PRINTED: 01/05/2017
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
	ALF031	A. BUILDING: ______ B. WING ______	12/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE COUNTY ASSISTED LIVING	98 19TH STREET WHEATLAND, WY 82201

(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 . An initial Licensure survey was conducted by the Office of Healthcare Licensing and Surveys on 12/20/16. The following abbreviations are used throughout this document: ADLs: Activities of Daily Living RN: Registered Nurse	S 000	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied.	
S5067	Ch 12 Sec 7 (g) Assisted Living Facility (ALF) Core Services (g) Grievance Procedure. The written grievance procedure shall be posted in a conspicuous place within the facility. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the grievance procedure was posted in a conspicuous place within the facility. The findings were: Observation on 12/20/16 at 10:26 AM showed the facility did not have a written grievance procedure posted within the facility. Interview with RN #1 on 12/20/16 at 4:10 PM verified the facility had a grievance policy and procedure; however, she	S5067	S5067 – The facility posted the grievance procedure across from the dining room entrance on the wall for public viewing on 1/9/17. The facility will review the grievance procedure with *current and new* residents to ensure they know the procedure is posted in a visible area. Maintenance or designee will monitor the grievance procedure ssign quarterly for one year to ensure that it is posted in a visible area. All results will be taken to QA&A for further review and analysis. *LP change per Shane, NHA*	2/10/17

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	*Administrator*	*1/13/17*

STATE FORM 6899 IBT911 If continuation sheet 1 of 3

RECEIVED
JAN 13 2017
Healthcare Licensing and Surveys

Accepted w/ change to pg. 1. Change made per phone conversation w/ Shane Fillips, NHA/ALF ED
Loralee [signature] 1/26/17

PRINTED: 01/05/2017
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
	ALF031	A. BUILDING: _____ B. WING _____	12/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE COUNTY ASSISTED LIVING	98 19TH STREET WHEATLAND, WY 82201

(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
S5067	Continued From page 1 was unaware it was required to be posted.	S5067		
S5085	Ch 12 Sec 7 (k)(iv)(A-F) Assisted Living Facility (ALF) Core Servicse (k) Transfer and Discharge. (iv) Residents transferred to another health care facility shall be given written transfer/discharge notice which includes: (A) The name of the resident; (B) The reason for the transfer/discharge; (C) The effective date of the transfer/discharge; (D) The location to which resident is transferred/discharged; (E) The name, address, and telephone number of the Ombudsman; and (F) A listing of all outside contracted services. 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 notice of transfer/discharge was issued for 2 of 2 residents reviewed (#3, #4) who were transferred to other healthcare facilities. The findings were: 1. Review of the resident discharge/transfer status change dated 6/23/16 showed resident #3	S5085	S5085 – The facility will ensure transfer/discharge notices are provided to residents that are transferred or discharged from the facility. Resident #3 is deceased. On 1/12/17 the facility sent a transfer/discharge notice to resident #4. Staff will be educated by 1/20/17 on the appropriate times to provide the transfer discharge notice. The Assisted Living Coordinator or designee will audit all transfers/discharges for the last 6 months to ensure a transfer/discharge notice has been provided. The assisted living coordinator or designee will audit all transfer/ discharges monthly for one year to ensure transfer/discharges notices were provided. All results will be taken to QA&A for further review and analysis.	2/10/17

PRINTED: 01/05/2017
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
	ALF031	A. BUILDING: _____ B. WING _____	12/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE COUNTY ASSISTED LIVING	98 19TH STREET WHEATLAND, WY 82201

(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
S5085	Continued From page 2 was being discharged to the attached long term care facility due to increased agitation and confusion, and was no longer able to perform ADLs at the level required to reside in an assisted living facility. 2. Review of the 10/7/16 nurse's note timed at 8:30 PM showed resident #4 was transferred to the emergency room due to chest pain. The 10/8/16 nurse's note timed at 10:30 AM showed after the hospitalization, the resident was transferred to the nursing home and was not expected to return to the assisted living facility. 3. Interview with RN #1 on 12/20/16 at 4:10 PM verified there was no notice of transfer or discharge issued to the residents or their responsible party.	S5085		