PRINTED: 03/24/2016
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
	ALF010	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF EVANSTON	1949 WEST UINTA STREET EVANSTON, WY 82930

(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 08/28/2001 A survey was conducted by Healthcare Licensing and Surveys on 3/10/16. The survey was prompted by complaint intake #LIC-16-022.	S 000	A. A registered nurse is currently employed by our facility. B. The RN duties will include: - Nursing Assessment prior to admission, annually, and if a change in condition occurs. - Plan of Care prior to admission, annually, and if a change in condition occurs. - ALF 102 prior to admission, annually, and if a change in condition occurs. - Medication Review prior to admission, every 30-60 days, annually, and if a change in condition occurs. - Discharge Potential assessment prior to admission, annually, and at discharge. - Sign off on medications as needed, organize medications for the week, and assessments after a fall or injury occurs. C. Facility Manager will review all nursing documents for completeness and proper signatures for quality assurance and resolution of improper and incomplete documentation. D. A current nursing assessment, plan of care, ALF 102, medication review, and discharge potential assessment will be updated on all current resident files by April 30, 2016.	4/30/16
S6018	Ch 12 Sec 7 (a)(ix)(A) Assisted Living Facility (ALF) Core Services (a) The assisted living facility core services include the following: (ix) Assessments completed by a Registered Nurse. (A) Registered Nurse medication review every two (2) months or sixty-two (62) days or whenever new medication is prescribed or the resident's medication is changed; 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 registered nurse (RN) was available to review medications every 62 days or with each new medication change for 2 of 2 residents reviewed who had medication orders (#1, #2). The findings were: 1. Medical record review showed resident #1 was admitted to the facility on 1/23/15 with diagnoses which included schizophrenia and type II	S6018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sharon R Laurence	Resident/CEO	4/15/16

STATE FORM 6899 XVWZ11 If continuation sheet 1 of 9

4/15/16 - This POC accepted with agreed to change between Sonna Kontz, Executive Secretary and Troy Madden, Surveyor.

4/15/16

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S5018	Continued From page 1 diabetes. Review of the resident's March 2016 medication administration record (MAR) showed the resident received medications. Further review showed no indication an RN had reviewed those medications. 2. Medical record review showed resident #2 was admitted to the facility on 1/31/14 with diagnoses which included schizophrenia, dementia, chronic obstructive pulmonary disease, and chronic kidney disease. Review of the resident's March 2016 MAR showed the resident received medications. Further review showed no indication an RN had reviewed those medications. 3. Interview with licensed practical nurse (LPN) #1 and Executive Secretary #1 on 3/10/16 at 1 PM confirmed the facility failed to ensure an RN was available to review resident medications, and residents #1 and #2 had physician's orders for medications. In addition, both confirmed the facility had failed to have a staff or contracted RN since the end of 2015.	S5018	The QA Committee will monitor this as an ongoing process-	
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	S5020		

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S6020	Continued From page 2 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 registered nurse (RN) was available to complete annual ALF 102 assessments for 2 of 2 residents reviewed who required an updated ALF 102 (#1, #2). The findings were: 1. Medical record review showed resident #1 had a completed ALF 102 assessment dated 1/23/15. Further review showed there was no ALF 102 with a more recent date. 2. Medical record review showed resident #2 had a completed ALF 102 assessment dated 1/23/15. Further review showed there was no ALF 102 with a more recent date. 3. Interview with licensed practical nurse (LPN)	S6020	A. A registered nurse is currently employed by our facility. B. The RN duties will include: - Nursing Assessment prior to admission, annually, and if a change in condition occurs. - Plan of Care prior to admission, annually, and if a change in condition occurs. - ALF 102 prior to admission, annually, and if a change in condition occurs. - Medication Review prior to admission, every 30-60 days, annually, and if a change in condition occurs. - Discharge Potential assessment prior to admission, annually, and at discharge. - Sign off on medications as needed, organize medications for the week, and assessments after a fall or injury occurs. C. Facility Manager will review all nursing documents for completeness and proper signatures for quality assurance and resolution of improper and incomplete documentation. D. A current nursing assessment, plan of care, ALF 102, medication review, and discharge potential assessment will be updated on all current resident files by April 30, 2016.	4/30/16

The QA Committee will monitor this as an ongoing process.

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S6020	Continued From page 3 #1 and Executive Secretary #1 on 3/10/16 at 1 PM confirmed the facility failed to ensure an RN was available to perform ALF 102 assessments, and residents #1 and #2 had ALF 102 assessments that were overdue. In addition, both confirmed the facility had failed to have a staff or contracted RN since the end of 2015.	S6020	A. A registered nurse is currently employed by our facility. B. The RN duties will include: - Nursing Assessment prior to admission, annually, and if a change in condition occurs. - Plan of Care prior to admission, annually, and if a change in condition occurs. - ALF 102 prior to admission, annually, and if a change in condition occurs. - Medication Review prior to admission, every 30-60 days, annually, and if a change in condition occurs. - Discharge Potential assessment prior to admission, annually, and at discharge. - Sign off on medications as needed, organize medications for the week, and assessments after a fall or injury occurs. C. Facility Manager will review all nursing documents for completeness and proper signatures for quality assurance and resolution of improper and incomplete documentation. D. A current nursing assessment, plan of care, ALF 102, medication review, and discharge potential assessment will be updated on all current resident files by April 30, 2016.	4/30/16
S6053	Ch 12 Sec 7 (d)(v)(A) Assisted Living Facility (ALF) Core Services (d) Medications. (v) Medication Administration (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. 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 registered nurse (RN) was available to supervise and manage medication administration at the facility for 2 of 2 residents reviewed who had medication management needs (#1, #2). The findings were: 1. Medical record review showed resident #1 was admitted to the facility on 1/23/15 with diagnoses which included schizophrenia and type II diabetes. Review of the resident's March 2016 medication administration record (MAR) showed the resident received medications. Further review showed no indication an RN had reviewed those medications.	S6053		

The QA committee will monitor this & ongoing basis.

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S5053	Continued From page 4 2. Medical record review showed resident #2 was admitted to the facility on 1/31/14 with diagnoses which included schizophrenia, dementia, chronic obstructive pulmonary disease, and chronic kidney disease. Review of the resident's March 2016 MAR showed the resident received medications. Further review showed no indication an RN had reviewed those medications. 3. Interview with licensed practical nurse (LPN) #1 and Executive Secretary #1 on 3/10/16 at 1 PM confirmed the facility failed to ensure an RN was available to supervise and manage medications, and residents #1 and #2 had physician's orders for medications. In addition, both confirmed the facility had failed to have a staff or contracted RN since the end of 2015.	S5053		
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:	S5054		

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S5054	Continued From page 5 (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; (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	S5054		

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S5054	Continued From page 8 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 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;	S5054		

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S5054	Continued From page 7 (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 medical record review and staff interview, the facility failed to report a change of condition to the resident's guardian for 1 of 3 sample residents (#1). The findings were: Medical record review showed resident #1 had diagnoses which included type II diabetes. Further review showed the resident visited the local emergency room on 3/3/16 for issues with his/her feet, and s/he was discharged from the emergency room the same day with diagnoses of neurodermatitis and type II diabetes mellitus with foot ulcer. The instructions called for a local home health agency to visit the resident at the facility for dressing changes, and for a podiatrist to visit on 3/8/16. Observation on 3/8/16 at around 4:30 PM (surveyor was at the facility unrelated to this complaint) showed the podiatrist visited the resident, who was ambulatory without any assistive devices. Observation on 3/10/16 at 11:10 AM showed the resident ambulated without any assistive devices. The following concerns were identified: a. Review of the entire medical record	S5054	A. New manager was advised that the resident's guardian needs to be notified if the resident has any change in condition or when care has been transferred to an emergency facility, regardless of where the emergency took place. B. Manager is aware that verbal communication is not sufficient. Any communication with the resident's guardian or outside agency needs to be fully documented for quality assurance and future reference. C. During a quality assurance meeting held 3/30/16, manager discussed the chain of command regarding issues or emergencies relating to residents. The importance of documentation and notifying the manager were highly stressed. The QA Committee will monitor these on going process.	3/30/16

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S5054	Continued From page 8 revealed there was no documentation to show resident's guardian was notified that the resident had visited a local emergency room. b. Interview with licensed practical nurse (LPN) #1 and Executive Secretary #1 on 3/10/16 at 1 PM confirmed the facility failed to notify the resident's guardian of the emergency room visit. The interview revealed the resident was sent to the emergency room by staff at a local outpatient mental health center, and the facility was unaware that they were still required to ensure the guardian was notified of the visit.	S5054		

4/15/16