Healthcare Licensing and Surveys

PRINTED: 06/02/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF020	A. BUILDING: ______ B. WING ______	05/23/2017

NAME OF PROVIDER OR SUPPLIER: LEGACY HOMES ASSISTED LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE: 2391 MUDDY STRING RD 117, THAYNE, WY 83127

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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 licensure survey was conducted by Healthcare Licensing and Surveys on 5/23/17.	S 000		
S5006	Ch 12 Sec 6 (c) Personnel and Staffing Requirements (c) Background checks. All staff of the assisted living facility shall successfully complete, at a minimum, a State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check and a Department of Family Services Central Registry Screening before direct resident contact. This State Rule and Regulation is not met as evidenced by: Based on review of personnel files and staff interview, the facility failed to ensure Division of Criminal Investigation (DCI) criminal background checks were completed for 2 of 3 employees (employee #1, employee #3) reviewed and failed to ensure the (DFS) central registry screening was conducted prior to resident contact for 3 of 3 employees reviewed. The findings were: 1. Review of personnel files revealed no evidence of DCI fingerprint background checks for employee #1, a certified nurse aide (CNA), and employee #3, a CNA. During an interview on	S5006	The Facility will ensure that all current and new employees will provide all necessary documentation to the administrator And that all employees will consent to a Wyo. State DFS Central Registry check, Criminal background check and finger prints, prior to completing orientation and resident contact. Management will monitor compliance through facility Quality Assurance program.	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE (X6) DATE

STATE FORM 6899 IK8R11 If continuation sheet 1 of 9

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Changes made per email by Elaine Merritt, manager, on 7/26/17. POC accepted. [signature] 8/2/17

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S5006	Continued From page 1 5/23/17 at 12:36 PM the manager confirmed there were no DCI background checks for the employees. She stated she thought if she hired a CNA who had recently received their CNA license, she didn't need to do the check because it would have been done as part of the licensure procedure. 2. Review of personnel files revealed the following: a. Employee #1, a CNA, had a completed orientation checklist dated 8/31/14. The results of the DFS central registry screening were dated 10/17/14. b. Employee #2, a cook, had a completed orientation checklist dated 12/6/13. There was no evidence of a DFS central registry screening. c. Employee #3, a CNA, had a completed orientation checklist dated 8/17/14. The results of the DFS central registry screening were dated 9/22/14. During an interview on 5/23/17 at 12:36 PM the manager confirmed the DFS screening results were not received prior to resident contact for employees #1 and #3. The manager stated she did not have results of the DFS screening for employee #2.	S5006	1) A staff meeting will be held on 6/23/2017 with current staff to review policy. All will sign and date a copy of this policy that will be placed in their employee file. A standard copy will be added to the new employee hire packet, for new highers to read and sign as well. 2) All current staff will have finger prints and background checks completed by 06/30/2017 and in files by 07/15/2017	7/12/17 6/12/17
S5052	Ch 12 Sec 7 (d)(iv)(A) Assisted Living Facility (ALF) Core Services (d) Medications. (iv) Medication assistance. (A) The staff shall be responsible for providing necessary assistance to residents deemed capable of self-medicating, but are	S5052		

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S5052	Continued From page 2 unable to do so because of a functional disability, in taking oral medications. Non-licensed staff can only assist with oral medications. Medication assistance may include: (I) Reminding resident to take medications; (II) Removing medication containers from storage; (III) Assisting with removal of cap; (IV) Assisting with the removal of a medication from a container for residents with a disability which prevents independence in this act; (V) Observing the resident take the medication; and (VI) Documentation of observation. This State Rule and Regulation is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure residents were deemed safe for self-administration of medications before staff assisted them due to functional limitations for 11 of 11 residents in the facility (#1 through #11). The findings were: 1. Observation on 5/23/17 at 1:04 PM revealed certified nurse aide (CNA) #1 assisted resident #9 with his/her medications. The CNA brought the bubble pack of medications to the resident, and punched a pill out onto a spoon. The resident then put the spoon, with the pill on it, into his/her mouth.	S5052	1) Staff meeting will be held 06/23/2017, to educate staff members by facility RN on rules and regulations on type of assistance for each resident. Management will monitor continued compliance through facility Quality Assurance program.	

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S5052	Continued From page 3 2. Review of the medical records for sample residents #1, #7, and #10 revealed no assessment to determine if the residents were deemed capable of self-administration of medications. An interview with CNA #2 on 5/23/17 at 1:23 PM revealed all of the residents, including #1, #7, and #10, received medication assistance by CNAs. 3. During an interview on 5/23/17 at 1:28 PM the manager confirmed CNAs assisted all of the residents with medication administration. She further stated none of the residents had an assessment to determine they were capable of self-administration of medications, but only needed assistance due to physical limitations.	S5052	2) The facility will ensure that all current and new residents intake forms will have an assessment done to determine if the residents are deemed capable of self-administration of medications, by residents physician and facility RN that will include reasoning for medication assistance and type of assistance needed. This portion will be added to the Medication Policy questionnaire and new resident intake form. This will also be added to the current and new resident information packet. Management will monitor compliance with facility RN , Staff, and resident physician through annual reviews and upon significant change.	7/17/17 6/2/17
S5070	Ch 12 Sec 7 (i)(ii) Assisted Living Facility (ALF) Core Services (i) Adult Protection. (ii) The facility must adhere to written policies and procedures that prohibit the abuse of any resident. These policies and procedures must identify how the facility will screen employees before hiring, ongoing in-servicing of abuse topics with employees, and a protocol that specifies how allegations of abuse will be investigated. Each staff member must be accountable to report any suspicion or knowledge of abuse to the appropriate facility personnel immediately. This State Rule and Regulation is not met as evidenced by: Based on review of policies and procedure and staff interview, the facility failed to develop written policies to prohibit abuse. The findings were:	S5070	3) The Facility will ensure that all current and new residents intake forms will have as assessment done to determine if the resides are deemed capable of self-administration of medications, by residents physician and facility RN that will include reasoning for medication assistance and type of assistance needed. This portion will be added to the Medication Policy questionnaire and new resident intake form. This will also be added to the current and new resident information packet by7/17/17. Management will monitor compliance with the facility Quality Assurance program.	

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S5070	Continued From page 4 Review of policies and procedures revealed no policy related to abuse. On 5/23/17 at 12:27 PM, interview with the manager confirmed the facility did not have a policy to address abuse.	S5070	1) A policy has been developed to identify screen, investigate, and provide inservice and accountability to prohibit abuse and will be implemented at staff meeting on 6/23/2017. All current staff members will be trained and oriented of this new policy, then will sign and date policy and it will be added to individual personnel files. This policy will also be added to new hire packets. Copies will also be giving to current residents and family member, and also will be added to new resident information packet.	6/23/17
S5074	Ch 12 Sec 7 (j)(iii)(A) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (iii) Food service supervision: (A) Day to day responsibilities for food production and management of the dietary services shall be assigned to a person with nutrition and food service management experience equivalent to that of a Certified Dietary Manager. This State Rule and Regulation is not met as evidenced by: Based on staff interview, the facility failed to ensure the day to day responsibilities of dietary services was assigned to a person who was a certified dietary manager (CDM) or the equivalent. The findings were: During an interview on 5/23/17 at 1:30 PM the manager stated the facility did not have a CDM or staff person who was the equivalent of a CDM.	S5074	1) The Facility will see out an appropriate Dietary Management Program that meets state requirements for that of a Certified Dietary Manager. The facility will designate and individual staff member to begin this program to completion. Management will monitor staff member for completion of said course to completion and have certification on sight and in file.	12/31/17
S5079	Ch 12 Sec 7 (j)(viii) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (viii) Cleaning and sanitizing of dishes and silverware shall be done by automatic dishwashers.	S5079		

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S5079	Continued From page 5 This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure monitoring of the dish machine water temperatures to ensure the dish machine was sanitizing dishes and silverware. The findings were: Observation on 5/23/17 at 10:24 AM in the kitchen revealed the facility had a residential under-the-counter automatic dishwasher. During an interview on 5/23/17 at 1 PM the manager stated the dishwasher was a hot temperature machine but stated the facility did not use a thermometer or thermolabel (temperature-sensitive tape) to monitor the water temperature. She confirmed the facility did not have any logs to show monitoring of the water temperature. According to Food Code, 2013, by U.S. Public Health Service, Food and Drug Administration, 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures, "(A) Except as specified in (B) of this section, in a mechanical operation, the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than 90 degrees C (194 degrees F), or less than: (1) For a stationary rack, single temperature machine, 74 degrees C (165 degrees F); or (2) For all other machines, 82 degrees C (180 degrees F)."	S5079	1) The facility manager will ensure that all kitchen staff will be trained on Food Code 2013 by U.S. Public Health Service, Food and Drug administration 4-501.112 Mechanical wash house equipment, hot water sanitation temperatures. With appropriate temperatures logged in the sanitation logs placed in the kitchen location next to the dish washer. A digital thermometer has been purchased and the forms have been updated for temperatures, training and monitoring of temperatures on 6/23/17. Management will monitor compliance through facilities Quality Assurance Program	~~6/13/17~~ 6/23/17
S5094	Ch 12 Sec 7 (o)(iii)(A-E) Assisted Living facility (ALF) Core Services (o) Evacuation Capability, Emergency Procedures, and Fire Safety.	S5094		

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S5094	Continued From page 6	S5094		

(iii) Fire Safety.

(A) Portable fire extinguishers shall be installed, inspected, and maintained according with NFPA 10, Standard for Portable Fire Extinguishers.

(I) State of Wyoming certified individuals shall inspect and service the extinguishers. All extinguishers shall have a tag or label securely attached that indicate the month and year the maintenance was performed and that identifies the person performing the service.

(B) Readily available and clearly readable telephone numbers for emergency contacts shall be located near all telephones.

(C) Clearly readable floor diagrams reflecting the actual floor arrangement showing the exit locations and evacuation routes shall be posted in conspicuous places. Each resident shall be instructed with its use on the first day of admission.

(D) Resident training for the fire emergency plan shall be in accordance with the Life Safety Code Operating Features sections.

(I) On the first day of admission, each resident shall be instructed in the proper action of the fire emergency plan, including the location of all the exits. A record of this instruction shall be in each resident file.

(E) Fire exit drills shall be conducted in accordance to the Life safety Code Operating Features sections. The minimum number of

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S5094	Continued From page 7 drills, as amended, shall be held at least twelve (12) times per year on a monthly basis with a minimum of one drill conducted each quarter on each shift. Fire exit drill records over a two-year period shall be available upon request at the facility. (l) The facility shall be responsible for recording fire exit drills on an evaluation form that include at least the following: (1.) Date of drill; (2.) Time of day; (3.) Type of drill (Practice, Announced, Surprise); (4.) Residents who participated including staff and family members; (5.) Time required (minutes and seconds) to evacuate all residents (including staff) from the occupied areas to a point of assembly as defined in the Life Safety Code; (6.) List of anyone, including staff and family members, who did not evacuate in the required time allowed by the evacuation capability rating of the facility. Evacuation capability rating for each facility shall be listed on the form; (7.) Comments on the factors that contributed to each individual's inability to evacuate successfully and any corrective actions recommended; and (8.) Signature and date of the person completing the form.	S5094		

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S5094	Continued From page 8 This State Rule and Regulation is not met as evidenced by: Based on resident record review and staff interview, the facility failed to document training on the fire emergency plan on the first day of admission for 3 of 3 sample residents (#1, #7, and #10). The findings were: Review of resident records for residents #1, #7 and #10 revealed no evidence of training on the fire emergency plan on the first day of admission. During an interview on 5/23/17 at 12:12 PM the manager stated residents were trained, but they did not document it.	S5094	1) A form has been developed to show that new residents are trained on emergency fire plan on the 1st day of admissions as are of our admission documentation. All staff will be educated on the form, read and sign a copy as well. This form will be signed and added to all current residents and staff, and placed in their personal files. This form will also be added to new resident and new hire packets by 7/15/2017. Management will monitor compliance through the facilities Quality Assurance program.	7/15/17