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WY Dept of Health
AUG 21 2015
Healthcare Licensing and Surveys

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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 07/15/2015

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

(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
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 On 7/15/15 a complaint investigation was conducted by Healthcare Licensing and Surveys. The investigation was prompted by intake #WY...LIC-15-049.	S 000		
S5023	Ch 12 Sec 7 (b)(iv)(A-C) Assisted Living Facility (ALF) Core Services (b) Resident Assessment and Services. The staff/contract Registered Nurse (RN) shall conduct initial and, at a minimum annually, an accurate, standardized, reproducible assessment of each resident's functional capacity, physical assessment and medication review. (iv) Frequency of assessment. An assessment must be conducted: (A) No earlier than one (1) week prior to admission; (B) Immediately upon any significant change in the resident's mental or physical condition; or (C) No less than once every twelve (12) months. This State Rule and Regulation is not met as evidenced by:	S5023		

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

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

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S5023	Continued From page 1 Based on medical record review and staff interview, the facility failed to ensure an elopement risk assessment was completed for 1 of 1 sample residents (#60) who required a significant change assessment. In addition, the facility failed to ensure assessments were accurate for 2 of 8 sample residents (#24, #76) who were reviewed for elopement risk. The findings were: 1. Medical record review showed resident #60 had an elopement risk assessment completed on 1/27/15 and had a score of 4 indicating the resident was a low elopement risk. The following concerns were identified: a. Review of a nurse's note dated 1/31/15 and timed 11 PM showed resident #60 seemed confused by the call button and "may be a wander risk." b. Review of a nurse's note dated 2/1/15 and timed 11 AM showed resident #60 was brought back to the building by the police department. The resident was found to be at a local grocery store when the police got involved. c. Review of a nurse's note dated 2/7/15 and untimed for resident #60 showed "P.t. came in around 11:00 asking where [resident] was at." The nurse initiated a full building search and notified the administrator and the director of nursing. Further review of the note showed the resident's daughter called and the resident was found at King Soopers [grocery store]: Continued review showed the resident "tried to leave the facility again twice since first elopement." d. Review of a nurse's note dated 7/6/15 and timed 10:30 AM for resident #60 showed "Nurse received a call at 7:30 AM from police dispatch asking if [resident's name] was our resident. We said he was and asked for them to bring him home." Continued review of the note indicated the	S5023		

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S5023	Continued From page 2	S5023		

guardian was told "we will need to look for another living situation due to elopement."

e. Review of a nurse's note dated 7/8/15 and timed 3 PM for resident #60 showed the facility "received phone call from CPD [Cheyenne Police Department] stating that this resident was at Hallmark store next to King Soopers. Per CPD resident refusing to ride in police car." Continued review showed "resident can freely go in and out of building and there is no way to monitor, since this is assisted living."

f. Review of the care plan for #60 dated 2/25/15 showed the resident was not identified as an elopement risk.

g. Review of the medical record showed there was not an updated elopement risk assessment completed as a result of the 2/1/15, 2/7/15, 7/5/15 and 7/8/15 elopement incidents.

2. Medical record review showed resident #24 had a resident care plan that listed diagnosis that included dementia. Review of the elopement risk evaluation completed on 6/7/15 showed the resident had an elopement risk score of 6 indicating the resident was low risk for elopement. Further review of the elopement risk evaluation showed the resident received 4 points for being "fully ambulatory" 2 points for being "disoriented" and was not marked as having dementia or any type of mental illness. The points associated with the dementia diagnosis was 2, which would have increased the overall score to 8.

3. Medical record review showed resident #78 had a resident care plan that listed diagnosis that included dementia. Review of the elopement risk evaluation completed on 5/13/15 showed the resident had an elopement risk score of 4 indicating the resident was low risk for elopement. Further review of the elopement risk evaluation

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S5023	Continued From page 3 showed the resident received 4 points for being "fully ambulatory" and was not marked as having dementia or any type of mental illness. The points associated with the dementia diagnosis was 2, which would have increased the overall score to 6. 4. Interview with the director of nursing on 7/16/15 at 5:15 PM confirmed the elopement risk evaluation for resident #60 should have been updated and care planned. Further interview at that time confirmed the elopement risk evaluations for resident #24 and #78 were not accurate.	S5023	Elopement risks were updated for residents #60, #24, and #78. An audit will be completed of the remaining medical records to ensure elopement risks are accurate and completed as necessary. 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 elopement risks are being updated and any issues will be noted in the Quality Assurance Program which is reviewed quarterly.	9/11/15
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 address;	S5054		

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S5054	Continued From page 4 (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 records;	S5054		

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S5054	Continued From page 5 (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	Resident #60 family's was issued a 30 day written notice to transfer resident to a higher level of care on 7/20/15. Resident was placed on 15 minute safety checks until resident can be transferred. 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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S5054	Continued From page 6 (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, and staff interview, the facility failed to record and/or report incidents or accidents for 1 of 1 sample residents (#60) with occurrences affecting the health, welfare, or safety of the resident to the Licensing Division. The findings were: 1. Review of a nurse's note dated 2/1/15 and timed 11 AM showed resident #60 was "brought back to the building by police department. Resident was by King Soopers [a grocery store] when police got involved." 2. Review of a nurse's notes dated 2/7/15 and untimed for resident #60 showed "P.t. came in around 11:00 asking where [resident] was at." The nurse initiated a full building search and notified the administrator and director of nursing. Further review of the note showed resident's daughter called and the resident was found at King Soopers. 3. Review of a nurse's note dated 7/8/15 and timed 3 PM for resident #60 showed the facility "received phone call from CPD [Cheyenne Police Department] stating that this resident was at	S5054		

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S5054	Continued From page 7 Hallmark store next to King Soopers. Per CPD resident refusing to ride in police car." 4. Review of the Licensing Division incident logs revealed the elopements had not been reported. 5. Interview with the director of nursing on 7/15/15 at 5:15 PM confirmed the facility did not report any of the elopements to the Licensing Division.	S5054		
S5100	Ch 12 Sec 8 (a)(vi) Services Which Cannot Be Provided By Level I Services which cannot be provided by the Level I Assisted Living Facility staff. (a) The following services cannot be provided: (vi) Care of resident whose wandering jeopardizes the health and safety of the resident; This State Rule and Regulation is not met as evidenced by: Based on medical record review, incident report review, and staff interview, the facility failed to ensure appropriate level of care for 1 of 1 sample residents (#60) where wandering and/or elopement potentially jeopardized the health and safety of the resident. The findings were: 1. Medical record review showed resident #60 had an elopement risk assessment completed on 1/27/15 and had a score of 4 indicating the resident was a low elopement risk. The following concerns were identified: a. Review of a nurse's note dated 1/31/16 and timed 11 PM showed resident #60 seemed confused by the call button and "may be a wander	S5100		

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S5100	Continued From page 8 risk." b. Review of a nurse's note dated 2/1/15 and timed 11 AM showed resident #60 was brought back to the building by police department. The resident was found to be at a local grocery store when the police got involved. c. Review of a nurse's note dated 2/7/15 and untimed for resident #60 showed "P.t. came in around 11:00 asking where [resident] was at." The nurse initiated a full building search and notified the administrator and the director of nursing. Further review of the note showed the resident's daughter called and the resident was found at King Soopers [grocery store]. Continued review showed the resident "tried to leave the facility again twice since first elopement." d. Review of a nurse's note dated 7/6/15 and timed 10:30 AM for resident #60 showed "Nurse received a call at 7:30 AM from police dispatch asking if [resident's name] was our resident. We said he was and asked for them to bring him home." Continued review of the note indicated the guardian was told "we will need to look for another living situation due to elopement." e. Review of a nurse's note dated 7/8/15 and timed 3 PM for resident #60 showed the facility "received phone call from CPD [Cheyenne Police Department] stating that this resident was at Hallmark store next to King Soopers. Per CPD resident refusing to ride in police car." Continued review showed "resident can freely go in and out of building and there is no way to monitor, since this is assisted living." 2. Interview with the director of nursing on 7/15/15 at 5:15 PM revealed the facility has spoken to the guardian about alternate placement for the resident; however, no discharge planning had been initiated. Continued interview revealed the resident should have had an updated elopement	S5100	Incident report for resident #60 an elopement on 2/1/15 was sent to the State of Wyoming Licensing Division. Incident report for resident #60 an elopement on 2/7/15 was sent to the State of Wyoming Licensing Division. Incident report for resident #60 an elopement on 7/8/15 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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S5100	Continued From page 9 risk evaluation completed and residents who elope could be gone for several hours before the facility identifies they are gone.	S5100		