SR 10/1/15

PRINTED: 09/15/2015
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF019	A. BUILDING _____ B. WING _____	C 09/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNDANCE ASSISTED CARE	106 ABBY LANE SUNDANCE, WY 82729

(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
S5064	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; (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;	S5064	S5064 1 a. The survey and corrective actions will be posted for all residents and employees to review. Resident number 20 was received back into the assisted care after hospitalization with a full recovery. Resident number 8, 13 and 19 will have incident accident reports sent to the state. b. Policy has been revised to include any incident accident to be faxed to the state licensing division within 24 hours if requiring more than 1st aid. Including all reportable allegations of neglect or abuse. A follow up in house investigation report will submitted to the state licsensing division within 5 days. c. Staff will be instructed as to the new policy that has been established. Education has been provided. d. The quality assurance system will be adjusted to include monitoring of reported incident accidents and allegations of neglect or abuse. Records of the fax transmittal form will be sent to the state and will be monitored and	

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: OWNER | (X6) DATE: 9/30/15

STATE FORM 6899 P6CD11 If continuation sheet 1 of 6

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WY Dept of Health
OCT 01 2015
Healthcare Licensing and Surveys

Accepted by Lori Rivers on 10/1/15. Linda Johnson was notified via email.
DOC = 10/1/15

RR 10/1/15

PRINTED: 09/18/2015
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S5054	Continued From page 1 (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 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.	S5054	stored together with the in house investigation reports with follow up within the required 5 days. e. The completion of this corrective action will be established 10-01-2015	

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S5054	Continued From page 2 (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. (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 resident incident and accident reports, and staff interview, the facility failed to ensure 5 of 5 resident incidents reviewed were reported to the state licensing division. The findings were:	S5054		

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S5054	Continued From page 3 Review of incident/accident information showed residents #8, #13, #19, #20 were sent to the hospital for evaluation and treatment related to falls. Interview on 9/2/15 at 2:15 PM with the administrator revealed these types of instances were not reported to the state licensing division. The administrator stated each quarter the incidents and accidents were sent to he ombudsman. She was not aware of the reporting requirement to the state licensing division. The following incidents were identified as needing to be reported: a. Resident #19 had a fall on 7/16/15 which resulted in a transfer to the hospital. The resident did not return to the facility, s/he was admitted to the nursing home. b. On 3/26/15 and on 8/25/15 resident #20 had falls at the facility which resulted in transport to the emergency room (ER). The 8/25/15 fall resulted in a pelvic fracture. c. On 7/13/15 resident #8 fell at the facility hitting his/her face and injuring a finger. The resident was sent to the ER for evaluation and treatment. d. Resident #13 had a fall on 3/16/15 which required transfer to the ER.	S5054	S5082 1 a. The survey and corrective actions will be posted for all residents and employees to review. b. Policy has been revised to include a written dicharge notice of 30 days and shall include a verbal explanation of the resident's assessment and how it relates to the discharge. The written and verbal discharge will be conducted through a resident care conference to involve all parties. c. Staff will be instructed as to the new policy that has been established. d. The quality assurance system will be adjusted to include records of the discharge in the residents charts. e. The completion of this corrective action will be established 10-01-2015	
S5082	Ch 12 Sec 7 (k)(i) Assisted Living Facility (ALF) Core Services (k) Transfer and Discharge. (i) Residents shall receive a thirty (30) day written notice prior to any facility initiated transfer or discharge, unless the resident imposes an imminent danger to self and/or others or the resident's level of care exceeds that which can be provided by an assisted living facility. Residents shall have the right to object to the request,	S5082		

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S5082	Continued From page 4 except where undue delay might jeopardize the health, safety or well-being of the resident or others. The notice shall include contact information for the Long Term Care Ombudsman. This State Rule and Regulation is not met as evidenced by: Based on staff interview and medical record review, the facility failed to issue a discharge notice for 1 of 1 resident (#16) facility initiated discharges. The findings were: Review of the medical record showed resident #16 was discharged to home on 6/28/15. Continued review showed no evidence of a written discharge notice. Interview with the administrator on 9/2/15 at 2:15 PM revealed the facility initiated the discharge due to the resident's increased behaviors and psychological issues. She further confirmed no written discharge notice was issued to the resident or family.	S5082		