PRINTED: 12/03/2015
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
	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
{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 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 7/15/15 for complaint intake LIC-15-049. The following common abbreviations are used throughout the document: RN - Registered Nurse LPN - Licensed Practical Nurse CNA - Certified Nursing Assistant CSD - Clinical Service Director mg - milligrams Less commonly used abbreviations will be annoted in each deficiency.	{S 000}		
{S6023}	Ch 12 Sec 7 (b)(iv)(A-C) 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. (iv) Frequency of assessment. An assessment must be conducted:	{S6023}	The facility will ensure a change of condition assessment will be done immediately upon any significant change in the resident's mental or physical condition:	03/31/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M. Hunter — TITLE: ED — (X6) DATE: 3/6/16

RECEIVED
WY Dept of Health
MAR 06 2016
Healthcare Licensing and Surveys

Spoke with Mike ED on 3/7/16 at 4:14. POC Accepted with compliance date 3/31/16

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(S5023)	Continued From page 1 (A) No earlier than one (1) week prior to admission; (B) Immediately upon any significant change in the resident's mental or physical condition; or (C) No less than once every twelve (12) months. 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 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: 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: 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. 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	(S5023)	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. An assessment was done on resident #15. Resident #15 was found to be not appropriate for this facility. Resident #15 was moved to the Cheyenne VA hospice unit. Resident #46 was determined to be not appropriate for facility. Aspen Winds did assessment and accepted when room becomes available. Resident #46 moved to Aspen Winds. An assessment was done on resident #53. Resident #53 was found to be not appropriate for facility. A care meeting with resident and family was done on 01/12/16 at which time a 30 day letter was issued. Resident lives with spouse at facility. Family wants resident to go to Life Care Center of Cheyenne and spouse will go to Pointe Frontier. Resident is on top of waiting list, but family still has not secured a bed.	~~12/26/15~~ ~~01/11/16~~ ~~12/04/15~~ ~~01/12/16~~ 3/31/16

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{S5023}	Continued From page 2 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." 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. 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 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: a. Review of the list of residents who needed assistance, provided by the facility on 11/16/15, showed the resident required "full assist." 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. 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. 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	{S5023}	Clinical Services Director/Assistant Clinical Services Director will do an assessment of remaining residents. The assessment will identify any significant change of condition. Any resident identified with a significant change of condition will have an ALF 102 and care plan updated within 24 hours. Administrator/Clinical Services Director/Assistant Clinical Services Director reviewed regulations to ensure understanding. Administrator/Clinical Services Director/Assistant Clinical Services Director will ensure any change of conditions are completed as per state regulations and any issues will be noted in the Quality Assurance Program which will be reviewed quarterly.	

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(S5023)	Continued From page 3 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. 3. Medical record review showed resident #46 had an elopement risk evaluation completed on 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: 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]." 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. c. Review of the resident's care plan dated 6/24/15 showed diagnoses that included dementia. 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." 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." f. Interview with the CSD and executive director on 11/18/15 at 2:07 PM confirmed the elopement risk evaluation was not accurate.	(S5023)		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE CHEYENNE, WY 82009

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{S5023}	Continued From page 4 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 identified: a. Review of the list of residents who needed assistance, provided by the facility on 11/18/15, showed the resident required "full assist." 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. 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. d. Review of a nursing/progress note dated 10/24/15 showed the resident was alert and oriented times 2. 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. 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 residents' charts were not accurate.	{S5023}		
{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	{S5054}		

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	ALF006	A. BUILDING: _____ B. WING _____	R-C 11/18/2015

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SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE CHEYENNE, WY 82009

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{S5054}	Continued From page 5 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; (VII) A written inventory of all personal possessions; however, this inventory need not include personal clothing.	{S5054}		

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{S5054}	Continued From page 6	{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 7 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 medical record review, staff interview, and State Survey Agency record review, the facility failed to report incidents involving the health, safety, or welfare of residents to Licensing Division for 1 of 1 sample resident (#15) with reportable incidents. The findings were: 1. Medical record review showed resident #15	{S5054}	The facility will report all future incidents meeting state regulations criteria will be reported to the state of Wyoming licensing division. Incident report for resident #15 for incident on 10/22/15 was sent to the state of Wyoming licensing division. Administrator/Clinical Services Director/Assistant Clinical Services Director reviewed regulations pertaining to incident reporting to ensure understanding. Incident reports will be reviewed at daily department head meetings (M-F). Any incident report meeting state criteria will be sent to the state of Wyoming licensing division. Administrator and CSD will ensure all reportable events are completed and any issues will be noted in the Quality Assurance Program binder which is reviewed quarterly.	~~01/31/16~~ ~~01/31/16~~ 3/3/16

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{S5054}	Continued From page 8 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: 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." b. Review of Licensing Division records showed the facility did not report the incident. 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 (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	S5088		

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S5088	Continued From page 9 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 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 effectively utilize the quality improvement program to address problems identified during previous surveys conducted by the Healthcare Licensing and Surveys. The	S5088	A Quality Assurance state binder will be specifically created with tabs for each state tag that the facility was out of correction. Under each tab will be the supporting documents to show what the facility states will be done is in fact being done. 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. 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. Administrator will ensure all documentation is completed in the quality assurance state binder.	~~01/31/16~~ 3/3/16

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S5088	Continued From page 10 findings were: 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. 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. 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
ALF008	A. Building B. Wing	11/18/2015

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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 S5100 Reg. # Ch 12 Sec 8 (a)(vi) LSC	Correction Completed 09/01/2015	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
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	ID Prefix Reg. # LSC	Correction Completed
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) TS 5/24/16	DATE	SIGNATURE OF SURVEYOR Jim Cozad by [signature]	DATE 5/24/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/15/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: ZLMN12