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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 _____ | R-C 11/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SIERRA HILLS ASSISTED LIVING COMMUNITY | 4605 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 |
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| {S 000} | Opening Comments<br><br>Rules and Regulations utilized for this survey are:<br><br>Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 12/12/2007<br><br>Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001<br>A follow up survey was conducted by Healthcare Licensing and Surveys on 11/16/15 - 11/18/15. The survey was prompted by findings from a survey on 6/9/15 for complaint intakes LIC-09-029, LIC-09-030, and LIC-09-032.<br><br>The following common abbreviations are used throughout the document:<br><br>RN - Registered Nurse<br>LPN - Licensed Practical Nurse<br>CNA - Certified Nursing Assistant<br>CSD - Clinical Service Director<br>mg - milligrams<br><br>Less commonly used abbreviations will be annoted in each deficiency. | {S 000} | | |
| {S5017} | Ch 12 Sec 7 (a)(viii) Assisted Living Facility (ALF) Core Services<br><br>(a) The assisted living facility core services include the following:<br><br>(viii) Care of individuals who require any or all of the following services:<br><br>(A) Partial assistance with personal care; e.g. bathing, shampoos;<br><br>(B) Limited assistance with dressing; | {S5017} | The facility will identify each resident will be appropriate for the core services level of care:<br><br>An assessment was done on resident #3. Resident #3 was found to be not appropriate for this facility. A 30 day letter was issued on 11/20/15. Resident #3 moved to a higher level of care. | 03/31/16 |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ED | 3-7-16



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WY Dept of Health
MAR 07 2016
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Spoke with Mike ED on 3/9/16 at 12:21 PM. Accepte Plan of Correction. Date of compliance 3/31/16.

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| {S5017} | Continued From page 1<br><br>(C) Minor non-sterile dressing changes;<br><br>(D) Stage I skin care - skin integrity intact;<br><br>(E) Infrequent assistance with mobility. The resident may use an assistive device; e.g., wheel chair, walker, cane;<br><br>(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;<br><br>(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;<br><br>(H) Care of the resident incontinent of bowel or bladder if the condition can be managed independently;<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure 1 of 12 (#3) sample residents was appropriate for the core services level of care. The findings were:<br><br>1. Medical record review showed resident #3 had an ALF 102 assessment completed on 4/1/15. The resident was determined to be independent with bathing, continent of bowel and bladder, independent and appropriately able to transfer, and had appropriate behavior. Review of the resident's care plan dated 5/20/15 showed the resident was alert and oriented to name, place, time, date, and family. The following concerns | {S5017} | Clinical Services Director/Assistant Clinical Services Director will do assessment of remaining residents. The assessment will identify if a resident is appropriate for the core services level of care.<br><br>Any resident that is not appropriate for the core services level of care will be issued a 30 day written notice and a meeting with POA/family will be held to assure that the needs of the resident are met until resident can be placed to a higher level of care. Documentation of this meeting will be placed in the nursing notes.<br><br>Administrator and CSD reviewed regulations to ensure understanding.<br><br>Ongoing monitoring of assessments will be done annually or when a significant change of condition occurs.<br><br>Administrator and CSD will ensure assessments are completed and any issues will be noted in Quality Assurance Program which will be reviewed quarterly. | |

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| {S5017} | Continued From page 2<br>were identified:<br>a. Review of the list of residents who needed assistance, provided by the facility on 11/16/15, showed the resident required "full assist. [assistance]."<br>b. Review of a nursing/progress note dated 11/2/15 and timed 12:15 PM showed the resident was alert and oriented times 2 with "periods of confusion." Further review showed the resident required 1 person assist with ADLs and was incontinent of bowel and bladder.<br>c. Review of an ALF 102 assessment completed on 11/18/16 showed the resident was occasionally incontinent, completely dependent for transfers, and had intermittent confusion and/or was agitated.<br>d. Interview with the CSD and executive director on 11/18/15 at 2:07 PM revealed the facility was pursuing long term care placement for the resident, but there was no evidence of communication with the family. Further, the interview revealed the resident required services that were no longer appropriate for the facility. | {S5017} | | |
| {S5020} | Ch 12 Sec 7 (b)(i)(A) Assisted Living Facility (ALF) Core Services<br><br>(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.<br><br>(i) The completion of the ALF 102.<br><br>(A) The current version of the ALF 102 is the designated screening tool. The form may be updated and/or revised periodically by the | {S5020} | | |

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| {S5020} | Continued From page 3<br>Program Division. Providers will be notified of changes in the form. The following guidelines apply to the ALF 102;<br><br>(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.<br><br>(II) The ALF 102 must be completed and signed by an RN.<br><br>(III) The ALF 102 may be completed telephonically; however, it must be verified in person by an RN.<br><br>(IV) A new ALF 102 shall be completed at least annually, and when there is a change in the resident's condition.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure a new ALF 102 assessment was completed for 2 of 12 sample residents (#3, #15) who had a change in condition. The findings were:<br><br>1. Medical record review showed resident #15 had an ALF 102 assessment completed on 9/14/15. The resident was determined to be independent and appropriate with mobility and medically stable at that time. The following concerns were identified:<br>a. Review of facility incident reports from 10/22/15 through 11/14/15 showed the resident had 5 unwitnessed falls while attempting to ambulate or transfer without assistance.<br>b. Review of a nursing/progress note dated 10/22/15 and timed 12:50 AM showed the | {S5020} | The facility will complete an ALF 102 on each resident with a change of condition.<br><br>ALF 102 was completed for resident #3 and resident #15. Resident #3 and Resident #15 have been moved to a higher level of care.<br><br>An audit of remaining medical records was completed to ensure any residents that had a noted change of condition to ensure new ALF 102 was completed as needed.<br><br>Administrator and CSD reviewed regulations to ensure understanding.<br><br>An audit or remaining residents ALF 102 will be completed with each resident's assessment to be completed.<br><br>Administrator and CSD will ensure ALF 102 is completed with each change of condition and any issues will be noted in the Quality Assurance program which is reviewed quarterly. | 03/31/16 |

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| (S5020) | Continued From page 4<br>resident "called [his/her] son at 12:30 AM and his son brought him a bottle of Advil PM." Review of a progress note dated 10/22/15 and time 4 PM showed the resident "fell in apartment and the daughter decided to take the resident to the ER [emergency room]..." The resident had contacted staff by telephone to tell them "I want to throw up...No position feels good..." Further review showed "...the resident's daughter arrived and wanted to know how many Advil PM the resident took. This nurse counted the bottle with the daughter, the total pill count was 107/120. 13 pills were not accounted for. Resident left with daughter to the ER."<br>c. Interview with the CSD and executive director on 11/18/15 at 2:07 PM confirmed the resident had a physical and/or mental change in condition and a significant change assessment was not completed.<br><br>2. Medical record review showed resident #3 had a ALF 102 assessment completed on 4/1/15. The resident was determined to be independent with bathing, continent of bowel and bladder, independent and appropriately able to transfer, and had appropriate behavior. Review of the residents care plan dated 5/20/15 showed the resident was alert and oriented to name, place, time, date, and family. The following concerns were identified:<br>a. Review of the list of residents who needed assistance, provided by the facility on 11/16/15, showed the resident required "full assist. [assistance]."<br>b. Review of nursing/progress note dated 11/2/15 and timed 12:15 PM showed the resident was alert and oriented times 2 with "periods of confusion." Further review showed the resident required 1 person assist with ADLs and was incontinent of bowel and bladder. | (S5020) | | |

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| {S5020} | Continued From page 6<br><br>c. Review of an ALF 102 assessment completed on 11/18/15 showed the resident was occasionally incontinent, completely dependent for transfers, and had intermittent confusion and/or was agitated.<br>d. Interview with the CSD and Executive Director on 11/18/15 at 2:07 PM revealed the facility was pursuing long term care placement but there was no evidence of communication with the family. Further, the interview revealed the resident required services that were no longer appropriate for the facility.<br><br>3. Interview with the CSD and Executive Director on 11/18/15 at 2:07 PM confirmed a new ALF-102 should have been completed because the assessment in the residents' charts were not accurate. | {S5020} | | |
| {S5023} | Ch 12 Sec 7 (b)(iv)(A-C) Assisted Living Facility (ALF) Core Services<br><br>(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.<br><br>(iv) Frequency of assessment. An assessment must be conducted:<br><br>(A) No earlier than one (1) week prior to admission;<br><br>(B) Immediately upon any significant change in the resident's mental or physical condition; or | {S5023} | | |

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| (S5023) | Continued From page 6<br>(C) No less than once every twelve (12) months.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure a change of condition assessment was completed for 2 of 12 sample residents (#3, #15) who had a change in condition. In addition, the facility failed to ensure assessments were accurate for 2 of 12 sample residents (#46, #53) who were reviewed for elopement risk. The findings were:<br><br>1. Medical record review showed resident #15 had an ALF 102 assessment completed on 9/14/15. The resident was determined to be independent and appropriate with mobility and medically stable at that time. The following concerns were identified:<br>a. Review of facility incident reports from 10/22/15 through 11/14/15 showed the resident had 5 unwitnessed falls while attempting to ambulate or transfer without assistance.<br>b. Review of a nursing/progress note dated 10/22/15 and timed 12:50 AM showed the resident "called [his/her] son at 12:30 AM and [his/her] son brought him a bottle of Advil PM." Review of a progress note 10/22/15 and time 4 PM showed the resident "fell in apartment and the daughter decided to take the resident to the ER [emergency room]..." The resident had contacted staff by telephone to tell them "I want to throw up...No position feels good..." Further review showed "...the resident's daughter arrived and wanted to know how many Advil PM the resident took. This nurse counted the bottle with the daughter, the total pill count was 107/120. 13 pills were not accounted for. Resident left with daughter to the ER." | (S5023) | The facility will ensure a comprehensive assessment will be completed on any resident with a change of condition.<br><br>A comprehensive assessment was done on resident's #3, #15, and #53. (resident #46 has been discharged from facility on 12/3/15)<br><br>Resident's #3, and #15 have been discharged from the facility. Resident #53 has been issued a 30 day notice.<br><br>All remaining resident's will have a comprehensive assessment completed to identify any change of condition.<br><br>Administrator and CSD reviewed regulations to ensure understanding.<br><br>An audit of current resident's comprehensive assessments will be completed with each resident's care plan meeting to ensure compliance.<br><br>Administrator and CSD will ensure assessments will be completed on any resident with a change of condition and any issues will be noted in the Quality Assurance Program which will be reviewed quarterly. | 03/31/16 |

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| (S5023) | Continued From page 7<br>c. Interview with the CSD and executive director on 11/18/15 at 2:07 PM confirmed the resident had a physical and/or mental change in condition and a significant change assessment was not completed.<br><br>2. Medical record review showed resident #3 had an ALF 102 assessment completed on 4/1/15. The resident was determined to be independent with bathing, continent of bowel and bladder, independent and appropriately able to transfer, and had appropriate behavior. Review of the resident's care plan dated 5/20/15 showed the resident was alert and oriented to name, place, time, date, and family. The following concerns were identified:<br>a. Review of the list of residents who needed assistance, provided by the facility on 11/18/15, showed the resident required "full assist."<br>b. Review of a nursing/progress note dated 11/2/15 and timed 12:15 PM showed the resident was alert and oriented times 2 with "periods of confusion." Further review showed the resident required 1 person assist with ADLs and was incontinent of bowel and bladder.<br>c. Review of an ALF 102 assesement completed on 11/18/15 showed the resident was occasionally incontinent, completely dependent for transfers, and had intermittent confusion and/or was agitated.<br>d. Interview with the CSD and executive director on 11/18/15 at 2:07 PM revealed the facility was pursuing long term care placement but there was no evidence of communication with the family. Further, the interview revealed the resident required services that were no longer appropriate for the facility.<br><br>3. Medical record review showed resident #46 had an elopement risk evaluation completed on | (S5023) | | |

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| {S5023} | Continued From page 8<br>6/24/15 and had a score of 4 indicating the resident was a low elopement risk. Further review of the elopement risk evaluation showed the resident received 4 points for being "fully ambulatory." The following concerns were identified:<br>a. Review of the list of residents who needed assistance, provided by the facility on 11/16/15, showed the resident required "full assist. [assistance]."<br>b. Review of the elopement risk evaluation dated 6/24/15 showed the resident was not marked for having dementia or any type of mental illness and was not marked as being disoriented. The points associated with each area was 2, which would have increased the overall score to 8.<br>c. Review of the resident's care plan dated 6/24/15 showed diagnoses that included dementia.<br>d. Review of a nursing/progress note dated 11/1/15 at 10:15 AM showed the resident is "alert and oriented to person. Needs to be cued to get up and dressed."<br>e. Review of a nursing/progress note dated 11/16/15 and timed 6 PM showed the facility "spoke with the son in regard to resident being transferred to [facility name] memory unit d/t [due to] decline in cognition."<br>f. Interview with the CSD and executive director on 11/18/15 at 2:07 PM confirmed the elopement risk evaluation was not accurate.<br><br>4. Medical record review showed resident #53 had an elopement risk evaluation completed on 6/1/15 and had a score of 4 indicating the resident was a low elopement risk. Further review of the elopement risk evaluation showed the resident received 4 points for being "fully ambulatory." The following concerns were | {S5023} | | |

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| (S5023) | Continued From page 9<br>Identified:<br>a. Review of the list of residents who needed assistance, provided by the facility on 11/16/15, showed the resident required "full assist."<br>b. Review of the elopement risk evaluation dated 6/1/15 showed the resident was not marked as being disoriented. The points associated with this area was 2, which would have increased the overall score to 6.<br>c. Review of the care plan dated 6/1/15 showed the resident was alert and oriented to person, place, and time. The resident has to be reminded of the date.<br>d. Review of a nursing/progress note dated 10/24/15 showed the resident was alert and oriented times 2.<br>e. Interview with the CSD and executive director on 11/18/15 at 2:07 PM confirmed the resident was confused and the elopement risk evaluation was not accurate.<br><br>5. Interview with the CSD and executive director on 11/18/15 at 2:07 PM confirmed a new RN assessment should have been completed because the assessments in the resident's charts were not accurate. | (S5023) | | |
| S5053 | Ch 12 Sec 7 (d)(v)(A) Assisted Living Facility (ALF) Core Services<br><br>(d) Medications.<br><br>(v) Medication Administration<br><br>(A) An RN shall be responsible for the supervision and management of all medication administration as required by the Wyoming Nurse Practice Act, and the Wyoming Board of Nursing Rules and Regulations. | S5053 | | |

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| S5053 | Continued From page 10<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on observation, staff interview, and medical record review the facility failed to ensure medications were administered according to the physician orders during one medication pass. The practice affected resident #31. The findings were:<br><br>1. Observation of medication administration on 11/18/15 at 4:04 PM showed LPN #1 obtained Coumadin (anticoagulant) 2 mg tablets and removed 3 tabs from the container. Two tablets were placed in a medication cup and the 3rd tablet was placed in a pill splitting device and cut in half. Half of the 3rd tablet was placed in the medication cup, for a total of 5 mg of coumadin, and the other half was returned to the medication container. The LPN added the other medications ordered to the cup at that time and approached resident #31. The LPN told the resident what medications were in the cup and explained that the half tablet was part of the residents coumadin that had to be cut in half so the resident would get 4.5 mg. The resident took the medications and the nurse returned to the medication cart. Review the physician orders dated 11/11/15 showed the resident had an order for coumadin 4.5 mg on Monday, Wednesday, and Friday and 3 mg on all other days. Interview with LPN #1 on 11/18/15 at 4:12 PM revealed the resident should have received 4.5 mg and confirmed the dose administered was 5 mg. | S5053 | The facility will ensure medications will be administered according to the physician orders during medication pass.<br><br>Resident #31 physician was notified on 11/18/16. Resident #31 was sent to the CRMC Coumadin clinic on 11/19/16. An Elevated INR was noted and it was recommended to hold her Coumadin dose for 11/19/16.<br><br>A medication error report was written on the nurse that administered the incorrect medication.<br><br>All nursing staff will be trained/retrained regarding medication errors.<br><br>All resident's on anticoagulants will be audited to ensure that they will have anticoagulant protocol in place for nursing staff to see.<br><br>Any resident receiving anticoagulants will have a second signature at time of administration to ensure proper dosage is given.<br><br>Administrator and CSD will ensure all medication errors will be discussed and take proper action. Any issues will be noted in the Quality Assurance Program which is reviewed quarterly. | 03/31/16 |
| {S5054} | Ch 12 Sec 7 (e)(i)(A-K) Assisted Living Facility (ALF) Core Services<br><br>(e) Resident Records and Reports. Each resident's records shall be current, organized and | {S5054} | | |

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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 _____ | R-C 11/18/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SIERRA HILLS ASSISTED LIVING COMMUNITY | 4608 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 |
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| (S5054) | Continued From page 11<br>maintained in individual folders which shall be made available to the resident, the Licensing Division, or designated representative upon request.<br><br>(I) Each folder shall include the following:<br><br>(A) Information from the referring agent, if applicable;<br><br>(B) History and physical performed by a physician or physician extender;<br><br>(C) Individual admission form. The form shall, at a minimum, contain the following information:<br><br>(I) Full name of resident and former address;<br><br>(II) Date of admission;<br><br>(III) Sex, race, date of birth, social security number, and former occupation;<br><br>(IV) Name, home address, and telephone number of relative, friend, Power of Attorney, or guardian;<br><br>(V) Name, address, and telephone number of resident's personal physician, dentist, ophthalmologist or optometrist;<br><br>(VI) Medicare number of other medical insurance identifying data;<br><br>(VII) A written inventory of all personal possessions; however, this inventory need not include personal clothing. | (S5054) | The facility will ensure all incidents involving the health, safety, or welfare of residents to the Licensing Division.<br><br>Incident report for resident #15 from incident on 10/22/15 was sent to the State of Wyoming Licensing Division.<br><br>Administrator and CSD reviewed regulations pertaining to incident reporting to ensure understanding.<br><br>All future incidents meeting the state regulations criteria will be reported to the State Licensing Division.<br><br>All incident reports will be reviewed at daily department head meetings. (M-F) and incident reports meeting criteria will be sent/faxed to the state.<br><br>Administrator and CSD will ensure incident reports are being reported and any issues will be noted in the Quality Assurance Program which is reviewed quarterly. | 03/31/16 |

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| {S5054} | Continued From page 12 | {S5054} | | |

(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.

(3.) Upon the death of a resident with a personal fund deposited with the facility, the

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| {S5054} | Continued From page 13<br>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.<br><br>(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.<br><br>(F) A signed copy of the resident's rights;<br><br>(G) The resident's assessment and individualized assistance plan;<br><br>(H) Copies of all applicable resident assistance contracts, signed by both parties;<br><br>(I) Written acknowledgment of the receipt and explanation of all facility policies including admission/discharge policies;<br><br>(J) Copy of all ALF 102's; and<br><br>(K) Copy of outside contractual responsibilities, if applicable.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on medical record review, staff interview, and State Survey Agency (Licensing Division) record review, the facility failed to report incidents involving the health, safety, or welfare of residents to the Licensing Division for 1 of 1 sample residents (#15) with reportable incidents. The findings were: | {S5054} | | |

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| {S5054} | Continued From page 14<br>1. Medical record review showed resident #15 had an ALF 102 assessment completed on 9/14/15. The resident was determined to be independent and appropriate with mobility and medically stable at that time. The following concerns were identified:<br>a. Review of a nursing/progress note dated 10/22/15 and timed 12:50 AM showed the resident "called [his/her] son at 12:30 AM and [his/her] son brought him a bottle of Advil PM." Review of a progress note 10/22/15 and time 4 PM showed the resident "fell in apartment and the daughter decided to take the resident to the ER [emergency room]..." The resident had contacted staff by telephone to tell them "I want to throw up...No position feels good..." Further review showed "...the resident's daughter arrived and wanted to know how many Advil PM the resident took. This nurse counted the bottle with the daughter, the total pill count was 107/120. 13 pills were not accounted for. Resident left with daughter to the ER."<br>b. Review of Licensing Division records showed the facility did not report the incident.<br>c. Interview with the CSD and executive director on 11/18/15 at 2:07 PM confirmed the incident report should have been reported to the Licensing Division. | {S5054} | | |
| S5088 | Ch 12 Sec 7 (I)(i)(A-D) Assisted Living Facility (ALF) Core Services<br><br>(I) Quality Improvement.<br><br>(i) The facility shall have an active quality improvement program to ensure effective utilization and delivery of resident care services.<br><br>(A) A member of the facility's staff shall be | S5088 | | |

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| S5088 | Continued From page 15<br>designated to coordinate the quality improvement program.<br><br>(B) The quality improvement program shall encompass a review of all services and programs provided for all residents. The program shall have:<br><br>(I) A written description;<br><br>(II) Problem areas identified;<br><br>(III) Monitor identification;<br><br>(IV) Frequency of monitoring;<br><br>(V) A provision requiring the facility to complete annually a self assessment survey of compliance with regulations; and<br><br>(VI) A satisfaction survey shall be provided to the resident, resident's family, or resident's responsible party at least annually.<br><br>(C) Problems identified during the annual survey or the quality improvement process shall be addressed with appropriate written corrective actions.<br><br>(D) The quality improvement program shall be re-evaluated at least annually.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on record review and staff interview the facility failed to effectively utilize the quality improvement program to address problems identified during previous surveys conducted by | S5088 | A Quality Assurance state binder will be specifically created with tabs for each state tag that the facility was out of correction.<br><br>Under each tab will be the supporting documents to show what the facility states will be done is in fact being done.<br><br>Every Wednesday for 3 months the Administrator will bring the state binder to review with the department heads as to the progress of what is needed.<br><br>Quality assurance implemented on 11/30/15 a comprehensive checkoff list that will be placed in the quality assurance binder weekly under appropriate tag supporting compliance.<br><br>Administrator will ensure all documentation is completed in the quality assurance state binder. | 03/31/16 |

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| S5088 | Continued From page 16<br>the Healthcare Licensing and Surveys. The findings were:<br><br>1. Review of the Healthcare Licensing and Surveys statements of deficiencies for a surveys conducted on 6/9/15, 7/15/15, and 11/18/15 showed the facility had continued non-compliance with state regulations in the areas of core services provided by the facility, completion of an ALF 102 assessment with change in condition of residents, completion of a change of condition assessment and/or accuracy of assessments for residents, and reporting incidents that affected resident health, safety, and welfare to the Licensing Division.<br><br>2. Review of the facility Quality Improvement program showed the facility failed to follow the plan of correction developed to correct previous survey deficiencies. The plan included audits and education to improve the quality of care.<br><br>3. Interview with CSD and executive director on 11/18/15 at 2:07 PM confirmed the facility did not follow the plan of correction developed for the previous surveys and was not monitoring the results in the quality improvement program. | S5088 | | |

# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| ALF008 Y1 | A. Building<br>B. Wing Y2 | 11/18/2015 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SIERRA HILLS ASSISTED LIVING COMMUNITY | 4606 NORTH COLLEGE DRIVE<br>CHEYENNE, WY 82009 |

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 S5007 | Correction | ID Prefix S5012 | Correction | ID Prefix S5024 | Correction |
| Reg. # Ch 12 Sec 6 (d)(i) | Completed | Reg. # Ch 12 Sec 7 (a)(ii) | Completed | Reg. # Ch 12 Sec 7 (b)(v)(A) | Completed |
| LSC | 07/25/2015 | LSC | 09/11/2015 | LSC | 09/11/2015 |
| ID Prefix S5028 | Correction | ID Prefix S5050 | Correction | ID Prefix S5052 | Correction |
| Reg. # Ch 12 Sec 7 (c)(i) | Completed | Reg. # Ch 12 Sec 7 (d)(ii)(A-B) | Completed | Reg. # Ch 12 Sec 7 (d)(iv)(A) | Completed |
| LSC | 09/11/2015 | LSC | 09/11/2015 | LSC | 09/11/2015 |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
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| LSC | | LSC | | LSC | |

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|---|---|---|---|---|
| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) KB 3/9/16 | DATE | SIGNATURE OF SURVEYOR Tina Tarver | DATE 11/25/15 |
| 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: W2ZY12