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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
	ALF008	A. BUILDING: _____ B. WING _____	C 08/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE CHEYENNE, WY 82009

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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 survey was conducted by Healthcare Licensing and Surveys on 6/8/15 through 6/9/15. The survey was prompted by complaint intakes LIC-09-029, LIC-09-030, and LIC-09-032. The following common abbreviations are used throughout the document: RN - Registered Nurse LPN - Licensed Practical Nurse CNA - Certified Nurse Assistant CSD - Clinical Service Director mg - milligrams Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5007	Ch 12 Sec 6 (d)(i) 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: (I) Ensure a safe and sanitary environment for residents and personnel.	S5007		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael Quintal — TITLE: Executive Director — (X6) DATE: 8-21-15

Plan of Correction accepted on 10/9/15 at 10:12Am. Spoke with Michael Quintal. Originals to be Submitted on 10/9/15.

Tina

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S5007	Continued From page 1 This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe and sanitary environment for 2 of 2 non-sample residents (#6, #8) observed during a random medication pass. The findings were: Observation on 6/8/15 at 3:45 PM showed RN #1 used a glucometer to obtain the blood glucose level of resident #8. After use, the nurse did not clean the glucometer, and placed it ready for use for another resident on top of the medication cart. Continued observation on the same day at 4:25 PM showed the nurse used the same glucometer to obtain the blood glucose level of resident #6. After use, the nurse did not clean the glucometer, and again, placed the device on top of the medication cart ready for use for another resident. Interview at that time with the nurse verified she should have cleaned the glucometer after each use; however, she would have cleaned the device with alcohol. Interview with the CSD on 6/9/15 at 4 PM revealed each resident had their own glucometer, and the nurse should not have used the device for more than one resident. Further, she stated she was not aware the Federal Drug Administration (FDA) determined alcohol was not effective for cleaning point of use instruments like the glucometer, and that she would not have received the updated manufacturer instructions for cleaning the device with an Environmental Protection Agency (EPA) approved cleaning solution because each resident owned their own glucometer, and the resident would have received	S5007	Glucometers will be obtained for each resident. All staff members were in-serviced on using glucometer only for the resident it is specified for. RNs/LPNs will be observed three times a week for a month and then every three months to ensure proper cleaning of the glucometers is being completed. Any issues will be noted in the quality assurance program. Administrator and CSD will ensure proper glucometer cleaning guidelines are being followed and any issues will be noted in the quality assurance program which is reviewed quarterly.	7/25/15

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S5007	Continued From page 2 the updated instructions. Review of the manufacturer instructions for the glucometer showed the device should have been cleaned between uses.	S5007		
S5012	Ch 12 Sec 7 (a)(ii) Assisted Living Facility (ALF) Core Services (a) The assisted living facility core services include the following: (ii) A safe and clean environment. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe and clean environment for 2 of 2 laundry rooms. The findings were: Observation on 6/8/15 at 9:30 AM showed the door to laundry room #1 was propped open with a garbage can. Additionally, the ceiling vent, the ceiling, and the East wall were coated with dust and grime. Observation on 6/8/15 at 9:05 PM showed the door to laundry room #2 was propped open with a garbage can. Observation on the same day at 9:08 PM showed the door to laundry room #1 was propped open with a garbage can. Observation on 6/9/15 at 10:30 AM showed the door to laundry room #1 was propped open with a garbage can.	S5012	Vents and walls were cleaned in laundry room #1. An audit of the remaining vents and walls within the building was completed and cleaned as needed. The staff was in-serviced on keeping laundry room doors closed. 9/11/15 Laundry room doors will be observed Monday, Wednesday and Friday for a month. Then every 3 months to ensure they are being kept closed. Any issues will be noted in the quality assurance program. A monthly check of laundry rooms will be done by Environmental Services Director or Executive Director to ensure laundry rooms are clean. Monthly checks will be recorded on log. Administrator will ensure the laundry room doors are closed at all times. Any issues will be noted in the quality assurance program which is reviewed quarterly.	

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S5012	Continued From page 3 Interview at that time with the environmental services manager revealed the laundry room doors were self-closing, but were often propped open by residents as they did their laundry. He stated that his expectation was the doors "should be kept closed at all times." Additionally, he confirmed the ceiling, vent, and wall needed to be cleaned, and there was no cleaning schedule for housekeeping to follow. According to the 1994 Edition of the National Fire Protection Association (NFPA) 101 Life Safety Code: Section 22-3.3.2.2: "Every hazardous area shall be separated from other parts of the building by construction having a fire resistance rating of at least 1 hour with communicating openings protected by self-closing fire doors, or such areas shall be equipped with automatic fire extinguishing systems..." and Section 6-4.1.2: "In new construction, where protection is provided with automatic extinguishing systems without fire-resistive separation, the space protected shall be enclosed to resist the passage of smoke, and doors shall be self-closing or automatic closing and resist the passage of smoke."	S5012		
S5017	Ch 12 Sec 7 (a)(viii) Assisted Living Facility (ALF) Core Services (a) The assisted living facility core services include the following: (viii) Care of individuals who require any or all of the following services: (A) Partial assistance with personal care;	S5017		

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S5017	Continued From page 4 e.g. bathing, shampoos; (B) Limited assistance with dressing; (C) Minor non-sterile dressing changes; (D) Stage I skin care - skin integrity intact; (E) Infrequent assistance with mobility. The resident may use an assistive device; e.g., wheel chair, walker, cane; (F) Cuing guidance with ADLs for the visually impaired resident, or the intermittently confused and/or agitated resident requiring occasional reminders to time, place and person; (G) Care of the resident who can independently manage his own catheter or ostomy, e.g., resident who can change his own catheter bags, able to clean and care for his ostomy; (H) Care of the resident incontinent of bowel or bladder if the condition can be managed independently; This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure residents cared for their own bowel and bladder incontinence independently for 2 of 4 sample residents (#13, #46) identified with incontinence of the bowel or bladder. The findings were: 1. Observation on 6/8/15 at 1:15 PM showed CNA #1 assisted resident #13 into the restroom. The following concerns were noted: a. During this observation the CNA removed	S5017		

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S5017	Continued From page 5 the resident's wet brief, the resident had a bowel movement, the aide performed perineal care, and then replaced the brief with a new one. Further, the resident did not attempt to manage their bowel and bladder incontinence independently at any time during this observation. b. Interview with the CNA at that time revealed this is the level of care provided to the resident every two hours all day long. c. Interview with CNA #2 on 6/8/15 at 1:30 PM revealed this is also the level of care provided to the resident by her every two hours all day long. d. Review of the 4/7/15 Care Plan showed the resident was continent of bowel and bladder. 2. Review of the 12/17/14 Care Plan showed resident #46 was incontinent of bowel and bladder and "will need to be reminded to change and occasionally needs assistance cleaning herself up." Observation on 6/9/15 at 9:15 AM showed CNA #1 assisted resident #46 into the restroom. The following concerns were noted: a. During this observation the CNA removed the resident's soiled brief, assisted the resident into the shower, and cleaned the resident's lower body and perineum. Further, the resident did not attempt to manage their bowel and bladder incontinence independently at any time during this observation. b. Interview with the CNA at that time revealed this is the level of care provided by her to the resident every two hours all day long. 3. Interview with the CSD on 6/9/15 at 2 PM confirmed residents in the facility should be independent with their bowel and bladder incontinence management.	S5017	Resident # 13 was reassessed by CSD and family will be issued a 30 day written notice to transfer resident to a higher level of care. Resident # 46 was reassessed by CSD and family will be issued a 30 day written notice to transfer resident to a higher level of care. An audit of remaining residents will be completed and reassessed as needed to ensure residents are appropriate for Assisted Living. Administrator and CSD reviewed regulations to ensure understanding. An audit of residents' needs will be completed with each resident's semiannual care plan meeting to ensure compliance. Administrator and CSD will ensure the resident assessments are completed and residents who need higher level of care will be transferred and any issues will be noted in the Quality Assurance Program which is reviewed quarterly.	9/11/15

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S5020	Continued From page 6	S5020		
S5020	Ch 12 Sec 7 (b)(i)(A) 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. (I) The completion of the ALF 102. (A) The current version of the ALF 102 is the designated screening tool. The form may be updated and/or revised periodically by the Program Division. Providers will be notified of changes in the form. The following guidelines apply to the ALF 102; (I) The ALF 102 is only valid if completed within forty-five (45) days prior to admission and there is no change in the resident's condition. (II) The ALF 102 must be completed and signed by an RN. (III) The ALF 102 may be completed telephonically; however, it must be verified in person by an RN. (IV) A new ALF 102 shall be completed at least annually, and when there is a change in the resident's condition. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a new ALF 102 form was completed for a change in	S5020	ALF 102 was completed for resident #67. An audit of remaining medical records was completed to ensure any residents that had a noted change of condition to ensure new ALF 102 and were completed as needed. Administrator and CSD reviewed regulations to ensure understanding. An audit of residents' ALF 102 will be completed with each resident's semiannual care plan meeting to ensure compliance. Administrator and CSD will ensure ALF 102 is completed with each change in condition and any issues will be noted in the Quality Assurance Program which is reviewed quarterly.	9/11/15

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S5020	Continued From page 7 condition for 1 of 1 sample resident (#67) who had a change in condition. The findings were: Review of the nursing note dated 2/27/15, untimed, showed resident #67 "is incontinent of bowel and bladder." The nursing note dated 3/28/15, untimed, showed the resident was "Full assist c [with] showers & [and] toileting." The nursing note dated 5/10/15, untimed, showed the resident "is incontinent of bowel and bladder." The following concerns were noted: a. Review of the ALF 102 form dated 12/3/14 showed the resident was continent of bowel and bladder. b. Interview with the CSD on 6/9/15 at 4 PM verified a new ALF 102 form should have been completed for the resident because the form in the resident's chart was not accurate.	S5020		
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	S5023		

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S5023	Continued From page 8 (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 a new RN assessment was completed for a change in condition for 1 of 1 sample resident (#67) who had a change in condition. The findings were: 1. Review of the nursing note dated 2/27/15, untimed, showed resident #67 "is incontinent of bowel and bladder." The nursing note dated 3/26/15, untimed, showed the resident was "Full assist c [with] showers & [and] toileting." The nursing note dated 5/10/15, untimed, showed the resident "is incontinent of bowel and bladder." The following concerns were noted: 2. Review of the Nurse Screening Tool dated 11/19/14 showed the resident was continent of bowel and bladder. 3. Interview with the CSD on 6/9/15 at 4 PM verified a new RN assessment should have been completed for the resident because the assessment in the resident's chart was not accurate.	S5023	A comprehensive assessment will be completed for residents #67. An audit will be completed of the remaining medical records to ensure comprehensive assessment is completed and comprehensive assessments will be completed as needed. Administrator and CSD reviewed regulations to ensure understanding. An audit of residents' comprehensive assessments will be completed with each resident's semiannual care plan meeting to ensure compliance. Administrator and CSD will ensure comprehensive assessments are completed per state regulations and any issues will be noted in the Quality Assurance Program which is reviewed quarterly.	9/11/15
S5024	Ch 12 Sec 7 (b)(v)(A) 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.	S5024		

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S5024	Continued From page 9 (v) Use of the assessment. (A) The results of the assessment are used to develop, review, and revise the resident's individualized assistance plan. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a new care plan was completed for a change in condition for 1 of 1 sample resident (#67) who had a change in condition. The findings were: 1. Review of the nursing note dated 2/27/15, untimed, showed resident #67 "is incontinent of bowel and bladder." The nursing note dated 3/28/15, untimed, showed the resident was "Full assist c [with] showers & [and] toileting." The nursing note dated 5/10/15, untimed, showed the resident "is incontinent of bowel and bladder." The following concerns were noted: a. Review of the Resident Care Plan dated 2/18/15 showed the resident was continent of bowel and bladder and independent with his/her toileting. b. Interview with the CSD on 6/9/15 at 4 PM verified a new Resident Care Plan should have been completed for the resident because the care plan in the resident's chart was not accurate.	S5024	The care plan was updated for resident #67. An audit will be completed of the remaining medical records to ensure the care plans were updated and care plans will be updated as needed. Administrator and CSD reviewed regulations to ensure understanding. An audit of residents' care plan will be completed with each resident's semiannual care plan meeting to ensure compliance. Administrator and CSD will ensure care plans are completed per state regulations and any issues will be noted in the Quality Assurance Program which is reviewed quarterly.	9/11/15
S5026	Ch 12 Sec 7 (c)(i) Assisted Living Facility (ALF) Core Services (c) Resident Rights. The facility shall adopt and follow a written policy of resident rights. The policy shall be posted in a conspicuous place, and there shall be documentation in the resident's	S5026		

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S5028	Continued From page 10 record that the resident read, or management explained, the policy. This policy shall not exclude, take precedence over, or in any way abrogate the legal and constitutional rights enjoyed by all adult citizens and shall include, but is not limited to the following: (i) Be treated with respect and dignity; This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure residents were treated with dignity for 1 of 1 sample resident (#59) with a catheter. The findings were: 1. Review of the medical record showed resident #59 was admitted on 11/18/14 with a catheter. The following concerns were noted: a. Observation on 6/8/15 at 9:15 AM showed the resident had an uncovered catheter down-drain bag hanging from the bottom of his/her wheelchair, with urine visible in the tubing and the bag. b. Observation on 6/9/15 at 8:40 AM showed the resident had an uncovered catheter down-drain bag hanging from the bottom of his/her wheelchair, with urine visible in the tubing and the bag. c. Interview with the CSD on 6/9/15 at 4 PM revealed the resident should have his/her down-drain bag placed in a dignity bag in order to preserve the resident's dignity, but the facility did not have any bags available for this purpose.	S5028	A new leg bag was obtained for resident #59 and resident began wearing leg bag when outside of room. An audit of the remaining residents was completed to ensure any positive issue with dignity and respect and changes made as needed. Staff was in-serviced on residents being treated with respect and dignity. An audit of residents will be completed with each resident's semiannual care plan meeting to ensure compliance. Administrator and CSD will ensure all residents are being treated with respect and dignity and any issues will be noted in the Quality Assurance Program which is reviewed quarterly.	9/11/15
S5050	Ch 12 Sec 7 (d)(ii)(A-B) Assisted Living Facility (ALF) Core Services (d) Medications.	S5050		

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S5050	Continued From page 11 (ii) Prescription drugs shall be dispensed from a licensed pharmacy, labeled with the name, address and telephone number of the pharmacy, name of resident, name and strength of drug, directions for use, date filled, expiration date, prescription number and name of physician. Controlled substances shall have a warning label on the bottle. (A) An RN shall destroy all discontinued prescriptions; other than controlled substances, using acceptable standards or practice. (B) Discontinued or outdated controlled substances shall be destroyed by the RN in the presence of a licensed pharmacist and documented in the resident's record. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, medical record review, and policy review, the facility failed to ensure narcotics (controlled substances) were accounted for according to acceptable standards of practice, during a random narcotic count which affected resident #69. The findings were: A random narcotic count (controlled medications) was performed with LPN #1 on 8/9/15 at 1 PM. 1. The following concerns were noted: a. LPN #1 stated resident #69 had 21 tablets of oxycodone/acetaminophen 10/325 mg. Review of the corresponding narcotic record confirmed the nurse's statement. However, review of the corresponding bubble pack showed the resident had only 20 tablets of oxycodone/acetaminophen 10/325 mg available. b. Review of the medication administration record showed the resident received the	S5050	Narcotic count for resident #69 was corrected. Nurse was called back in to sign out narcotic she failed to sign out at the time of administration. An audit of the remaining residents' narcotic records was completed and any issues were corrected. RNs/LPNs were in-serviced on proper controlled substance management. CSD will conduct random narcotic audits for 1 month then quarterly after that to ensure compliance. Administrator and CSD will ensure the controlled substance policy is being followed and any issues will be noted in the Quality Assurance Program which is reviewed quarterly.	9/11/15

PRINTED: 06/16/2015
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 06/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE CHEYENNE, WY 82009

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S5050	Continued From page 12 medication that day. c. Interview with the nurse at that time revealed the shift change narcotic count had occurred, and she was unsure why the narcotic count was not correct. Further, the narcotics in the plastic bottles were not counted every time during the shift change count if the narcotics had not been used during the previous shift. Additionally, the nurse confirmed this was not the proper procedure for the shift change narcotic count. d. Interview with the CSD at that time revealed she expected the on-coming and off-going nurses to do a full count of all the narcotics in the medication cart at every shift change. 2. Review of the facility policy titled "Controlled Substances (Narcotics) Policy" dated May 2015 showed "5. At each shift change, the number of each controlled substance on hand must be counted by two staff members together...with this number compared to the last number in the 'Amount Remaining' column in the bound Narcotic Book."	S5050		
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	S5052		

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	ALF009	A. BUILDING: _____ B. WING _____	C 06/09/2015

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S5052	Continued From page 13 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 (VI) Documentation of observation. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure the nurse supervised the administration of medications for 1 of 1 sample resident (#9), and 5 of 7 non-sample residents (#6, #8, #10, #22, #69) observed during a random medication pass. The findings were: 1. Observation on 6/8/15 at 2:40 PM showed RN #1 administered cephalexin 500 mg one tablet to resident #9. During the observation, the nurse left the medication with the resident and did not observe the medication being taken. Review of the list of residents assessed for self-administration of medications showed the resident was not assessed as being safe for self-administration. 2. Observation on 6/8/15 at 3:00 PM showed LPN	S5052		

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S5052	Continued From page 14 #2 administered ibuprofen 200 mg four tablets to resident #69. During this observation, the nurse left the medications with the resident and did not observe the medications being taken. Review of the list of residents assessed for self-administration of medications showed the resident was not assessed as being safe for self-administration. 3. Observation on 6/8/15 at 3:45 PM showed RN #1 administered metoprolol tartrate 50 mg one tablet and ranitidine 150 mg one tablet to resident #8. During the observation, the nurse left the medications with the resident and did not observe the medications being taken. Review of the list of residents assessed for self-administration of medications showed the resident was not assessed as being safe for self-administration. 4. Observation on 6/8/15 at 4:05 PM showed RN #1 administered tamsulosin 0.4 mg two tablets, metoprolol 25 mg 1/4 tablet, senna laxative 8.6 mg two tablets, FeroSul (iron) 325 mg one tablet, simvastatin 40 mg 1/2 tablet, tramadol 50 mg one tablet, and Combivent respimat (an inhaler) to resident #10. During the observation, the nurse administered the inhaler, but left the medications in pill form with the resident and did not observe the medications being taken. Review of the list of residents assessed for self-administration of medications showed the resident was not assessed as being safe for self-administration. 5. Observation on 6/8/15 at 4:20 PM showed RN #1 administered ranitidine 150 mg 1/2 tablet, simvastatin 40 mg 1/2 tablet, carvedilol 25 mg one tablet, FeroSul (iron) 325 mg one tablet, glipizide 5 mg two tablets, hydralazine 25 mg one tablet, isosorbide dinitrate 40 mg one tablet, warfarin 1 mg two tablets, and Novolog Flexpen	S5052		

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S5052	Continued From page 15 (insulin) 6 units to resident #6. The nurse injected the resident with the subcutaneous insulin, left the medications in pill form, and did not observe the medications being taken. The resident poured the medications from the cup into his/her mouth. One small white pill stuck to the cup, and the resident needed to shake the cup to dislodge the pill. Review of the list of residents assessed for self-administration of medications showed the resident was not assessed as being safe for self-administration. 6. Observation on 6/9/15 beginning at 9:05 AM showed LPN #3 administered metoprolol extended release (ER) 25 mg 1/2 tablet, loratadine 10 mg one tablet, Areds softgel vitamin one tablet, omeprazole 20 mg one tablet, probiotic supplement one capsule, aspirin 81 mg one tablet, diltiazem 120 mg one capsule, escitalopram 10 mg one tablet, furosemide 40 mg one tablet, and isosorb mononitrate 30 mg one tablet to resident #22. The nurse placed the cup of medications on the table next to the resident and did not observe the resident attempt to take the medication. During this observation, the resident experienced some nausea after attempting to take a large pill. The nurse then left the room to find some crackers, leaving the medications on the table within reach of an unidentified resident. Review of the list of residents assessed for self-administration of medications showed the resident was not assessed as being safe for self-administration. 7. During this observation there were several residents seen wandering the facility. 8. Interview with the CSD on 6/9/15 at 3:20 PM revealed her expectation is for nursing staff to stay by the resident who has not been assessed	S5052		

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S5052	Continued From page 16 as safe to self-administer medications to ensure all medication is swallowed. B. Wyoming State Board of Nursing Advisory Opinion "LPN and RN Scope of Practice" dated July 2014 "In participating in the nursing process and implementing client care across the lifespan, a LPN shall... 4. Implement aspects of a client's care consistent with the LPN scope of practice in a timely and accurate manner including ... e. promote a safe client environment...In utilizing the nursing process to plan and implement nursing care for clients across the life-span, a RN shall...d. Demonstrates attentiveness by providing ongoing client surveillance and monitoring."	S5052	Self-medication interviews were completed for residents #6, #8, #10, #22 and #69. An audit will be completed of the remaining medical records to ensure self-medication interviews are completed and comprehensive assessments will be completed as needed. RNs/LPNs were in-serviced on medication management.	
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; (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	S5054	An audit of residents' self-medication interviews will be completed with each resident's semiannual care plan meeting to ensure compliance. Administrator and CSD will ensure self-medication interviews are completed and any issues will be noted in the Quality Assurance Program which is reviewed quarterly.	9/11/15

PRINTED: 06/16/2015
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S5054	Continued From page 17 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 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	S5054		

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S5054	Continued From page 18 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. (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;	S5054		

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S5064	Continued From page 19 (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, and State Survey Agency record review, the facility failed to report incidents involving the health, safety, or welfare of residents to the Licensing Division for 3 of 3 sample residents (#9, #13, #34) with reportable incidents. The findings were: 1. Review of the medical record showed resident #9 was admitted to the facility on 1/18/11 with diagnoses that included cerebral vascular accident (CVA). The following concerns were noted: a. Review of the nursing note dated 6/3/15 timed 9:30 PM showed the resident had a fall, and was sent to the emergency department where s/he received 9 stitches to the forehead and was diagnosed with a nasal fracture. b. Review of Licensing Division records showed the facility did not report the incident. c. Interview with the Executive Director on 6/9/15 at 4 PM confirmed the incident should have been reported to the Licensing Division. 2. Review of the medical record showed resident #34 was admitted to the facility on 3/19/14 with	S5054	Incident report for resident #9 from fall on 6/3/15 was sent to the State of Wyoming Licensing Division. Incident report for resident #34 from ER visit on 2/19/15 was sent to the State of Wyoming Licensing Division. Incident report for resident #13 an unwitnessed fall on 5/9/15 was sent to the State of Wyoming Licensing Division. Administrator and CSD reviewed regulations pertaining to incident reporting to ensure understanding. All future incidents meeting the state regulations criteria will be reported to the State of Wyoming Licensing Division. Incident reports will be reviewed at daily department head meetings and incident reports meeting criteria will be sent in. Administrator will ensure incident reports are reported to the Licensing Division any issues will be noted in the quality assurance program which is reviewed quarterly.	9/1/15

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S5054	Continued From page 20	S5064		

diagnoses that included weakness and pain. The following concerns were noted:

a. Review of the nursing note dated 2/17/15 timed 9:15 AM showed the resident was found on the floor laying on his/her back, and the resident's spouse reported the resident fell while transferring to the wheelchair.

b. Review of the nursing note dated 2/19/15 timed 2 PM (2 days later) showed the resident was sent to the emergency department due to lower extremity weakness and urinary frequency. Further, the resident was admitted to the hospital.

c. Review of the nursing note dated 3/10/15, untimed, showed the resident returned to the facility 20 days later.

d. Review of Licensing Division records showed the facility did not report the incident.

e. Interview with the CSD on 6/9/15 at 4 PM confirmed the incident should have been reported to the Licensing Division.

3. Review of the nursing note dated 5/9/15, untimed, showed resident #13 had a possible unwitnessed fall that resulted in pain and bruising to the resident's knee. The following concerns were noted:

a. Review of the Licensing Division records showed no evidence the incident was reported to the office.

b. Interview with the CSD on 6/9/15 at 4 PM revealed an incident report was not submitted to the facility administration, the incident was not investigated, and she confirmed the incident should have been reported to the Licensing Division.

4. Review of the facility policy titled "Incident Management" dated May 2015 showed "B. Use of the Incident Report Form. 1. An incident report should be completed in the following

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S5054	Continued From page 21 circumstances: a. an unexpected event or near-miss involving a resident or a visitor. b. an unusual event which results in personal injury or that is inconsistent with normal resident care...G. Incident Investigation. 1. An investigation is completed within 24 hours of each incident...2. The goal of the investigation is to identify the underlying causes...assists in making necessary system changes and/or promote actions needed to address human error."	S5054		