. The nurse's note indicated the Heimlich maneuver was performed with success. The nurse's note failed to indicate that the physician and family were notified. Review of facility incident reports showed that an incident report was not completed. c. Review of an incident report dated 12/6/14 and timed 10:45 AM showed the resident was found on the floor lying partially on her knees and side. Further review of the incident report and nurse's notes for that time failed to show evidence that the facility had contacted the family	S5054	that occurred as they saw them. Nursing staff will determine the need for an assessment of all residents involved in the incident, complete the assessments including documentation, and call or report to the home manager who in turn will notify the family and physicians. We will document this complete process with detailed dates and responses. D. Incidents required to be reported to the state licensing authorities will occur within the required one day time frame and the details of the investigation of the incident will be reported in writing to the state licensing division and the long term care Ombudsmen within the five day reporting requirement. E. Staff has been informed of what is expected of them during incidents and are educated on what is required from the Licensing Division. Having an informed staff will help prevent further incidents like this one from occurring in the future. F. The DON will audit incident reports weekly to ensure proper procedure. Findings will be reported the QA meeting Quarterly.	

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S5054	Continued From page 7	S5054		

or physician of the incident.

d. Review of an incident report dated 12/08/14 and timed 12:00 PM showed the resident "began to get agitated due to the sound of the vacuum " and s/he threw a glass of water on another resident. The incident report then indicated that after being removed from the setting, the resident returned to the dining area and "threw a fork at the other residents still in the dining room." The incident report did not indicate if any other resident was struck with the fork. When removing the resident from the dining area, it was documented that the resident grabbed a staff members wrist and would not let go. Further review of the incident report and nurse's notes for that time failed to show evidence that the facility had notified the physician or family of the incident. Review of facility incident reports revealed there was not an incident report completed on any other residents involved in the incident. Interview with CNA manager on 3/12/15 at 11 AM revealed no incident reports were completed for the other residents involved in the incident and there was no documentation to confirm the physician or family was notified.

e. Review of nurse's note dated 12/20/14 and timed 11:31 AM showed the resident became "angry" when a visitor refused to go to her room with her. Staff unsuccessfully attempted to redirect the resident from the stimuli. The resident then "buckled his/her knees and threw [him/herself] on the floor." Further review showed the facility notified the physician of the incident, but there was no documentation to show the family was notified. Review of the facility incident reports showed that an incident report was not completed.

f. Review of an incident report dated 12/25/14 and timed 1:55 PM showed the resident was "agitated this morning" and had been banging on

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S5054	Continued From page 8 the door, screaming, and wanted to get out. The staff redirected the resident during this episode by assisting the resident to his/her room. The resident returned to the dining area where s/he picked up another resident's granddaughter's toy and threw it across the room. Further review of the incident report and nurse's notes for that time failed to show evidence that the facility notified the physician and family. g. Review of an incident report dated 3/10/15 and timed 10:00 AM showed the resident was ambulating without the use of his/her walker. The resident lost his/her balance and fell into a recliner. Continued review showed the resident "bumped his/her head before [the resident] hit the floor." Further review of the incident and nurse's notes for that time failed to show evidence that the facility had notified the physician and family. 2. Medical record review showed resident #2 required bathing set-up before a shower, utilized a shower chair to sit in during bathing, had a diagnosis that included dementia, and utilized glasses for decreased vision. Review of an incident report dated 12/21/14 and timed 8 PM showed the resident attempted to stand from the shower chair and fell. A small bruise was noted to the resident's left hip. Review of the incident report and nurse's notes for that time failed to show evidence that the facility had notified the physician and family. Review of nurse's note dated 12/25/14 and timed 7:16 PM revealed the resident had indicated to his/her granddaughter that the resident was having tailbone pain. Further review showed the resident's daughter-in-law called after seeing a post on social media made by the granddaughter indicating the resident was having pain. The nurse's notes showed the daughter-in-law felt the facility had a "communication problem." Interview	S5054		

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S5054	Continued From page 9 with the CNA manager on 3/12/15 at 11 AM verified the family was not notified at the time of the fall. 3. Interview with the CNA manager on 3/12/15 at 11 AM revealed an incident "around October" in which two residents engaged in sexual activity in an unoccupied room. The residents involved in the incident had dementia. The incident occurred on a weekend when the facility had less staff. The facility did not complete incident reports and there was no documentation that the physician and family had been notified. The facility had no documentation the incident was investigated or reported to the State Licensing Agency. 4. Review of the facility "Incident and Complaint Policy" showed "all incidents and/or complaints will be brought to the attention of the Operator/Administrator. All problems will be documented in writing." Further review showed the facility will investigate incidents and complaints. Review of facility's incidents revealed the facility had no evidence that incidents were investigated or reported to the State Licensing Agency when necessary.	S5054		
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 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.	S5088		

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S5088	Continued From page 10 (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: Based on record review and staff interview, the facility failed to develop and implement a Quality Improvement Program. The findings were: 1. Review of facility incident reports revealed the facility did not have a tracking method that	S5088	A. Implementation of a Quality Improvement Program, coordinated by the manager, will be in place and fully functional by May 31, 2015. B. As part of the QI program quarterly meetings will be conducted and all staff members, including nurses, will be in attendance. The meetings will be held during the first month of each calendar quarter, and minutes will be prepared and maintained. Areas of concern and problem areas identified during the previous quarter will be the topics of discussion, with resolution along with corrective action to remedy and eliminate the reoccurrence going forward. C. We have just completed a resident/family satisfaction survey in the fourth quarter of 2014. This process will continue to be undertaken in the fourth quarter of each year, with a summary report including the disposition of issues or remedies if any are deemed necessary. D. will review audits related to survey findings at Quarterly QA meeting.	5/31/15

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S5086	Continued From page 11	S5088		

allowed for trends to be identified related to incidents and accidents that occurred in the facility. The facility failed to identify other residents at risk, a plan of correction, or incident trends.

2. Review of facility environment showed the facility failed to identify hazards that could result in resident or staff injury.

3. Review of the facility staffing showed the facility failed to identify concerns that resulted in missed medication administration, non-licensed staff administering medications, and failure to perform neurological assessment for residents that may have sustained a head injury from a fall.

4. Interview with CNA manager on 3/12/15 at 11 AM verified the facility did not have a Quality Improvement Program.

S5091 Ch 12 Sec 7 (n)(ii)(A-AA) Assisted Living Facility (ALF) Core Services — S5091

(n) Furnishings, Buildings, Physical Plant.

(ii) Sleeping rooms shall be homelike, well lighted, ventilated and equipped in compliance with the requirements below:

(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

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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.

(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

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	ALF024	A. BUILDING: _____ B. WING _____	C 03/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOME OF BUFFALO	1 NORTH KLONDIKE 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
S5091	Continued From page 13	S5091		

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 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;

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S5091	Continued From page 14	S5091		

(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 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.

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S5091	Continued From page 15 (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 and staff interview, the facility failed to ensure 1 of 1 dining/kitchen area was free of hazards that created an unsafe environment. The findings were: 1. Observation on 3/11/15 at 1:41 PM showed an area in the kitchen where the flooring was damaged and raised creating a trip hazard for staff and residents. The area was located in front of the refrigerator that was closest to the dining area. The kitchen area had two entrances and nothing restricting entrance to the area. The	S5091	A. The kitchen floor area identified as a hazard will be fully repaired and eliminated as a trip hazard by April 20, 2015. B. Staff has been informed to carefully observe their surroundings for any possible hazards on a daily basis. If a hazard is located the staff member is to report it to the manager. Repairs will be completed in a timely manner to protect resident's health and safety.	4/20/15

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S5091	Continued From page 16 raised area was 3 feet in length and 4 inches wide. Food preparation, including hot items, was completed near the area that was raised. 2. Interview with CNA #1 on 3/11/15 at 1:42 PM confirmed the raised area in front of the refrigerator had been there "for a while." 3. Observation on 3/12/15 at 11:20 PM showed a confused resident was ambulating near the raised area during meal preparation, while the oven was hot.	S5091	c. will have a buildings, grounds, and equipment audit completed monthy and as needed by the facility manager. Findings will be reported to the Quarterly QA meeting.	
S5118	Ch 12 Sec 10 (b)(i)(A) Secure Dementia Units Secure Dementia Units. Level 2 assisted living facilities require adherence to all Level I requirements with the following additional criteria for a Level 2 Assisted Living Facility License. (b) Level 2 Staffing Requirements (i) Nursing Staff. (A) A licensed nurse must be on duty on all shifts. (1.) May be an LPN if an RN is available on premises or by telephone. (2.) To administer P.R.N. medications. (3.) To perform ongoing resident evaluations in order to ensure appropriate, timely interventions. This State Rule and Regulation is not met as evidenced by:	S5118		

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S5118	Continued From page 17 Based on record review and staff interview, the facility failed to provide a nurse on all shifts for 4 of 4 (#1, #2, #3, #4) sample residents requiring medication administration and 1 of 2 (#1) sample residents with incidents requiring routine assessment for injury. The findings were: 1. Review of the Medication Administration Record (MAR) for resident #1 for December 2014 showed the resident had no documentation for 2 medications on 12/4/14. Review of the MAR for January 2015 showed the resident had no documentation of administration for 11 medications on 1/7/15. Further review showed a CNA had initialed administration of 10 medications on 1/19/15, 9 medications on 1/26/15, and 11 medications on 1/29/15. 2. Review of the MAR for resident #2 for January 2015 showed the resident had no documentation of 2 medications on 1/7/15. Further review showed a CNA had initialed administration of 2 medications on 1/19/15, 1/26/15, and 1/29/15. 3. Review of the MAR for resident #3 for January 2015 showed the resident had no documentation for 4 medications on 1/7/15. Further review showed a CNA had initialed administration for 6 medications on 1/19/15, 7 medications on 1/26/15, and 6 medications on 1/29/15. 4. Review of the MAR for resident #4 for January 2015 showed the resident had no documentation for 1 medication on 1/7/15. Further review showed a CNA initialed administration of 1 medication on 1/19/15, 1/26/15, and 1/29/15. 5. Review of an incident report dated 3/10/15 and timed 10 AM showed resident #1 was ambulating without the use of his/her walker. The resident	S5118	A. It has been determined that we no longer qualify as a Level II Assisted Living Facility due to the absence of a full-time nursing staff. B. Our current nursing services qualify us at a Level I Assisted Living Facility. Our nursing services will continue at that level. C. Currently between our Director of Nurses and the other nursing staff on board we have on site coverage that averages anywhere from 30 to 50 hours per week. The nurses do all med passes, all medical assessments at least annually or specifically related to resident medical changes, or specific incidences that occur such as falls, doctor's orders, etc. D. Application to convert to a Level I Assisted Facility was submitted on June 11, 2015. E. Our fall protocol, if there is concern of possible physical damage including head trauma, is to first call 911 and request an ambulance to assist in moving the resident, checking vital sign, etc. At the same time we would notify our on call nurse.	6/10/15

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S5118	Continued From page 18 lost his/her balance and fell into a recliner. Continued review showed the resident "bumped his/her head before [the resident] hit the floor." Further review of the incident report and nurse's notes for that time failed to show evidence that the facility had conducted a neurological assessment. 6. Review of an incident report dated 12/6/2014 and timed 10:45 AM for resident #1 showed s/he was found on the floor lying partially on his/her knees and side. Further review of the incident report and nurse's note for that time failed to show evidence that the facility had conducted a neurological assessment. 7. Interview with CNA manager on 3/11/15 at 2:48 PM revealed the facility contracted with nurses and they are not at the facility 24 hours per day. 8. Interview with RN #1 3/11/15 at 4 PM confirmed that nurses are not in the facility 24 hours per day and the nurses do not conduct neurological assessments after a fall.	S5118	F. The resident files will be audited monthly ~~and as~~ as needed to ensure appropriately Placed and findings reported To Quarterly QA meeting.	