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Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 01/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 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 06/28/2001 A survey was conducted by Healthcare Licensing and Surveys on 1/4/17 through 1/5/17. The survey was prompted by complaint intake LIC-17-012 and LIC-17-013. The following common abbreviations are used throughout the document: RN- Registered Nurse LPN- Licensed Practical Nurse CNA- Certified Nursing Assistant CSD- Clinical Service Director Less commonly used abbreviations will be annoted in each deficiency.	S 000	**S5023** 02/19/2017 The facility will ensure that the Clinical Services Director (RN) or the Assistant Clinical Services Director (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, the Clinical Services Director (RN) or the Assistant Clinical Services Director (RN) will 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, the Clinical Services Director (RN) and the Assistant Clinical Services Director (RN) will have sole duty of completing annual and change of condition assessments and their corresponding ALF 102. B). During non-regular business hours,	
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	S5023	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 communicate all changes to the Clinical Services Director (RN) to ensure that an accurate standardized, reproducible assessment was in fact completed and signed by a Registered Nurse (RN). The Clinical Services Director (RN) and/or the Assistant Clinical Services Director (RN) will also review and sign the ALF 102 to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeff Shahan | TITLE: Executive Director | (X6) DATE: 1/25/17

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Accepted on 1/26/17 by Loralee Pinson
Message left for Jeff the ED.
on 1/26/17

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S5023	Continued From page 1 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 resident assessments were complete and accurate for 2 of 12 sample residents (#43, #45). The findings were: 1. Review of the ALF 102 assessment completed on 7/13/16 showed resident #45 had diagnoses which included dementia. The resident was determined to be independent for bathing and dressing, continent of bowel and bladder, had appropriate behavior, was well motivated, and was capable of performing ADLs. Review of the elopement risk assessment dated 7/14/16 revealed a score of 8 which indicated a "low elopement risk." The following concerns were identified: a. A review of a fax order form from the facility to the resident's healthcare provider dated 10/4/16 showed "resident has had an increase in confusion, incontinence, wandering and refused [his/her] medication this last week." Further review showed the healthcare provider requested an appointment be made for the resident. An appointment was made to see the provider on 10/6/16 and again on 10/27/16. The resident refused both appointments. b. Review of a nursing/progress note dated	S5023	ensure the completed ALF 102 is an accurate reflection of a resident's current condition. **C).** The Clinical Services Director (RN) and the Assistant Clinical Services Director (RN) will communicate daily with nursing staff to ensure that residents' current mental and physical condition are compliant with the current assessment. If a discrepancy is noted, the resident will be reassessed by the Clinical Services Director (RN) to ensure an accurate reflection of the resident's condition is compliant with the current assessment. **D).** Executive Director, Clinical Services Director (RN), and Assistant Clinical Services Director (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, Clinical Services Director (RN), and Assistant Clinical Services Director (RN) will 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. Residents receiving outside services will also be identified and monitored to ensure communication and documentation with community staff and the outside services is understood.	

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S5023	Continued From page 2 10/27/16 showed a wanderguard was placed on the resident's ankle. c. Review of nursing/progress notes dated 11/9/16, 11/12/16, 11/13/16, 11/17/16, and 11/20/16 showed the facility had replaced the wanderguard and the resident had removed it. d. Review of a nursing/progress note dated 11/17/16 showed "Resident still continues to remove [his/her] wanderguard-pacing and wandering at times-still refuses cares from staff-no showering-CNAs have to sneak in room to change linens-does not want them in there-[his/her] clothes are unchanged for weeks at a time-body odor." e. Review of a nursing/progress note dated 11/23/16 and timed 5 PM showed "Tried to put wrist lifesaver on [him/her] but [s/he] refused it." In addition, the resident stated "I will cut it off if you put it on me." f. Interview with the administrator and the CSD on 1/5/17 at 2:10 PM confirmed the ALF 102 did not accurately reflect the resident's care needs and needed to be updated. 2. Review of the ALF 102 assessment completed on 7/7/16 showed resident #43 was determined to be "occasionally incontinent," needed "occasional help to clean self," and required "occasional supervision to assure nutritional needs are met." Further review showed the resident was "appropriate and independent" with dressing and was "intermittently confused and/or agitated." Review of the resident's care plan dated 7/7/16 showed diagnoses which included diabetes, hypothyroidism, and hypertension. The following concerns were identified: a. Review of a nursing/progress note dated 9/20/16 showed "Resident has been expressing anger to staff - refused to eat - very incontinent-not changing clothes or briefs."	S5023	F). In regards to resident #45: An updated assessment, ALF 102, and elopement risk assessment will be completed and signed by the Clinical Services Director (RN) on 01/25/2017. The Clinical Services Director (RN), Assistant Clinical Services Director (RN), and staff floor nurses will monitor and report any changes that occur. G). In regards to resident #43: An updated assessment and ALF 102 was completed on 01/12/2017 by the Clinical Services Director (RN **S5101** 02/19/2017 The Facility will ensure that Ch 12 Sec 8 (a)(vii) Services Which Cannot Be Provided by Level 1, "Incontinence care by facility staff" will be followed. This will be accomplished by the following: A). The Clinical Services Director (RN) and the Assistant Clinical Services Director (RN) will communicate with nursing staff to ensure that residents' current mental and physical condition are compliant with the current assessment. Communication and oversight will allow the community to accurately identify changes in resident mental and physical conditions. All Certified Nursing Assistants and Nursing staff will be in serviced on what services cannot be provided in a Level 1 Assisted Living Community. Through the use of change of condition assessment and ALF 102 screening tool, the community will ensure all residents are in appropriate placement.	

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S5023	Continued From page 3 b. Review of a nursing/progress note dated 10/6/16 showed "Resident was seen going out of the building walking down toward the bus-going to [his/her] brother's house on [street name]-I was able to get [him/her] back into the building-called son about this-[s/he] wants to leave." c. Review of a nursing/progress note dated 10/7/16 showed "Resident came to nurses [sic] station very agitated asking to make a call to [his/her] son. [S/he] stated [s/he] needed him to come pick [him/her] up or [s/he] would start walking to [his/her] brother's house down the street. I had [him/her] sit in the chair and called son, letting him know the changes in [his/her] behavior." d. Review of a nursing/progress note dated 10/9/16 showed "I followed resident and observed [him/her] walking out the front door and proceeded to leave the building. [S/he] made it out to the parking lot & I was able to convince resident to come back inside & [s/he] requested to call [his/her] son. We will monitor resident Q (every) 1-2 hours tonight." e. Review of a nursing/progress note dated 10/26/16 showed a wanderguard was placed on the resident's ankle.	S5023	**B).** Clinical Services Director (RN), Assistant Clinical Services Director (RN), and the 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. **C).** In regards to resident #43: An updated assessment and ALF 102 was completed on 01/12/2017 by the Clinical Services Director (RN). **D).** In regards to resident #40: An updated assessment and ALF 102 was completed on 01/11/2017 by the Clinical Services Director (RN). Review of the residents care plan revealed the resident needed a higher level of placement. The resident family was involved in the care plan and agreed with the community's decision. The resident and family were issued a 30 day notice for other placement on 01/11/2017.	
	f. Review of a nursing/progress note dated 11/8/16 showed the resident was prescribed Celexa (an antidepressant). g. Review of a nursing/progress note dated 11/17/16 showed "Monthly summary Oct-2016 Resident is A&O x 1 (alert and oriented to name)-has angry [sic] issues going on-incontinent of bladder-unable to manage this-CNAs are assisting [him/her] and cueing [him/her]-does not clean [him/herself] up from her BM (bowel movement) also-has to be cued to come to meals often times [s/he] is up for days at a time-wandering the halls-sitting in the TV room-[s/he] often times is cued to eat [his/her] meal &			

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S5023	Continued From page 4 stay at the table to eat-gets angry often & leaves table if [s/he] isn't served ASAP." In addition, "[s/he] wants to leave-does do exit seeking." h. Review of a nursing/progress note dated 11/21/16 showed "It was reported to this nurse that on Sunday morning the resident was ambulating the hallway wearing nothing but [his/her] briefs." i. Review of a nursing/progress note dated 12/1/16 and timed 10 AM showed "Resident packed [his/her] clothes & some food-drink-was leaving-wanted [the nurse] to get the [expletive] out of [his/her] room & leave [him/her] alone-then turned around & stated-this is not my room-I don't belong here." j. Review of a nursing/progress note dated 12/1/16 and timed 1 PM showed "Resident has been up 24 plus hours-not eating-Ensure offered-still wants to leave." k. Review of a nursing/progress note dated 12/5/16 showed "Resident was dressed in [his/her] clothes from a few days ago-not changing and putting on new clothes [s/he] had 3 sweatshirts on-incontinent of bladder." l. Review of a nursing/progress note dated 12/7/16 showed "Resident is still dressed in same clothes as Monday-numerous layers of clothes on-has been up for 24 plus hours-apparently last night per eve shift-resident wanted to leave-Sierra Hills is closing." Further review showed "[s/he] still remains incontinent-not eating-only sweets most of the time. Ensure is offered. Resident continues to be monitored with [his/her] project lifesaver." m. Interview with CNA #1 on 1/5/17 at 12:55 PM revealed the resident had shown a rapid decline since July 2016 and, in addition, s/he was incontinent of urine 50% of the time and nearly always incontinent of bowel. n. Interview with the administrator and the CSD on 1/5/17 at 2:10 PM confirmed the ALF 102	S5023		

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S5023	Continued From page 6 did not accurately reflect the resident's care needs and needed to be updated.	S5023		
S5101	Ch 12 Sec 6 (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 medical record review and staff interview, the facility failed to ensure residents were appropriate for the core services level of care for 2 of 12 sample residents (#40, #43) who required incontinence care by the facility. The findings were: 1. Review of the ALF 102 assessment for resident #43 showed it was completed on 7/7/16. The resident was determined to be "occasionally incontinent" and needed "occasional help to clean self." Review of the resident's care plan dated 7/7/16 showed the resident was "completely independent" for toileting, marked as incontinent of bladder and had nothing marked related to bowel continence. The following concerns were identified: a. Review of a nursing/progress note dated 11/8/16 showed "resident is incontinent of urine - recliner in fireplace room had to [be] totally cleaned - resident was soaked - had to be encouraged to go up with staff to clean & to be showered by staff - does not (unable) take care of	S5101		

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S5101	Continued From page 6 [his/her] incontinence issues." b. Review of a nursing/progress note dated 11/17/16 showed "Monthly summary - Oct-2016. Resident is A&O x 1 (alert and oriented to name)...incontinent of bladder - unable to manage this. CNAs are assisting [the resident] and cueing [him/her] - does not clean him/herself up from [his/her] BM (bowel movement)." c. Review of a nursing/progress note dated 11/20/16 showed "Observed with soiled pants in the dining room for breakfast. Attempted to redirect to room to change [his/her]clothes but [s/he] refused." d. Review of a nursing/progress note dated 11/23/16 and timed 1:25 PM showed the resident was being treated for a urinary tract infection. e. Review of a nursing/progress note dated 12/1/16 and timed 1 PM showed "[the resident] is still incontinent of bladder - not able to take care of this [him/herself] - occasional problems with bowel movements - unable to clean [him/herself] properly." f. Review of the 24-hour CNA communication note dated 11/8/16 showed [the resident] showered very inc (incontinent) and not changing brief." Review of a 24-hour CNA communication noted dated 11/12/16 showed [the resident] bed soaked this am. Went to bed without a brief on." Review of a 24-hour CNA communication note dated 11/13/16 showed "put a load of laundry in that smelled of urine that was on the ground of closet with soiled brief and chuck." Review of a 24-hour CNA communication note dated 11/25/16 showed "[the resident] smelled of urine, gave shower and changed clothes." Review of a 24-hour communication note dated 12/2/16 showed "[the resident] bed wet, sheets changed." g. Review of the 24-hour CNA communication sheets between 11/1/16 and 1/3/17 showed 53 entries related to incontinence care during the 63	S5101		

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S5101	Continued From page 7 day period. h. Interview with CNA #1 on 1/5/17 at 12:55 PM revealed the resident had shown a rapid decline since July 2016 and, in addition s/he was incontinent of urine 50% of the time and nearly always incontinent of bowel. i. Interview with the administrator and the CSD on 1/5/17 at 2:35 PM revealed they were unaware of the increased need for ADL assistance and further confirmed the resident required a higher level of care than was appropriate for the facility. 1. Review of an ALF 102 assessment dated 8/11/16 showed resident #40 had occasional incontinence and required occasional assistance to clean him/herself. The following concerns were identified: a. Review of a nursing progress note dated 11/17/16 showed the resident "still continues to be incontinent of bowel and bladder-unable to manage these issues by [him/herself]-staff is cleaning [the resident] removing old dirty briefs out of [his/her] room that have been thrown down on the floor [his/her] linens to [his/her] bed are usually always soaked and needs laundried.[sic] every day-[s/he] is still on a 2 hour toileting program-is confused and at times uncooperative toileting cares and staff." Review of a nursing progress note dated 11/25/16 showed the resident was "incontinent of bowel this am had to have a shower-unable to take care of this incontinence [him/herself]." Review of a nursing progress note dated 12/05/16 showed the resident was "very incontinent of urine." Review of a nursing progress note dated 12/07/16 showed the resident was "found not dressed in [his/her] room-very incontinent of urine briefs-wet and dirty ones found everywhere in [his/her] room." Review of a nursing progress note dated	S5101		

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S5101	Continued From page 8 12/3/16 showed the resident had "5 dirty briefs in [his/her] room stashed in the closet and under [his/her] clean clothes." Review of a nursing progress note dated 12/14/16 showed the resident had "increase [sic] reports of being incontinent." b. Review of the 24-hour communication note dated 12/20/16 on the 10 PM to 6 AM shift showed the resident refused toileting on rounds, was wet on last round, and had briefs changed. Review of the 24-hour communication note dated 12/23/16 on the 10 PM to 6 AM shift showed the resident was toileted 2 times, had a loose stool, and staff changed the resident and top sheet. Review of the 24-hour communication note dated 12/24/16 on the 10 PM to 6 AM shift showed the resident was toileted 2 times and his/her brief was changed at 5 AM. Review of the 24-hour communication note dated 12/26/16 on the 10 PM to 6 AM shift showed resident toileted at 11 PM and his/her brief was changed at 5 AM. Review of the 24-hour communication note dated 12/27/16 on the 10 PM to 6 AM shift showed "dried BM filled brief left on [his/her] floor obviously had been there awhile [his/her] hamper had clothes coated in BM, was wearing a brief coated in dried BM, skin breakdown we coated [him/her] in A&D." Review of the 24-hour communication note dated 12/31/16 on the 6 AM to 2 PM shift showed the resident had a "BM accident" at 9:45 AM and the staff "showered [him/her]." The resident's sheets and pajamas were wet. Further, on the 10 PM to 6 AM shift the resident "refused to be toileted on 2nd round" and "soiled briefs changed on last round." Review of the 24-hour communication note dated the 1/1/17 on the 10 PM to 6 AM shift showed resident "toileted on 2nd rounds refused last rounds...irritated that [s/he] had to be toileted." Review of the 24-hour communication note dated	S5101		

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S5101	Continued From page 9 1/2/17 on the 10 PM to 6 AM shift showed the resident was "toileted and changed." Review of the 24-hour communication note dated 1/3/17 on the 10 PM to 6 AM shift showed the resident had "a bad BM accident on 2nd rounds, very watery and runny." c. Interview with CNA #1 on 01/05/17 at 12:55 PM revealed that the resident has rapidly declined over the past year, is completely incontinent, and is unable to perform incontinence care. Further, the resident hides soiled briefs and staff toilet him/her every 2 hours. d. Interview with the administrator and the CSD on 1/5/17 at 4:15 PM revealed the resident's plan of care does not accurately describe the resident's care needs. The facility recognized that the resident required a higher level of services than they could provide. Further, the administrator indicated that the facility had been unable to contact the resident's POA concerning appropriate placement.	S5101		