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WY Dept of Health
NOV 24 2015

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 _____	R-C 09/16/2015

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
{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 follow up survey was conducted by Healthcare Licensing and Surveys on 9/16/15. The survey was prompeted by findings from a survey on 3/11/15-3/12/15 for complaint intakes LIC-15-020 and LIC-15-021.	{S 000}		
{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}		

Plan of correction accepted. Spoke with Dennis Lawrence on 01/4/16 at 8:25 AM to inform him.

Tim Cozad

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{S5054}	Continued From page 1 (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 2 (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; (I) Written acknowledgment of the receipt	{S5054}		

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{S5054}	Continued From page 3 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 incident report review and staff interview, the facility failed to record and/or report on incidents or accidents for 2 of 2 (#5, #8) residents with occurrences affecting the health, welfare, or safety. The findings were: 1. Review of an incident report for resident #5 dated 7/31/15 and timed 8:30 PM showed the resident exited the facility through the back door while staff was watering plants on the side of the building. The resident fell outside and scraped his/her forehead, hands, and knees. People from a nearby apartment in the neighborhood saw the resident and called the ambulance. 2. Review of an incident report for resident #8 dated 6/3/15 and timed 5 AM showed the resident had an unwitnessed fall and was found on the floor on hands and knees. Further review showed the incident report did not have evidence of an assessment of the resident for head injury and the resident's family, physician, and the home manager was not indicated as being notified. 3. Review of a Nurse's Note for resident #5 dated 7/28/15 and timed 6:52 PM showed it was reported that on 7/8/15, the certified nurse aid (CNA) on duty found the resident attempting to	{S5054}	A. Staff was educated on the rules and regulations regarding accidents, injuries, incidents, illnesses, and allegations of abuse, neglect or exploitation which affect the health, welfare, or safety of a resident. B. The following is our facility protocol for reporting incidents: - CNA on duty must contact emergency medical services if applicable. - CNA on duty must immediately notify the manager. - Manager must immediately notify the family. - Manager must contact the Licensing Division, by phone or fax, within one business day of the incident. - Manager must relay how the incident was managed, what the outcome was, and what will be done to prevent similar incidents from happening again to the Licensing Division and Long-term Care Ombudsman within five business days.	9/17/15

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{S5054}	Continued From page 4 put feces in his/her mouth and that the resident started to cry when the CNA threw the feces in the toilet. It was also reported in the same note that another similar episode had occurred on 7/5/15 when the CNA on duty found the resident with feces in his/her mouth. The note indicated the resident became upset when the CNA wouldn't "eat some as well" and then got angry when the CNA threw the feces in the toilet. Further review showed the resident stated, "That is food!" 4. Interview with the CNA manager on 9/16/15 at 5:30 PM revealed resident #5 was injured because of leaving the facility unattended, the incident was not investigated as an elopement, and the resident may not be appropriate for the facility at this time. Continued interview revealed the she was aware of the incidents on 7/5/15 and 7/8/15, however, she was not aware that an incident report should have been completed. Further interview revealed the facility had no documentation the incidents were reported to the State Licensing Agency. 5. Review of an incident report for resident #8 dated 6/9/15 at 7 PM showed the resident had an unwitnessed fall and was found on the floor in the closet with his/her pants down around the resident's ankles. Further review showed the facility "pulled [him/her] out of the closet and stood [him/her] up and put [him/her] into a chair." The incident report then noted the facility "checked [him/her] over" and put the resident in pajamas and then in bed. Further review showed the incident report did not have evidence of an assessment of the resident for head injury and the resident's family, physician, and the home manager was not indicated as being notified.	{S5054}	C. An assessment of a resident for head injury is required if the resident experienced an unwitnessed fall. Emphasis was given in regards to the importance of evaluating and assessing residents. D. Resident #8 moved out on July 21, 2015. After the incidents on 6/3/15 and 6/9/15, the family and the house manager determined resident #8 was no longer within the facility's scope of care. The family and the house manager found that it was in the resident's best interests that he/she be transferred to a nursing home. E. Manager and staff were reminded that particular incidents, such as those related to resident #5, need to follow our facility protocol for reporting incidents. Resident #5 has not exhibited inappropriate behavior, such as eating his/her feces, since the last noted incident. Resident #5 has been monitored and no further incidents have occurred since 7/8/15. If resident #5 starts to display inappropriate behaviors, the family will be contacted and an action plan will be established.	

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{S5054}	Continued From page 5 6. Interview with the CNA manager on 9/16/15 at 4:10 PM revealed there was no documentation that the physician, family, or home manager was notified of the falls for resident #8. Further interview revealed facility had no documentation the incident was reported to the State Licensing Agency.	{S5054}	F. Resident #5 has not exhibited wandering behaviors since the incident dated 7/31/15. It was determined that resident #5 was not an elopement risk due to the circumstances of the incident. Resident #5 wanted to say hi to the neighbors next door and tripped on his/her way over. The resident did suffer some minor injuries, which the family was informed of. Staff was made aware that in incidents involving a fall, especially one with injury, the licensing division needs to be contacted. G. A quality assurance meeting is scheduled for Friday, October 23, 2015. During this meeting the manager will discuss this Plan of Correction and topics covered within. H. An assessment of all current residents was performed to verify that they did not exhibit elopement and/or fall risks. Current residents did not display inappropriate behavior. If a resident were to fall, wander, or start to display inappropriate behavior, our staff will reassess the resident and discuss with the family and/or physician an action plan that would be in the best interest of the resident.	
{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. (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	{S5088}		

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{S5088}	Continued From page 6 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 an effective Quality Improvement program. The findings were: 1. Review of facility incident reports revealed the facility did not have a tracking method that 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 the facility's Quality Improvement meeting minutes showed the facility conducted a meeting on 3/20/15 and the facility documented concerns with findings of a recent survey. Further review showed the facility conducted a meeting on 4/10/15 however, the documentation stated "covered resident council meeting on 4/6/15. Talked about resident care." A meeting was conducted on 7/17/15 and documentation of the minutes showed "discussed TB tests w/ [with] employees. Meal planning and prep. Everyone on board w/ kitchen safety. Meeting went well,	{S5088}	A. The facility will conduct a quality assurance meeting monthly, starting October 23, 2015. In the meetings the following will be discussed: - Concerns, recommendations, etc. that the employees may have. - Incidents that took place that month. - Steps that will be enforced to prevent similar incidents from happening. - Prior incidents and if the preventative steps put in place are working. - Allow employees to ask questions. - Address other issues as deemed appropriated by the manager. B. Manager will delegate an employee to take thorough and detailed meeting notes of the topics discussed at each meeting. These notes, along with other quality assurance documents, will be placed in a binder for future reference.	10/23/15

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{S5088}	Continued From page 7 expressed concerns about safety while preparing meals for our residents." The program did not have a written description and the facility failed to identify monitoring and frequency of monitoring. Further review showed the facility failed to review problems identified from the survey or complete written corrective actions. 3. Interview with the CNA manager on 9/16/15 at 4:10 PM revealed she was not sure what the Quality Improvement meeting needed to include.	{S5088}	C. The number of incidents and the type of incident will be documented quarterly. This will allow our facility to evaluate trends over a period of time.	
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 incident report review and staff interview, the facility failed to ensure the level of care was appropriate for 1 of 1 sample residents (#5) where wandering and/or elopement potentially jeopardized the health and safety of the resident. The findings were: 1. Review of an incident report for resident #5 dated 7/31/15 and timed 8:30 PM showed the resident exited the facility through the back door while staff was watering plants on the side of the building. The resident fell outside and scraped his/her forehead, hands, and knees. People from	S5100	A. Resident #5 has not exhibited wandering behaviors since the incident dated 7/31/15. It was determined that resident #5 was not an elopement risk due to the circumstances of the incident. Resident #5 wanted to say hi to the neighbors next door and tripped on his/her way over. The resident did suffer some minor injuries, which the family was informed of. B. Staff was made aware that in incidents involving a fall, especially one with injury, the licensing division needs to be contacted within one day.	10/23/15

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S5100	Continued From page 8 a nearby apartment in the neighborhood saw the resident and called the ambulance. 2. Interview with the CNA manager on 9/16/15 at 5:30 PM revealed resident #5 was injured because of leaving the facility unattended, the incident was not investigated as an elopement, and the resident may not be appropriate for the facility at that time.	S5100	C. If resident #5 starts to exhibit wandering behaviors, a proper elopement risk assessment will be conducted. A family conference will also be held to discuss possible transfer of the resident to a facility that will be in the best interest of the resident. D. A quality assurance meeting will be held on Friday, October 23, 2015. The incident involving resident #5 will be discussed and employees will be informed as to what signs to look for regarding resident #5 behavior and if that behavior requires further evaluation. E. An assessment of all current residents was performed to verify that they did not exhibit elopement and/or fall risks. If a resident were to fall or wander, our staff will reassess the resident and discuss with the family and/or physician an action plan that would be in the best interest of the resident.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
ALF024 (Y1)	A. Building B. Wing (Y2)	9/16/2015 (Y3)

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S5049 Reg. # Ch 12 Sec 7 (d)(i)(A-K) LSC	Correction Completed 05/01/2015	ID Prefix S5091 Reg. # Ch 12 Sec 7 (n)(ii)(A-AA) LSC	Correction Completed 04/20/2015	ID Prefix S5100 Reg. # Ch 12 Sec 8 (a)(vi) LSC	Correction Completed 10/23/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) B	DATE 9/16/15	SIGNATURE OF SURVEYOR Tom Cozad by B	DATE 9/16/15
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/12/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: CUB512

STATE FORM: REVISIT REPORT (11/06)