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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
	ALF030	A. BUILDING: _____ B. WING _____	C 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE CHEYENNE, WY 82009

YA 10/10/16

(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 06/28/2001 A complaint survey was conducted by Healthcare Licensing and Surveys on 8/18/16 through 8/19/16. This survey was prompted by complaint intakes LIC-16-008 and LIC-16-037. The following common abbreviations were used throughout this document: ADON: Assistant Director of Nursing CNA: Certified Nurse Aide RN: Registered Nurse	S 000		
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 Program Division. Providers will be notified of changes in the form. The following guidelines apply to the ALF 102;	S5020	**S5020.** The facility will ensure the Director of Nursing(RN) or the Assistant Director of Nursing(RN) completes an accurate, standardized, reproducible assessment upon admission, annually thereafter, and with any change of condition for each resident. To accompany this assessment, the Director of Nursing(RN) or the Assistant Director of Nursing(RN) will also complete and sign a coordinating ALF 102. This will be accomplished by the following actions: A).During regular business hours, Director of Nursing(RN) will have sole duty of completing annual and change of condition assessments and their corresponding ALF 102.	

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

Executive Director — 10/06/2016

POC accepted. Spoke with David Sheppard 10/12/16 2:15 PM. State surveyor

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S5020	Continued From page 1 (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 observation, resident, family, and staff interview, medical record review, and review of facility policies and procedures, the facility failed to ensure an ALF 102 was completed at least annually or with a change in condition for 3 of 6 sample residents (#1, #2, #4). The findings were: 1. Review of the 6/3/16 ALF 102 showed resident #1 had occasional incontinence with occasional help needed to clean self, was able to transfer with minimal assistance, and did not receive assistance from any outside entities. Review of the 6/3/16 nursing assessment showed the resident required assistance with toilet use and the resident's spouse assisted with transfers. Further review showed the resident had increased fatigue following a hospital stay. The following concerns were identified: a. Review of a nurse's note dated 6/23/16 showed "Resident having difficulty with transfers.	S5020	B) During non-regular business hours, the Registered Nurse(RN) on call will be responsible for completing any necessary change of condition assessments and a corresponding ALF 102. That nurse will then communicate changes to the Director of Nursing(RN) to ensure that an accurate, standardized, reproducible assessment was in fact completed and signed by a Registered Nurse(RN). Director of Nursing will also review and sign ALF 102 to ensure the completed ALF 102 is an accurate reflection of a resident's current condition. C) Director of Nursing(RN), Assistant Director of Nursing(RN), and Executive Director will continue to coordinate and execute regular scheduled training focusing on skills that directly pertains to providing the best possible care for residents and their current needs. D) Assistant Director of Nursing(RN) will conduct routine resident care and staff communication interviews to regularly identify and possible changes in resident condition. If any change is reported or physically observed, Assistant Director of Nursing(RN) will communicate that change to Director of Nursing(RN) which will initiate the completion of a new assessment and ALF 102. E) Executive Director, Director of Nursing(RN), and Assistant Director of Nursing(RN) will continue to conduct monthly Quality and Assurance meetings with a specific focus area of identifying any possible changes in resident condition, ensuring all applicable assessments and ALF 102's have been signed by an RN. Other area of specific focus will review residents receiving outside services and ensuring that those services rendered are documented, communicated, and understood by both facility staff outside service providers, and resident(s)//family.	

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S5020	Continued From page 2 Unable to stand, two person assist with standing... incontinent of bladder." b. The nurse's note dated 7/4/16 showed the resident's "brief was soiled, CNA [and] nurse assisted to change [and] clean." c. Review of a nurse's note dated 7/14/16 showed the resident had a fall while being assisted to transfer by his/her spouse. Further review showed the resident "ate supper then had two staff assist back to bed." d. A nurse's note dated 7/17/16 showed "Nursing aide went to change [resident], [resident's] brief was filled with urine and feces. [Resident] stated [s/he] did not know [s/he] had been incontinent." e. Review of a nurse's note dated 7/27/16 showed "Resident called a few times after urinary incontinence episodes for assistance with changing." f. Review of a nurse's note dated 8/2/16 showed the "resident was a two person lift extensive with transfers." g. The nurse's note dated 8/11/16 showed "Resident continues to be a two person extensive assist and unable to do any peri [perineal] care." h. A nurse's note dated 8/14/16 showed "CNA reported resident was total lift. Resident would not bear any weight. Staff had to total assist with standing and peri care." Further review showed emergency medical services (EMS) was called to assist the staff to transfer the resident. Additionally, the note showed the resident "was total care with incontinent urine/peri care." i. Observation on 8/18/16 at 4:10 PM showed 2 CNAs exiting the resident's apartment. Interview with the resident and his/her spouse at that time confirmed the CNAs were assisting the resident with incontinence care. Further interview revealed facility staff members regularly provided care following incontinence episodes and two	S5020	F) In regards to resident #1: An updated assessment and ALF 102 has been completed and signed by Director of Nursing(RN). Through daily monitoring of resident by Director of Nursing(RN), Assistant Director of Nursing(RN), and staff nurses on duty, we have identified that her incontinence and limited ability to transfer is directly correlated to spending excessive periods of time outside the facility causing exhaustion to resident. Executive Director and Director of Nursing(RN) have discussed these findings with resident and spouse. Couple have agreed to utilize facility provided transportation which will reduce the need for excessive transfers and walking. Director of Nursing(RN), Assistant Director of Nursing (RN), and staff floor nurses will monitor and report any changes. G) In regards to resident #2: An updated assessment and ALF 102 has been completed and signed by Director of Nursing(RN). Through daily monitoring of resident by Director of Nursing(RN), Assistant Director of Nursing(RN), and staff nurses on duty have identified that additional care services for incontinence and socialization from outside caregivers would provide a benefit for resident #2. Executive Director and Director of Nursing have completed a Memorandum of Understanding which details the exact services that will be provided by additional outside caregivers. This memorandum will be signed by facility, family member, and any outside service provider. This service list will be made available to facility nursing staff, outside caregivers and family. H) In regards to resident #4: Resident #4 was transferred to CRMC on 9-1-2016. Resident #4 is currently receiving inpatient therapy. Director of Nursing(RN) will complete and sign a Change of Condition assessment and ALF 102 prior to discharge from inpatient therapy. I).Director of Nursing(RN) and Assistant Director of Nursing(RN) will communicate with nursing	

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S5020	Continued From page 3 staff members assisted with transfers. j. Interview on 8/18/16 at 2:50 PM with CNA #1 and CNA #2 revealed the resident required consistent incontinence care from staff, and also required two staff members to assist with transfers. k. Interview on 8/19/16 at 11:00 AM with CNA #3 and CNA #4 revealed the resident required consistent incontinence care from staff and two staff members to assist with transfers. CNA #4 further stated "it's getting to the point where [the resident] is hurting our backs" during transfers, and that s/he was "dead weight" during transfers. l. Interview with the administrator and ADON on 8/19/16 at 1:13 PM verified the 6/3/16 ALF 102 was the most recent completed. Additionally, they stated they did not consider the resident as having a change in condition, and they were going to "wait and see" if the resident improved. 2. Review of the 3/18/16 ALF 102 showed resident #2 was continent of bowel and bladder, and was intermittently confused and/or agitated. Review of the 3/18/16 nursing evaluation showed the resident required assistance with toilet use, was disoriented to time and place, was not continent of urine, and showed the resident "dribbles." Review of a Mini Mental Status Exam (MMSE) dated 3/17/16, showed the resident scored 8/30, suggesting severe cognitive impairment. The following concerns were identified: a. Review of a nurse's note dated 5/6/16 showed the resident was "found sleeping on the floor, next to couch, naked from waist down, socks neatly folded [and] on table, pants under [his/her] head, folded [and] being used as a pillow..." b. Review of a nurse's note dated 6/26/16	S5020	staff to identify any possible changes in any other current resident conditions. Will also conduct a chart audit to ensure the ALF 102 on file is an accurate reflection of the residents' current condition.	10/14/16

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S5020	Continued From page 4 showed the resident "is up [and] dresser [sic] without walker or O2 [oxygen] in place..." c. A nurse's note dated 7/4/16 showed the resident was found "... sitting on front wheel walker with soiled brief in hand. Assisted resident to safe area and helped to put on clean brief..." d. A 7/5/16 nurse's note showed "Nurse entered room at 00:20 [12:20 AM] resident was asleep in bed. O2 was off. Replaced O2... At 1:25 [AM] resident was in bathroom O2 off with dirty brief on floor. Nurse assisted to change brief and clean up..." e. A nurse's note dated 7/11/16 showed "[Resident] tried to leave dining room prior to eating meal. Appeared very confused. [S/he] repeatedly pointed at [his/her] walker and said 'What am I supposed to do?'" f. A 7/12/16 nurse's note showed "Resident had taken off O2 in bed [at] 00:25 [12:25 AM] and 01:20 [AM]. Had O2 on at 0200 [2 AM]. Resident was awake standing in living room with O2 off at 0310 [3:10 AM]. [Refused] to go to bed. Nurse assisted to chair. At 0330 [3:30 AM] resident was standing in bedroom at dresser with O2 off. Nurse assisted back to chair after resident refused bed..." g. A nurse's note dated 7/13/16 showed "... At 02:45 [AM] resident was up in living room with no walker or O2. Nurse replaced O2 [and] assisted to chair. Resident pointed to watch [s/he] was holding and asked 'what is her name?' in reference to the watch. Resident seems confused..." h. A nurse's note dated 7/18/16 showed "... At 03:00 [AM] resident was awake in room w/ [with] no walker [and] no O2. Had taken off brief [and] left in hallway. Assisted to put on new brief but R [refused] to go back to bed, sit in chair, etc..." i. A nurse's note dated 7/20/16 showed "freq noc [frequent night] checks finds [resident] either	S5020		

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S5020	Continued From page 5 sleeping or up to bathroom without incont [incontinence] pad. [S/he] is apparently removing them [and] wets the bed..." j. A 7/22/16 nurse's note showed "Resident found naked in living room closet with no walker or oxygen..." k. A 7/23/16 nurse's note showed "Resident found almost off bed arms and legs were hanging off, no O2 was on..." l. A nurse's note dated 8/1/16 showed "CNA went into room [and] noted resident on floor on L [left] side next to couch. Unable to remember what happened..." m. A nurse's note dated 8/3/16 showed resident was alert "but confused, which is normal." n. Interview on 8/19/16 at 11 AM with CNA #3 and CNA #4 revealed the resident was very confused. They further stated it was a "fight to get [him/her] to do things" such as bathing, dressing, and incontinence care. 3. Review of the medical record showed resident #4 was admitted on 11/12/14. Further review showed an ALF 102 dated 1/8/15. There was no evidence of a more recent ALF 102 in the resident's record. 4. Interview with the administrator and ADON on 8/19/16 at 1:13 PM revealed they were unsure if more current ALF 102 assessments had been completed on the above residents. As of 8/25/16, no further documentation had been provided by the facility. 5. Review of the policy and procedure titled "Assessments and Service Planning," revised 12/31/15, showed examples of significant changes in condition included "New intervention or removal of an intervention; ... 2 or more falls in	S5020		

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S5020	Continued From page 6 a month; Pattern of increasing falls (i.e. 1 per month for 3 months); ... Increased service needs...; ... Increased service needs due to a resident's increasing confusion and disorientation."	S5020		
S5023	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: (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 observation, resident, family, and staff interview, medical record review, and review of facility policies and procedures, the facility failed to ensure a nursing assessment was completed upon a change in condition for 2 of 3 sample residents (#1, #4) with a change in condition. The findings were:	S5023	S5023 The facility will ensure that the Director of Nursing(RN) or the Assistant Director of Nursing(RN) conducts initial and, at a minimum annually, an accurate, standardized, reproducible assessment of each resident's functional capacity, physical assessment and medication review. Additionally, Director of Nursing(RN) or Assistant Director of Nursing(RN) in ensure that an accurate, standardized, reproducible assessment is completed upon any significant change in a resident's mental or physical condition. This will be accomplished by the following: A). During regular business hours, Director of Nursing(RN) will have sole duty of completing annual and change of condition assessments and their corresponding ALF 102. B) During non-regular business hours, the Registered Nurse(RN) on call will be responsible for completing any necessary change of condition assessments and a corresponding ALF 102. That nurse will then communicate changes to the Director of Nursing(RN) to ensure that an accurate, standardized, reproducible assessment was in fact completed and signed by a Registered Nurse(RN). Director of Nursing will also review and sign ALF 102 to ensure the completed ALF 102 is an accurate reflection of a resident's current condition. C) Director of Nursing(RN) and Assistant Director of Nursing(RN) will communicate daily with nursing staff to ensure that residents' current mental and physical condition are compliant with	

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S5023	Continued From page 7 1. Review of the 6/3/16 ALF 102 showed resident #1 had occasional incontinence with occasional help needed to clean self, was able to transfer with minimal assistance, and did not receive assistance from any outside entities. Review of the 6/9/16 resident assessment showed the resident had urinary incontinence and wore protective undergarments, and indicated the resident managed the garments independently. Additionally, it showed the resident used a walker inside the apartment and utilized an electric scooter for mobility outside the apartment, but did not indicate transfer ability. The following concerns were identified: a. Review of nurse's note dated 6/23/16 showed: "Resident having difficulty with transfers. Unable to stand, two person assist with standing... incontinent of bladder." b. The nurse's note dated 7/4/16 showed the resident's "brief was soiled, CNA [and] nurse assisted to change [and] clean." c. Review of a nurse's note dated 7/14/16 showed the resident had a fall while being assisted to transfer by his/her spouse. Further review showed the resident "ate supper then had two staff assist back to bed." d. A nurse's note dated 7/17/16 showed "Nursing aide went to change [resident], [resident's] brief was filled with urine and feces. [Resident] stated [s/he] did not know [s/he] had been incontinent." e. Review of a nurse's note dated 7/27/16 showed "Resident called a few times after urinary incontinence episodes for assistance with changing." f. Review of a nurse's note dated 8/2/16 showed the "resident was a two person lift extensive with transfers." g. The nurse's note dated 8/11/16 showed	S5023	current assessment. If a discrepancy is noted, resident will be placed on Short-Term Health Monitoring. Short-Term Health Monitoring is outlined in facility's "Resident Care Services Policies and Procedures and duration should not exceed 14 days. D) Executive Director, Director of Nursing(RN), and Assistant Director of Nursing(RN) will discuss changes in resident service needs during morning stand up meetings and during Monthly Mandatory Nursing Meetings to ensure changes in resident conditions are identified and service plans are adjusted accordingly. E) Executive Director, Director of Nursing(RN), and Assistant Director of Nursing(RN) will continue to conduct monthly Quality and Assurance meetings with a specific focus area of identifying any possible changes in resident condition, ensuring all applicable assessments and ALF 102's have been signed by an RN. Other area of specific focus will review residents receiving outside services and ensuring that those services rendered are documented, communicated, and understood by both facility staff and outside service providers. F) In regards to resident #1: An updated assessment and ALF 102 has been completed and signed by Director of Nursing(RN). Through daily monitoring of resident by Director of Nursing(RN), Assistant Director of Nursing(RN), and staff nurses on duty, we have identified that her incontinence and limited ability to transfer is directly correlated to spending excessive periods of time outside the facility causing exhaustion to resident. Executive Director and Director of Nursing(RN) have discussed these findings with resident and spouse. Couple have agreed to utilize facility provided transportation which will eliminate the need for excessive transfers and walking.	

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S5023	Continued From page 8 "Resident continues to be a two person extensive assist and unable to do any peri [perineal] care." h. A nurse's note dated 8/14/16 showed "CNA reported resident was total lift. Resident would not bear any weight. Staff had to total assist with standing and peri care." Further review showed emergency medical services (EMS) was called to assist the staff to transfer the resident. Additionally, the note showed the resident "was total care with incontinent urine/peri care." i. Observation on 8/18/16 at 4:10 PM showed 2 CNAs exiting the resident's apartment. Interview with the resident and his/her spouse at that time confirmed the CNAs were assisting the resident with incontinence care, then transferred the resident to a recliner. Further interview revealed every time the resident had an incontinent episode, the resident or spouse pushed the call button and two staff members would respond to provide care. j. Interview on 8/18/16 at 2:50 PM with CNA #1 and CNA #2 revealed the resident required consistent incontinence care from staff, and also required two staff members to assist with transfers. k. Interview on 8/19/16 at 11:00 AM with CNA #3 and CNA #4 revealed the resident required consistent incontinence care from staff and two staff members to assist with transfers. CNA #4 further stated "it's getting to the point where [the resident] is hurting our backs" during transfers, and that s/he was "dead weight" during transfers. l. Interview with the administrator and ADON on 8/19/16 at 1:13 PM verified a nursing assessment had not been completed on the resident since s/he began requiring more care. Additionally, they stated "typically for a change in condition, they wait and see if it's a true change, then do an assessment." They confirmed the nursing assessment contributed toward	S5023	Director of Nursing(RN), Assistant Director of Nursing (RN), and staff floor nurses will monitor and report any changes. G) In regards to resident #4: Resident #4 was transferred to CRMC on 9-1-2016. After multiple attempts to diagnose a possible cause for resident's falls, resident #4 had a pacemaker surgically implanted which physician believes will greatly help resident not fall so frequently. Resident #4 is currently receiving inpatient therapy. Director of Nursing(RN) will complete and sign a Change of Condition assessment and ALF 102 prior to discharge from inpatient therapy. H) Director of Nursing(RN) and Assistant Director of Nursing will communicate with nursing staff to identify any possible changes in conditions of current residents. Will also conduct chart audits to ensure current assessment on file accurately reflects residents' current needs.	10/14/16

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S5023	Continued From page 9 determining the resident's assistance plan and needs. 2. Review of the medical record showed resident #4 had a resident assessment completed on 1/8/15. Further review showed the resident had occasional confusion, "does not utilize any ambulation devices," and had a history of falls. The following concerns were identified: a. Review of a nurse's note dated 5/27/16 showed the resident "Was on the floor, sitting next to the toilet." b. Review of a nurse's note dated 6/1/16 showed "Resident called, CNA found resident on knees next to bed. Resident states [s/he] was sitting on bed and lost balance when leaning over..." c. Review of a nurse's note dated 6/7/16 showed the resident "Was found on the floor of [his/her] apt [apartment] at 1230 AM rounds. Resident unable to explain why [s/he] was on the floor and for how long [s/he] had been there." d. Review of a nurse's note dated 7/12/16 showed "CNA states she found resident asleep standing up in middle of bedroom with walker. Brakes were unlocked" e. Review of a nurse's note dated 7/24/16 showed the resident was "Found standing in closet, right eye was red and covered in blood to iris... Denies falling or causing trauma to eye." f. Review of a nurse's note dated 8/2/16 showed "Resident found by CNA during room checks on bathroom floor. Resident stated [s/he] got up to use the restroom and fell backwards and hit [his/her] back on the wall, does not know if [s/he] hit [his/her] head..." g. Review of a nurse's note dated 8/3/16 showed the resident was "Still slightly confused and slow moving..." h. Review of a nurse's note dated 8/3/16	S5023		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF030	A. BUILDING: _____ B. WING _____	C 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE 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
S5023	Continued From page 10 showed resident "Continues to be very confused. Denies falling." i. Review of a nurse's note dated 8/4/16 showed the resident was "Having a hard time getting in/out of bed. Resident also mentioned young kids in [his/her] room, possible hallucination, management aware." j. Review of a nurse's note dated 8/17/16 showed "Nurse found [him/her] on the floor, again on [his/her] knee in the bathroom, [s/he] said [s/he] thinks [s/he] fell asleep and then fell." k. Interview with RN #1 on 8/19/16 at 12:45 PM revealed the resident was "Very confused." and "Falls have gone up, [s/he] falls quite a bit." The nurse further stated she had observed the resident with his/her clothes on backwards, adding "If you don't help, [s/he] can't do it." l. Interview with CNA #3 on 8/19/16 at 12:55 PM stated the resident "Is confused 3-4 days" in a week. She revealed she witnessed the resident with his/her clothes on backwards. 3. Interview with administrator and ADON on 8/19/16 at 1:12 PM revealed a comprehensive nursing assessment should be completed with each change of condition. Further, the administrator stated he was aware resident #4 had suffered multiple falls, and that while there was no "magic number", more than two falls would have been a reason to complete a change in condition. They added they were unsure if more current assessments had been completed for residents #1 or #4. As of 8/25/16, no further documentation had been provided by the facility. 4. The facility policy "Assessments and Service Planning," revised 12/31/15, stated "Each resident's service plan should be reviewed and updated within the time frames indicated by state regulations or whenever significant changes in	S5023		

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S5023	Continued From page 11 service needs/preferences occur." The policy listed examples of such changes include having "2 or more falls in a month", a "Pattern of increasing falls (i.e. 1 per month for 3 months)", "Any event that results in an injury", or "Increased service needs due to a resident's increasing confusion and disorientation."	S5023		
S5026	Ch 12 Sec 7 (b)(vii) 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. (vii) The assistance plan shall be reviewed and updated by the RN at least annually or when a significant change occurs, with input from direct care-givers, the resident, and others as designated by the resident. This State Rule and Regulation is not met as evidenced by: . Based on observation, resident and staff interview, medical record review, and review of facility policies and procedures, the facility failed to review and update the resident's assistance plan when there was a change in condition for 2 of 3 sample residents (#1, #4) with a change in condition. The findings were: 1. Review of the 6/3/16 ALF 102 showed resident #1 had occasional incontinence with occasional help needed to clean self, was able to transfer	S5026	S5026 The facility will ensure that the Director of Nursing(RN) or the Assistant Director of Nursing(RN) conducts initial and, at a minimum annually, an accurate, standardized, reproducible assessment of each resident's functional capacity, physical assessment and medication review. Additionally, Director of Nursing(RN) or Assistant Director of Nursing(RN) in ensure that an accurate, standardized, reproducible assessment is completed upon any significant change in a resident's mental or physical condition. This will be accomplished by the following: A). During regular business hours, Director of Nursing(RN) will have sole duty of completing annual and change of condition assessments, their corresponding ALF 102, and generating a new correlated service plan. B) During non-regular business hours, the Registered Nurse(RN) on call will be responsible for completing any necessary change of condition assessments, a corresponding ALF 102 and generating a new correlated service plan. That nurse will then communicate changes to the	

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S5026	Continued From page 12 with minimal assistance, and did not receive assistance from any outside entities. Review of the 6/9/16 resident assessment showed the resident had urinary incontinence and wore protective undergarments, and indicated the resident managed the garments independently. Additionally, it showed the resident used a walker inside the apartment and utilized an electric scooter for mobility outside the apartment. Review of the "Resident Negotiated Service Plan" dated 6/9/16 showed the resident had "Frequent UTI's [urinary tract infections] causes incontinence. Rare bowel incontinence. Wears a protective undergarment." Further review of the "General Mobility" section showed it was last updated on 4/16/15, indicating the resident "primarily uses [his/her] electric scooter." The resident's transfer status was not indicated. The following concerns were identified: a. Review of nurse's note dated 6/23/16 showed "Resident having difficulty with transfers. Unable to stand, two person assist with standing... incontinent of bladder." b. The nurse's note dated 7/4/16 showed the resident's "brief was soiled, CNA [and] nurse assisted to change [and] clean." c. Review of a nurse's note dated 7/14/16 showed the resident had a fall while being assisted to transfer by his/her spouse. Further review showed the resident "ate supper then had two staff assist back to bed." d. A nurse's note dated 7/17/16 showed "Nursing aide went to change [resident], [resident's] brief was filled with urine and feces. [Resident] stated [s/he] did not know [s/he] had been incontinent." e. Review of a nurse's note dated 7/27/16 showed "Resident called a few times after urinary incontinence episodes for assistance with changing."	S5026	Director of Nursing(RN) to ensure that an accurate, standardized, reproducible assessment and service plan was in fact completed and signed by a Registered Nurse(RN). Director of Nursing will also review and sign ALF 102 to ensure the completed ALF 102 and service plan accurately reflect the resident's current condition. **C)** Director of Nursing(RN) and Assistant Director of Nursing(RN) will communicate daily with nursing staff to ensure that residents' current mental and physical condition are compliant with current assessment and service plan. If a discrepancy is noted, resident will be placed on Short-Term Health Monitoring. Short-Term Health Monitoring is outlined in facility's "Resident Care Services Policies and Procedures and duration should not exceed 14 days. **D)** Executive Director, Director of Nursing(RN), and Assistant Director of Nursing(RN) will discuss changes in resident service needs during morning stand up meetings and during Monthly Mandatory Nursing Meetings to ensure changes in resident conditions are identified and service plans are adjusted accordingly. **E)** Executive Director, Director of Nursing(RN), and Assistant Director of Nursing(RN) will continue to conduct monthly Quality and Assurance meetings with a specific focus area of identifying any possible changes in resident condition, ensuring all applicable assessments, ALF 102's, and service plans have been modified and applicable forms signed by an RN. Other area of specific focus will review residents receiving outside services and ensuring that those services rendered are documented, communicated, and understood by both facility staff and outside service providers. **F)** In regards to resident #1: An updated assessment, ALF 102, and service plan has been completed and signed by Director of Nursing(RN). Through daily monitoring of resident by Director	

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	ALF030	A. BUILDING: _____ B. WING _____	C 08/19/2016

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S5026	Continued From page 13 f. Review of a nurse's note dated 8/2/16 showed the "resident was a two person lift extensive with transfers." g. The nurse's note dated 8/11/16 showed "Resident continues to be a two person extensive assist and unable to do any peri care." h. A nurse's note dated 8/14/16 showed "CNA reported resident was total lift. Resident would not bear any weight. Staff had to total assist with standing and peri care." Further review showed EMS was called to assist the staff to transfer the resident. Additionally, the note showed the resident "was total care with incontinent urine/peri care." i. Observation on 8/18/16 at 4:10 PM showed 2 CNAs exiting the resident's apartment. Interview with the resident and his/her spouse at that time confirmed the CNAs were assisting the resident with incontinence care, then transferred the resident to a recliner. Further interview revealed every time the resident had an incontinent episode, the resident or spouse pushed the call button and two staff members would respond to provide care. j. Interview on 8/18/16 at 2:50 PM with CNA #1 and CNA #2 revealed the resident required consistent incontinence care from staff, and also required two staff members to assist with transfers. k. Interview on 8/19/16 at 11:00 AM with CNA #3 and CNA #4 revealed the resident required consistent incontinence care from staff and two staff members to assist with transfers. CNA #4 further stated "it's getting to the point where [the resident] is hurting our backs" during transfers, and that s/he was "dead weight" during transfers. l. Interview with the administrator and ADON on 8/19/16 at 1:13 PM revealed they had recognized the facility staff were providing "too much care" to the resident. They further revealed	S5026	of Nursing(RN), Assistant Director of Nursing(RN), and staff nurses on duty, we have identified that her incontinence and limited ability to transfer is directly correlated to spending excessive periods of time outside the facility causing exhaustion to resident. Executive Director and Director of Nursing(RN) have discussed these findings with resident and spouse. Couple have agreed to utilize facility provided transportation which will reduce the need for excessive transfers and walking. Director of Nursing(RN), Assistant Director of Nursing (RN), and staff floor nurses will monitor and report any changes. G) In regards to resident #4: Resident #4 was transferred to CRMC on 9-1-2016. Director of Nursing(RN) will complete and sign a Change of Condition assessment and ALF 102 prior to discharge from inpatient therapy. H) Director of Nursing(RN) and Assistant Director of Nursing will communicate with nursing staff to identify any possible changes in conditions of current residents. Will also conduct chart audits to ensure current service plan on file accurately reflects residents' current needs	10/14/16

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dr 10/10/16

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S5026	Continued From page 14 the facility had not done a formal nursing assessment since the resident began requiring additional assistance, and confirmed the assessment determined the care plan for the resident. 2. Review of medical records showed resident #4 was admitted on 11/12/14. The Resident Negotiated Service Plan, dated 11/12/14 showed "Resident has diagnosis of mild cognitive disorder." It further stated "Resident is independent with all dressing and grooming tasks" as well as "Resident is independent in mobility. Resident does not utilize any ambulation devices." The following concerns were identified: a. Review of a nurse's note dated 5/27/16 showed the resident "Was on the floor, sitting next to the toilet." b. Review of a nurse's note dated 6/1/16 showed "Resident called, CNA found resident on knees next to bed. Resident states [s/he] was sitting on bed and lost balance when leaning over..." c. Review of a nurse's note dated 6/7/16 showed the resident "Was found on the floor of [his/her] apt [apartment] at 1230 AM rounds. Resident unable to explain why [s/he] was on the floor and for how long [s/he] had been there." d. Review of a nurse's note dated 712/16 showed "CNA states she found resident asleep standing up in middle of bedroom with walker. Brakes were unlocked" e. Review of a nurse's note dated 7/24/16 showed the resident was "Found standing in closet, right eye was red and covered in blood to iris... Denies falling or causing trauma to eye." f. Review of a nurse's note dated 8/2/16 showed "Resident found by CNA during room checks on bathroom floor. Resident stated [s/he] got up to use the restroom and fell backwards	S5026		

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S5026	Continued From page 15 and hit [his/her] back on the wall, does not know if [s/he] hit [his/her] head..." g. Review of a nurse's note dated 8/3/16 showed resident "Continues to be very confused. Denies falling." h. Review of a nurse's note dated 8/4/16 showed the resident was "Having a hard time getting in/out of bed. Resident also mentioned young kids in [his/her] room, possible hallucination, management aware." i. Review of a nurse's note dated 8/17/16 showed "Nurse found [him/her] on the floor, again on [his/her] knee in the bathroom, [s/he] said [s/he] thinks [s/he] fell asleep and then fell." j. Interview with RN #1 on 8/19/16 at 12:45 PM revealed the resident was very confused and that his/her "falls have gone up, [s/he] falls quite a bit." Further, the nurse stated she had observed the resident with his/her clothes on backwards, adding, "If you don't help [s/he] can't do it." 3. The facility policy "Assessments and Service Planning," revised 12/31/15, stated "Each resident's service plan should be reviewed and updated within the time frames indicated by state regulations or whenever significant changes in service needs/preferences occur." The policy listed examples of such changes include having "2 or more falls in a month", a "Pattern of increasing falls (i.e. 1 per month for 3 months)", "Any event that results in an injury", or "Increased service needs due to a resident's increasing confusion and disorientation."	S5026		
S5095	Ch 12 Sec 8 (a)(i) Services Which Cannot Be Provided by Level I Services which cannot be provided by the Level I Assisted Living Facility staff.	S5095		

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10/10/16

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S5095	Continued From page 16 (a) The following services cannot be provided: (i) Continuous assistance with transfer and mobility; This State Rule and Regulation is not met as evidenced by: Based on observation, resident, family, and staff interview, medical record review, and review of facility policies and procedures, the facility failed to ensure residents did not require continuous assistance with transfers and mobility for 1 of 6 sample residents (#1). The findings were: Review of the 6/3/16 ALF 102 showed resident #1 had occasional incontinence with occasional help needed to clean self, was able to transfer with minimal assistance, and did not receive assistance from any outside entities. Review of the 6/3/16 nursing assessment showed the resident's spouse assisted with transfers and the resident had increased fatigue following a hospital stay. Review of the "Resident Negotiated Service Plan" dated 6/9/16 for "General Mobility" showed it was last updated on 4/16/15, indicating the resident "primarily uses [his/her] electric scooter." The resident's transfer status was not indicated. The following concerns were identified: a. Review of a nurse's note dated 6/23/16 showed "Resident having difficulty with transfers. Unable to stand, two person assist with standing." b. A nurse's note dated 6/25/16 showed "Resident calling for assistance every hour. Staff two person, gait belt to transfer. Not steady." c. A nurse's note dated 6/27/16 showed "Resident 2 person assist..." d. Review of a nurse's note dated 7/14/16 showed the resident had a fall while being	S5095	S5095 The facility will ensure that Ch 12 Sec 8 (a)(i) Services Which Cannot Be Provided by Level 1, Continuous assistance with transfer and mobility will be followed. This will be accomplished by the following: A). Director of Nursing(RN) and Assistant Director of Nursing(RN) will communicate daily with nursing staff to ensure that residents' current mental and physical condition are compliant with current assessment. If a discrepancy is noted, resident will be placed on Short-Term Health Monitoring. Short-Term Health Monitoring is outlined in facility's "Resident Care Services Policies and Procedures and duration should not exceed 14 days. This communication and oversight will allow facility to accurately identify changes in resident mental and physical conditions. During the Short-Term Health Monitoring period, Director of Nursing(RN) and Assistant Director of Nursing(RN) will provide complete regular checks to determine if a change is permanent, or is caused by an acute condition. Through the use of a change of condition assessment and ALF 102 screening tool, if the resident continues to require services which cannot be provided by level 1 facility, Director of Nursing(RN) and Executive Director will complete the following actions: a) Determine if resident's needs which cannot be provided by facility, can be provided by an outside Third-Party. b) Schedule a meeting with the resident and family to discuss options for continued care with a Third-Party. 1) If resident(s)/family does not consent to adding outside/Third-Party Services, facility will issue 30-day to discharge.	

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(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
S5095	Continued From page 17 assisted to transfer by his/her spouse. Further review showed the resident "ate supper then had two staff assist back to bed." e. Review of a nurse's note dated 8/2/16 showed the "resident was a two person lift extensive with transfers." f. The nurse's note dated 8/11/16 showed "Resident continues to be a two person extensive assist and unable to do any peri [perineal] care." g. A nurse's note dated 8/14/16 showed "CNA reported resident was total lift. Resident would not bear any weight. Staff had to total assist with standing and peri care." Further review showed emergency medical services (EMS) was called to assist the staff to transfer the resident. h. Observation on 8/18/16 at 4:10 PM showed 2 CNAs exiting the resident's apartment. Interview with the resident and his/her spouse at that time confirmed the CNAs were assisting the resident with incontinence care, then transferred the resident to a recliner. i. Interview on 8/18/16 at 2:50 PM with CNA #1 and CNA #2 revealed the resident consistently required two staff members to assist with transfers. j. Interview on 8/19/16 at 11:00 AM with CNA #3 and CNA #4 revealed the resident consistently required two staff members to assist with transfers. CNA #4 further stated "it's getting to the point where [the resident] is hurting our backs" during transfers, and that s/he was "dead weight" during transfers. k. Interview with the administrator and ADON on 8/19/16 at 1:13 PM revealed they had recognized the facility staff were providing "too much care" for the resident. Review of the facility policy and procedure titled "[Facility] Assisted Living Admission, Retention, and Discharge Criteria," revised 11/10/15,	S5095	2) If resident(s)/family agrees to adding outside Third-Party, facility will complete the following: i) Arrange services by the appropriate professional based on resident(s)/family choice. ii) Incorporate these services in to resident(s) service plan ensuring the following details are included: Who will provide service(s), what service(s) will be provided, when the service(s) will be provided, and where the service(s) will be provided. B) Director of Nursing(RN), Assistant Director of Nursing(RN) and Executive Director will incorporate a transfer assistance monitoring section to monthly Quality and Assurance meetings to provide regular monitoring of any resident potentially requiring continuous assistance with transfer. C) Director of Nursing(RN), Assistant Director of Nursing(RN) and Executive Director will continue providing scheduled monthly training which will include a block on transfers. D) Director of Nursing(RN), Assistant Director of Nursing (RN) and Executive Director will ensure that New Nursing Staff Orientation thoroughly covers detailed job descriptions and sufficient hands on training. This will also include a four (4) hour Educare Training block. E) In regards to resident #1: An updated assessment and ALF 102 has been completed and signed by Director of Nursing(RN). Through daily monitoring of resident by Director of Nursing(RN), Assistant Director of Nursing(RN), and staff nurses on duty, we have identified that her incontinence and limited ability to transfer is directly correlated to spending excessive periods of time outside the facility causing exhaustion to resident. Executive Director and Director of Nursing(RN) have discussed these findings with resident and spouse. Couple have agreed to utilize facility provided	

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S5095	Continued From page 18 showed "The resident is able to bear weight and stand to transfer self... The resident does not require routine two-person assistance with standing, transfer or evacuation."	S5095	transportation which will reduce the need for excessive transfers and walking. Director of Nursing(RN), Assistant Director of Nursing (RN), and staff floor nurses will monitor and report any changes. If resident develops a need for continuous assistance with transfer and mobility, facility will follow protocol listed as note A) under ID PREFIX TAG S5095.	
S5101	Ch 12 Sec 8 (a)(vii) Services Which Cannot Be Provided By Level I Services which cannot be provided by the Level I Assisted Living Facility staff. (a) The following services cannot be provided: (vii) Incontinence care by facility staff; This State Rule and Regulation is not met as evidenced by: Based on observation, resident, family, and staff interview, medical record review, and review of facility policies and procedures, the facility failed to ensure residents did not require incontinence care by facility staff for 2 of 6 sample residents (#1, #5). The findings were: Review of the 6/3/16 ALF 102 showed resident #1 had occasional incontinence with occasional help needed to clean self, was able to transfer with minimal assistance, and did not receive assistance from any outside entities. Review of the 6/3/16 nursing assessment showed the resident's diagnosis was "freq UTIs [frequent urinary tract infections]," the resident required assistance with toilet use and the resident's spouse assisted with transfers. Additionally, the "Bowel and Bladder Evaluation" of the assessment did not indicate whether the resident was incontinent of bowel or bladder, or if s/he woke to toilet, but did show the resident	S5101	F) Director of Nursing(RN) and Assistant Director of Nursing will communicate with nursing staff to identify any possible changes in conditions of current residents. Will also conduct chart audits to ensure current assessment on file accurately reflects residents' current needs. 10/14/16 **S5101** The facility will ensure that Ch 12 Sec 8 (a)(vii) Services Which Cannot Be Provided by Level 1, Incontinence care by facility staff. This will be accomplished by the following: A). Director of Nursing(RN) and Assistant Director of Nursing(RN) will communicate with nursing staff to ensure that residents' current mental and physical condition are compliant with current assessment. If a discrepancy is noted, resident will be placed on Short-Term Health Monitoring. Short-Term Health Monitoring is outlined in facility's "Resident Care Services Policies and Procedures and duration should not exceed 14 days. This communication and oversight will allow facility to accurately identify changes in resident mental and physical conditions. During the Short-Term Health Monitoring period, Director of	

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF030	A. BUILDING: _____ B. WING _____	C 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE 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
S5101	Continued From page 19 "dribbles". Further review showed the resident had increased fatigue following a hospital stay. Review of the "Resident Negotiated Service Plan" dated 6/9/16 showed the resident had "Frequent UTI's causes incontinence. Rare bowel incontinence. Wears a protective undergarment." The following concerns were identified: a. Review of a nurse's note dated 6/23/16 showed "Resident having difficulty with transfers. Unable to stand, two person assist with standing... incontinent of bladder." b. The nurse's note dated 7/4/16 showed the resident's "brief was soiled, CNA [and] nurse assisted to change [and] clean." c. A nurse's note dated 7/17/16 showed "Nursing aide went to change [resident], [resident's] brief was filled with urine and feces. [Resident] stated [s/he] did not know [s/he] had been incontinent." e. Review of a nurse's note dated 7/27/16 showed "Resident called a few times after urinary incontinence episodes for assistance with changing." f. The nurse's note dated 8/11/16 showed "Resident continues to be a two person extensive assist and unable to do any peri [perineal] care." h. A nurse's note dated 8/14/16 showed "CNA reported resident was total lift. Resident would not bear any weight. Staff had to total assist with standing and peri care." Additionally, the note showed the resident "was total care with incontinent urine/ peri care." i. Observation on 8/18/16 at 4:10 PM showed 2 CNAs exiting the resident's apartment. Interview with the resident and his/her spouse at that time confirmed the CNAs were assisting the resident with incontinence care, then transferred the resident to a recliner. Further interview revealed every time the resident had an incontinent episode, the resident or spouse	S5101	Nursing(RN) and Assistant Director of Nursing(RN) will provide complete regular checks to determine if a change is permanent, or is caused by an acute condition. Through the use of a change of condition assessment and ALF 102 screening tool, if the resident continues to require services which cannot be provided by level 1 facility, Director of Nursing(RN) and Executive Director will complete the following actions: a) Determine if resident's needs which cannot be provided by facility, can be provided by an outside Third-Party. b) Schedule a meeting with the resident and family to discuss options for continued care with a Third-Party. 1) If resident(s)/family does not consent to adding outside/Third-Party Services, facility will issue 30-day notice requiring other placement. 2) If resident(s)/family agrees to adding outside Third-Party, facility will complete the following: i) Arrange services by the appropriate professional based on resident(s)/family choice. ii) Incorporate these services in to resident(s) service plan ensuring the following details are included: Who will provide service(s), what service(s) will be provided, when the service(s) will be provided, and where the service(s) will be provided. B) Director of Nursing(RN), Assistant Director of Nursing(RN) and Executive Director will incorporate an incontinence monitoring section to monthly Quality and Assurance meetings to provide regular monitoring of any resident potentially requiring assistance with incontinence care.	

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S5101	Continued From page 20 pushed the call button and two staff members would respond to provide care. j. Interview on 8/18/16 at 2:50 PM with CNA #1 and CNA #2 revealed the resident required consistent incontinence care from staff. k. Interview on 8/19/16 at 11:00 AM with CNA #3 and CNA #4 revealed the resident required consistent incontinence care from staff. l. Interview with the administrator and ADON on 8/19/16 at 1:13 PM revealed they had recognized the facility staff were providing "too much care." 2. Review of the 6/9/16 resident assessment showed resident #5 had "intermittent episodes of incontinence with employee partners assistance required." The following concerns were identified: a. A nurse's note dated 6/25/16 at 11:45 PM showed the resident had a bowel movement, after which "resident was cleaned up and helped back to bed." b. Review of a nurse's note dated 6/28/16 showed hospice evaluated the resident for services, and told the facility to call hospice with any concerns. Additionally, it stated "CNA's here [and] nursing is to continue usual care c [with] resident..." c. A nurse's note dated 7/3/16 at 6:00 AM showed the "resident was damp at 0000 [midnight] checks, refused toileting and change. Resident soaked at 0300 [3 AM] check, changed..." d. A nurse's note dated 7/4/16 showed the resident "has been incontinent of bowel." Additionally, the resident was "cleaned [and] redressed by staff." e. A nurse's note dated 7/12/16 showed "Peri care and creams applied." f. Nurse's note dated 7/30/16 stated resident "Able to roll [him/herself] over for a brief change."	S5101	C) Director of Nursing(RN), Assistant Director of Nursing(RN) and Executive Director will continue providing scheduled monthly training. D) Director of Nursing(RN), Assistant Director of Nursing (RN) and Executive Director will ensure that New Nursing Staff Orientation thoroughly covers detailed job descriptions and sufficient hands on training. This will also include a four (4) hour Educare Training block. Incontinence care will be an area of focus during these training blocks. E) In regards to resident #1: An updated assessment and ALF 102 has been completed and signed by Director of Nursing(RN). Through daily monitoring of resident by Director of Nursing(RN), Assistant Director of Nursing(RN), and staff nurses on duty, we have identified that her incontinence and limited ability to transfer is directly correlated to spending excessive periods of time outside the facility causing exhaustion to resident. Executive Director and Director of Nursing(RN) have discussed these findings with resident and spouse. Couple have agreed to utilize facility provided transportation which will eliminate the need for excessive transfers and walking. Director of Nursing(RN), Assistant Director of Nursing (RN), and staff floor nurses will monitor and report any changes. If resident develops a need for continuous assistance with transfer and mobility, facility will follow protocol listed as note A) under ID PREFIX TAG S5101 F) In regards to resident #5: An updated assessment and ALF 102 has been completed and signed by Director of Nursing(RN). Resident currently has a contract with Davis Hospice Center to receive Out-Patient Hospice Care. Resident is also receiving Third-Party care. Both outside services providers have been incorporated in to resident #5 most recent service plan. As an amendment to the service plan, facility has incorporated a Third-Party service agreement for both parties which outlines: who will provide	

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S5101	Continued From page 21 g. Staff interview with CNA #3 on 8/19/16 at 12:55 AM confirmed staff assist the resident with toileting and cleaning. She added the resident was consistently incontinent through the night. h. Interview with the administrator and ADON on 8/19/16 at 1:12 PM confirmed the facility provided incontinence care to the resident. 3. Review of the facility policy and procedure titled "[Facility] Assisted Living Admission, Retention, and Discharge Criteria," revised 11/10/15, showed "The resident is able to perform his or her own perineal care and maintain personal hygiene with assistance."	S5101	service, what services will be provided, when the services will be provided, where the services will be provided, and how services will be provided to specifically address incontinence. G) Director of Nursing(RN) and Assistant Director of Nursing will communicate with nursing staff to identify any possible changes in conditions of current residents. Will also conduct chart audits to ensure current assessment on file accurately reflects residents' current needs.	10/14/16
S5107	Ch 12 Sec 9 (a)(i-v) Contractual Svcs Provided Outside ALF Auth Contractual Services Provided Outside Assisted Living Facility Authority. Residents in an assisted living facility may receive services from an outside entity for care beyond that provided for or specified in the Assisted Living Program Administration Rules. These services must be arranged by the appropriate professional and be incorporated into the resident's assistance plan. The resident's choice of providers must be honored. (a) Components of the outside service(s) contract: (i) Who will provide service(s); (ii) What service(s) will be provided; (iii) When the service(s) will be provided; (iv) Where the service(s) will be provided;	S5107		

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S5107	Continued From page 22 (v) How the service(s) will be provided, and This State Rule and Regulation is not met as evidenced by: . Based on medical record review, staff interview, and review of facility policies and procedures, the facility failed to ensure outside service contracts were in place for 1 of 1 sample residents (#5) with outside services. The findings were: 1. Review of the 6/3/16 ALF 102 showed resident #5 was on swallowing/choking precautions, required significant assistance or cuing for dressing and grooming, and needed total assistance for bathing. a. A nurse's note dated 6/28/16 stated "Hospice nurse came in today to eval [evaluate] [resident] for services. Nsg [nursing] is to call hospice with pain concerns, wound care or any other concerning issues." b. Review of nurse's notes showed a hospice nurse saw the resident on 6/29/16, 6/30/16, and 7/2/16. c. Review of the resident's medical record showed no evidence of a contract with the hospice agency, including what services were provided by the hospice, the frequency of services, or how the services would be provided. d. Interview with the administrator and ADON on 8/19/16 at 1:12 PM confirmed the resident was receiving hospice services; however, the facility did not have a contract in place describing the services hospice provided for the resident. Review of the facility policy and procedure titled "Use of Third Party Providers," revised 12/31/15, showed "When approval for use of a third-party	S5107	S5107 The facility will ensure that any resident receiving services from an outside entity for care beyond that provided for or specified in the assisted Living Program Administration Rules will be arranged by the appropriate professional and be incorporated into the resident's service plan while honoring the resident's choice of providers. This will be accomplished by the following actions: A). During Assessment process; admission, annual, or change of condition and utilizing the ALF 102, Director of Nursing(RN) or Assistant Director of Nursing(RN) will identify if a resident requires or would like to elect to have additional services provided by an outside Third-Party care professional. B) Through the assessment process and utilization of ALF 102, if Third-Party care professionals will be used to support the overall care of a resident, Director of Nursing(RN) or Assistant Director of Nursing(RN) will review appropriate professional options with the resident(s)/family and incorporate those identified services into the resident's service plan. C) Director of Nursing(RN) or Assistant Director of Nursing(RN) will complete Primrose Retirement Communities Form titled "Resident Third Party Provider Agreement." This form will be completed with the following information detailed within: a) Who will provide service(s) b) What service(s) will be provided c) When the service will be provided d) Where the service will be provided e) How service(s) will be provided	

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S5107	Continued From page 23 provider has been obtained from the resident or responsible party and the third-party services are appropriate, a Resident Third Party Provider Agreement must be executed. This agreement requires a signature of the resident or financially responsible party. The signed Resident Third Party Provider Agreement is placed in the resident's chart as part of the clinical record."	S5107	To ensure effective communication through all parties, this for will be added to resident's chart and to resident's service plan. D) Director of Nursing(RN), Assistant Director of Nursing(RN), and Executive Director will continue conducting month Quality and Assurance meetings, in which, we will review and audit the charts of every resident receiving services from an outside Third-Party profession. During audit process, Director of Nursing(RN), Assistant Director of Nursing(RN), and Executive Director will ensure "Resident Third Party Provider Agreement" is completed in its entirety and is an accurate reflection of the services being provided to the resident(s). E) In regards to resident #5: An updated assessment and ALF 102 has been completed and signed by Director of Nursing(RN). Resident currently has a contract with Davis Hospice Center to receive Out-Patient Hospice Care. Resident is also receiving Third-Party care. Both outside services providers have been incorporated in to resident #5 most recent service plan. As an amendment to the service plan, facility has incorporated "Resident Third Party Provider Agreement" for both parties which outlines: who will provide service, what services will be provided, when the services will be provided, and where the services will be provided, and how the service will be provided.	10/14/16