2/19/16

PRINTED: 02/10/2016
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 _____	R-C 02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNDANCE ASSISTED CARE	108 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
{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; (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;	{S5054}		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: OWNER — (X6) DATE: 2/12/2016

STATE FORM 6899 P6CD12 If continuation sheet 1 of 4

Wayne Johnson

RECEIVED
WY Dept of Health
FEB 18 2016
Healthcare Licensing and Surveys

Accepted w/ No Changes on 2/19/16. Linda Johnson was notified. 2/19/16

2/9/16

Healthcare Licensing and Surveys

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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}	**A Quality Assurance form was created to record all incidents/accidents that result in medical attention requiring transfer to medical facility. The Manager will then direct personnel to record and report to the Licensing Division immediately (within one business day). This report may be done by telephone or fax. The facility will follow up with an in house investigation of t6he incident reported to the Licensing Division and Ombudsman within 5 working days of the incident.** **There was no effect to resident #1.** **An incident accident report was prepared at the time of the incident and documented in resident #1's chart.** **We have informed employees to the changes in the Quality Assurance form created to include immediate notification to the Licensing Division within 24hrs.** **To complete by 2-08-2016** **Page 7** **<u>Corrective Action for residents affected will be.. Posting of the survey and corrective actions taken.</u>** **All records have been examined for non-compliance with this regulation and identified to the manager.** **There was no effect on the resident #1.** **This was simply a late reporting issue.** **Follow up inspections will be performed through employee training, and adjustments made to the quality assurance program.** **To complete by 2-08-2016**	

SR 2/19/16

Healthcare Licensing and Surveys

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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 incident/accident record information, policy and procedure review, and staff interview, the facility failed to ensure 1 of 3 incidents reviewed (involving resident #1) was reported as required. The findings were:	{S5054}		

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{S5054}	Continued From page 3 Review of the procedure titled "Incidents/Accident" amended on 9/2/15 showed "Any accidents or incidents that affect the resident's health or well being must be reported to the Wyoming State Health Department...An investigation by the manager must be implemented with a summary of such, with a plan of correction submitted to the state within 5 days of occurrence." Review of the 1/2/16 incident/accident report for resident #1 showed the resident had a fall which resulted in complaints of pain to his/her head, bottom, and shoulder. The resident was sent to the emergency room for evaluation, no fractures were identified. Review of the "In-house Investigation of Incident/Accident" showed it was dated 2/4/16. Interview with the administrator on 2/5/16 at 10 AM verified the incident was not reported to the Licensing Division and an investigation was not completed within 5 days.	{S5054}		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
ALF019 Y1	A. Building B. Wing Y2	2/5/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNDANCE ASSISTED CARE	108 ABBY LANE SUNDANCE, WY 82729

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 S5082 Reg. # Ch 12 Sec 7 (k)(i) LSC	Correction Completed 10/01/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE 2/29/16	SIGNATURE OF SURVEYOR	DATE 2/5/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

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

 EVENT ID: P6CD12

STATE FORM: REVISIT REPORT (11/06)