PRINTED: 03/22/2016
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 _____	C 03/08/2016

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 06/26/2001 A complaint survey was conducted by Healthcare Licensing and Surveys on 3/8/16. The survey was prompted by complaint intakes LIC-15-045 and LIC-16-017. The following common abbreviations are used throughout this document: CNA- Certified nurse aide LPN- Licensed Practical Nurse POA- Power of Attorney RN- Registered nurse Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5082	Ch 12 Sec 7 (k)(i) Assisted Living Facility (ALF) Core Services (k) Transfer and Discharge. (i) Residents shall receive a thirty (30) day written notice prior to any facility initiated transfer or discharge, unless the resident imposes an imminent danger to self and/or others or the resident's level of care exceeds that which can be provided by an assisted living facility. Residents shall have the right to object to the request, except where undue delay might jeopardize the health, safety or well-being of the resident or	S5082	A. Discharge protocols have been updated as follows: - As soon as behavior and/or conduct, such as wandering or elopement, on behalf of the resident becomes a cause for concern, management will provide the resident and/or POA with a 30 day discharge notice. - Included in the discharge notice will be the reason for discharge, the date of discharge, who to contact if the resident and/or POA would like to appeal the decision (Healthcare Licensing and Surveys, Regional Ombudsman, Facility Owner), and a signature line indicating that the resident and/or POA received the notice.	3/8/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimmon K. Lawrence — TITLE: President/CEO — (X6) DATE: 4/15/16

STATE FORM 6899 60VB11 If continuation sheet 1 of 4

4/15/16 - This POC accepted with agreed to changes between Sommer Kontz, Executive Secretary and Tony Madden, Surveyor.

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S5082	Continued From page 1 others. The notice shall include contact information for the Long Term Care Ombudsman. This State Rule and Regulation is not met as evidenced by: Based on medical record review, review of previous survey results, and staff interview, the facility failed to ensure 1 of 4 residents (#1) received a 30-day written notice prior to discharge. The findings were: Medical record review for resident #1 showed a 6/17/16 Resident Discharge/Transfer Form with the following information documented in the section titled, "Reason for discharge/transfer": "No longer met our criteria to stay became a safety issue due to wandering away from facility was not able to be redirected safely." The following concerns were identified: a. The Resident Discharge/Transfer Form showed immediate discharge with no indication that the required 30-day notice was attempted. b. Medical record review showed the resident had wandering and elopement issues with behavior issues as early as 3/1/15 (119 days before discharge) with no indication the facility attempted to obtain a higher level of care placement for the resident. c. Review of the 6/9/15 survey results for the facility showed the facility was cited for the resident's wandering and elopement behavior, and for facility failure to notify the state survey agency concerning the resident's elopements. d. Interview with LPN #1 and Executive Secretary #1 on 3/8/16 at 5 PM confirmed the facility failed to notify the POA 30 days in advance of discharge, and failed to initiate a good faith effort to assist in placing the resident in a higher level of care.	S5082	- Physical address of the location the resident is being discharged to will be documented on the Resident Transfer/Discharge form. - Management will ensure sufficient preparation and orientation to the resident to guarantee a safe and orderly transfer from the facility. - Emergency discharge will only occur if the resident imposes imminent danger to themselves, employees, and/or other residents. Emergency discharge may also occur if the resident's level of care is no longer within the scope of practice of an assisted living facility, such as in the event of a stroke. B. For quality assurance and resolution, the facility manager will remain educated on proper discharge protocols and accurate documentation that will be consistent and thorough. Manager will also contact management for all discharge concerns. C. Management will supply facility manager with all discharge notices after management has evaluated all evidence to support reason for discharge. This will aid in the quality assurance and resolution of proper discharge policies and procedures. The discharge process will be audited in QA. until resolution - CT	

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S5086	Continued From page 2	S5086		
S5086	Ch 12 Sec 7 (k)(v) Assisted Living Facility (ALF) Core Services (k) Transfer and Discharge. (v) The facility shall provide sufficient preparation and orientation to residents to ensure an orderly transfer/discharge from the facility. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 1 of 4 residents (#2) received sufficient preparation prior to discharge. The findings were: Medical record review for resident #2 showed s/he was discharged on 1/19/16. Review of the 1/19/16 Resident Discharge/Transfer Form showed under Reason for Discharge/Transfer, "[S/he] no longer meets our level of care. [His/her] disease has progressed beyond our level of care. A thirty day notice was given per our policies." The review showed the resident had diagnoses which included Huntington's Disease. The following concerns were identified: a. Review of the 1/19/16 Resident Discharge/Transfer Form showed under "Next of Kin Notified" in the "Comments" section, "Son was going to help his [parent] with finding a place and stated that if a place could not be found he was willing to let [him/her] move in with him. Prior to [the resident's] discharge, [his/her] son declined to have any further involvement with the resident's relocation." However, review of the Resident Discharge/Transfer Notice dated 1/19/16 showed the resident was transferred to the son's home. b. Review of the medical record showed	S5086	A. New manager has been educated on the importance of proper and thorough documentation. - Documentation shall be detailed and provide dates, times, resident's name, and individuals involved. - Documentation shall not be completed until the time of discharge to prevent improper documentation and to reflect changes in the discharge process. - Information of all events leading up to and at the time of discharge should be documented for future reference. B. Manager is aware that verbal communication with outside entities, such as home health, is not sufficient. All communication will be documented as it occurs for quality assurance and future reference. C. Manager and RN will perform assessments as necessary to provide educated conclusions on the resident's ability to care for themselves or if a higher level of care would be more appropriate. The discharge process will be audited in 30 until resolution - AR	3/8/2016

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S5086	Continued From page 3 notes on 1/19/16 which revealed the following, "1/19/16 7/3 [7 AM to 3 PM] [Resident's name] is waiting to leave today. [S/he] feels [s/he] can care for [himself/herself] and would like to go live in a hotel. The Facility Director will be in today to discharge [him/her]." "1/19/16 7/11[7 AM to 11 AM] Left at beginning of shift went to hotel discharged." Review of the entire medical record failed to document an assessment or explanation as to why it was safe to discharge the resident to a hotel after the resident was assessed as requiring a higher level of care. c. Review of the entire medical record showed no documentation regarding a sufficient preparation for discharge, which would include a requirement for assistance in obtaining placement in a higher level of care. The review also identified a failure on the part of the facility to discuss with the resident the assessed needs for a higher level of care. d. Interview with LPN #1 and Executive Secretary #1 on 3/8/16 at 5 PM confirmed the facility failed to ensure required preparation and orientation was provided to the resident concerning placement in a higher level of care. In addition, they confirmed the facility failed to communicate that assessed need to the resident.	S5086		

4/15/16