Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF006	A. BUILDING: _____ B. WING _____	C 09/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN WIND ASSISTED LIVING COMMUNITY	4010 NORTH COLLEGE DRIVE CHEYENNE, WY 82001

(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 the Office of Healthcare Licensing and Surveys on 9/21/17 through 9/22/17. The survey was prompted by complaint intakes LIC-17-042 and LIC-17-044. The following common abbreviations are used throughout the document: CSD- Clinical Services Director Less commonly used abbreviations will be annoted in each deficiency.	S 000		
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	S5023	Facility will ensure ALF 102 will be conducted on any residents with changes in condition. A) ALF 102 will now be completed immediately with any change in condition by the CSD (Clinical Services Director), ACSD (Assistant Clinical Services Director), or Nursing staff.	10/29/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 10/16/2017

Over

11/7/17

Healthcare Licensing and Surveys

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S5023	Continued From page 1 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 an assessment was completed for 6 of 10 sample residents (#3, #6, #7, #8, #9, #10) with a significant change in condition. The findings were: 1. Medical record review for resident #7 showed diagnoses which included osteoporosis with vitamin D deficiency, and Alzheimer's disease. The review showed the resident's most recent ALF 102 assessment was dated 2/21/17. The assessment showed the resident was "able to transfer and/or ambulate with minimal or standby assistance." The following concerns were identified: a. Medical record review showed the resident had fallen on 7/28/17, 8/14/17, 8/15/17, 8/23/17, 8/27/17, 8/29/17, 9/1/17, 9/6/17, and 9/17/17. b. Review of the resident's Fall Risk Evaluation showed the resident was at high risk for falls on 8/14/17, 8/27/17, 8/29/17, and 9/7/17. However, the facility failed to perform an ALF 102 for a change in condition, or other comprehensive assessment, to address the resident's 9 falls from 7/28/17 to 9/17/17. In addition, the resident's falls on 8/23/17 and 9/6/17 involved the resident hitting his/her head. However, the review revealed that neurological assessments were not performed. c. Interview with the CSD on 9/22/17 at 1:45 PM revealed the facility did not perform neurological assessments because they "watch residents" and send them to the hospital if they are "different"; however, different was not defined.	S5023	The ALF 102 for resident #7, #9, #6, #8, #10, and #3 will be completed, and this includes all residents that have the potential to be affected. B) All falls involving the head or any non-witnessed falls now require 72 hours of neurological evaluations to be completed every shift with focus charting as deemed necessary. Upon completion the neurological sheet will be placed in the residents chart. C) All incidents will be reviewed at monthly safety meeting to ensure all documentation completed correctly. Clinical services director and assistant clinical services director will audit ALF 102 for all residents in the facility quarterly. Ensuring they are a current representation of the residents condition. This issue will be monitored by the Quality Assurance Committee until resolution. - LM	10/29/17

11/2/17 - This POC accepted with agreed to changes between Leslie Milliken, Executive Director and Tony Madden, State Health Surveyor.

11/2/17

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S5023	Continued From page 2 2. Medical record review for resident #9 showed diagnoses which included hypertension, Alzheimer's dementia, osteoporosis, and chronic obstructive pulmonary disease. The review showed the most recent ALF 102, dated 4/11/17, indicated the resident was "able to transfer and/or ambulate with minimal or stand assistance." The following concerns were identified: a. Medical record review revealed that the resident had fallen on 7/9/17, 7/10/17, 7/12/17, 8/2/17, and 9/3/17. However, the record review showed no ALF 102 or comparable comprehensive assessment was completed after the 4/11/17 ALF 102. 3. Medical record review for resident #10 showed diagnoses which included cerebral vascular accident, depression, anxiety, and hypertension. The record review revealed that the resident fell in the shower room in the presence of staff on 8/25/17 and hit his/her head. Further record review showed the facility failed to complete neurological checks after the fall. 4. Medical record review for resident #6 showed diagnoses which included Alzheimer's disease. The review showed the most recent ALF 102 assessment was dated 2/21/17. The assessment showed the resident was "intermittently confused and/or agitated; requires occasional reminders as to person, place, and time." The following concerns were identified: a. Review of the Focus Charting Log revealed the resident made a "suicidal comment" on 8/7/17 at 1800 [6 PM]. However, continued medical record review showed the facility failed to complete an ALF 102 or other comprehensive assessment to address this issue. b. Review of the 2/21/17 ALF 102 showed the	S5023		

11/2/17

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S5023	Continued From page 3 area was left blank for "Safety concerns. In danger of self-inflicted harm or self-neglect. Continuous surveillance required. Excessive wandering." 5. Medical record review for resident #8 showed diagnoses which included dementia. The review showed the most recent ALF 102 assessment was dated 4/17/17. The assessment showed the resident was "intermittently confused and/or agitated; requires occasional reminders as to person, place, and time." The following concerns were identified: a. Review of a 9/8/17 note showed "Claiming [s/he] is going to commit suicide, [his/her] daughter is spending [his/her] money and not taking care of [him/her]...[Staff name] asked if [s/he] had plans for suicide and [s/he] said no plans. [S/he] said [s/he] wanted to commit suicide several times..." b. Review of a 9/11/17 nursing progress note revealed the following, "Resident is expressing being unhappy here and sometimes voices harming [himself/herself]..." c. Review of the 4/17/17 ALF 102 showed the area was left blank for "Safety concerns. In danger of self-inflicted harm or self-neglect. Continuous surveillance required. Excessive wandering." 6. Medical record review for resident #3 showed diagnoses which included hypertension, hypothyroidism, arthritis and bursitis. The review showed the resident's most recent ALF 102 assessment was dated 3/21/17. The assessment showed the resident was "independently and appropriately able to transfer and/or ambulate with or without a device". The following concerns were identified: a. Medical record review revealed a fax order	S5023		

11/2/17

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S5023	Continued From page 4 form, dated 9/2/17, which stated under present issue/concern: "Resident has needed 2 person moderate to max assist with all transfers to & from her chair, wheelchair & toilet chair. She hasn't been using her walker for over a week." b. Medical record review revealed a physician visit form, dated 9/7/17, which stated under present status/reason for visit "Left proximal fibula fracture." However, the facility failed to perform an ALF 102 for a change in condition, or other comprehensive assessment, to address the resident's current physical condition. c. Interview on 9/22/17 at 3:51 PM with the Administrator, DON and ADON revealed they were not aware an assessment must be conducted immediately upon any significant change in the resident's mental or physical condition, and verified the current ALF 102 did not reflect the resident's current physical condition. 7. Interview with the administrator, CSD, and assistant CSD on 9/22/17 at 3:43 PM revealed the facility's system for updating assessments did not include changes of condition.	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	S5026	Facility will ensure the resident care plan will be updated yearly per state regulations and upon every significant change in condition. A) Care plans will be updated with any new change in condition, concern and /or incident reports concerning a resident's mental or physical well-being and yearly per state regulations.	10/29/17

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S5026	Continued From page 5 designated by the resident. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the resident assistance plan was updated for 5 of 10 sample residents (#3, #6, #7, #8, #9) with a significant change in condition. The findings were: 1. Medical record review for resident #7 showed diagnoses which included osteoporosis with vitamin D deficiency, and Alzheimer's disease. Review of the 2/21/17 Resident Care Plan showed an update to transfers on 8/29/17. Until the 8/29/17 update, the Care Plan indicated the resident was completely independent with bed mobility and transfers. On 8/29/17 the plan was revised to show the resident required 1 staff to assist the resident to move from a lying position to sitting in bed, and physical assistance for transfers (by hand-to-hand) to move from one place to another. The following concerns were identified: a. Medical record review revealed that the resident had fallen on 7/28/17, 8/14/17, 8/15/17, 8/23/17, 8/27/17, 8/29/17, 9/1/17, 9/6/17, and 9/17/17. Six of the falls were before or on the date of the care plan revision. b. Review of the resident's Fall Risk Evaluation showed the resident was at high risk for falls on 8/14/17, 8/27/17, 8/29/17, and 9/7/17. However, the facility failed to update the resident care plan until 8/29/17 to include staff assistance with bed mobility and transfers. 2. Medical record review for resident #9 showed diagnoses which included hypertension, Alzheimer's dementia, osteoporosis, and chronic	S5026	B) Resident #9, #6, #8, #3, and #7 have a new care plan and will be revised with any new change in condition. All residents in the facility will have their care plans reviewed and changes will be made as necessary. C) IDT Team (Interdisciplinary Team) to meet monthly to schedule following months' care plan meetings. Nurses will be educated to modify resident care plans after receiving approval from Management. CNA (Certified Nursing Aids) will be educated to notify the floor nurses or nursing management of any variance in residents needs to their care plans. Clinical services director and assistant clinical services director will audit the resident care plan for all residents bi-annually, ensuring they are a current representation of the residents condition. This issue will be monitored by the Quality Assurance Committee until resolution. - 93	

11/7/17

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S5026	Continued From page 6	S5026		

obstructive pulmonary disease. Review of the 4/11/17 Resident Care Plan showed the resident required verbal cues while transfering. The following concerns were identified:

a. Medical record review revealed that the resident had fallen on 7/9/17, 7/10/17, 7/12/17, 8/2/17, and 9/3/17. However, the record review showed the facility failed to update the Resident Care Plan to reflect the resident's increased requirements due to multiple falls.

3. Medical record review for resident #6 showed diagnoses which included Alzheimer's disease. The review of the 2/21/17 Resident Care Plan showed "Resident demonstrates sad mood in the form of crying-sad/lonely/weepy" and "[Resident's name] is sad at times, redirects with staff interaction. The following concerns were identified:

a. Review of the Focus Charting Log revealed the resident made a "suicidal comment" on 8/7/17 at 1800 [6 PM]. However, continued medical record review showed the facility failed to update the 2/21/17 Resident Care Plan.

b. Review of the 2/21/17 Resident Care Plan showed the area was left blank for, "Resident demonstrates sad mood in the form of wishing to die."

4. Medical record review for resident #8 showed diagnoses which included dementia. Review of the 3/17/17 Resident Care Plan showed "Resident demonstrates sad mood in the form of crying-sad/lonely/weepy" and "[Resident's name] is sad at times, has excessive restlessness, and is fearful." The following concerns were identified:

a. Review of a 9/8/17 note showed "Claiming [s/he] is going to commit suicide, [his/her] daughter is spending [his/her] money and not taking care of [him/her]...[Staff name] asked it

11/3/17

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S5026	Continued From page 7 [s/he] had plans for suicide and [s/he] said no plans. [S/he] said [s/he] wanted to commit suicide several times..." b. Review of a 9/11/17 nursing progress note revealed the following: "Resident is expressing being unhappy here and sometimes voices harming [himself/herself]..." c. Review of the 3/17/17 Resident Care Plan showed the area was left blank for "Resident demonstrates sad mood in the form of wishing to die." 5. Medical record review for resident #3 showed diagnoses which included hypertension, hypothyroidism, arthritis and bursitis. The review showed the resident's most recent ALF 102 assessment was dated 3/21/17. The assessment showed the resident was "independently and appropriately able to transfer and/or ambulate with or without a device." The following concerns were identified: a. Medical record review revealed a fax order form, dated 9/2/17, which stated under present issue/concern: "Resident has needed 2 person moderate to max assist with all transfers to & from her chair, wheelchair & toilet chair. She hasn't been using her walker for over a week". b. Medical record review of the resident care plan, dated 3/21/17, showed the resident was marked as "completely independent" for transfers, with additional comments which included "[Resident] is independent with her transfers. Uses a walker and a lift chair for transfer assistance. She does at times need assistance with rising from a sitting position. 7/3/17 Resident educated on safe bending & calling for assistance when needed. 8/25/17 Re-orient to call light." c. Interview on 9/22/17 at 3:51 PM with the Administrator, DON and ADON revealed they	S5026		

11/7/17

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S5026	Continued From page 8 were not aware an assessment must be conducted immediately upon any significant change in the resident's mental or physical condition, and verified the resident care plan did not reflect the resident's current physical condition and need for assistance. 6. Interview with the administrator, CSD, and assistant CSD on 9/22/17 at 3:43 PM revealed the facility's system for updating assessments did not include changes of condition.	S5026		
S5032	Ch 12 Sec 7 (c)(v) Assisted Living Facility (ALF) Core Services (c) Resident Rights. The facility shall adopt and follow a written policy of resident rights. The policy shall be posted in a conspicuous place, and there shall be documentation in the resident's record that the resident read, or management explained, the policy. This policy shall not exclude, take precedence over, or in any way abrogate the legal and constitutional rights enjoyed by all adult citizens and shall include, but is not limited to the following: (v) Not to be physically, psychologically, sexually, or verbally abused, humiliated, intimidated, or punished; This State Rule and Regulation is not met as evidenced by: Based on staff and resident interview, and review of policy and procedure, the facility failed to ensure resident's rights were implemented to prevent residents being humiliated, intimidated, or punished for reporting concerns. The census was 65. The findings were:	S5032	The facility will ensure resident's rights are implemented to prevent residents being humiliated, intimidated, or punished for reporting concerns. A) A monthly resident council meeting will continue to be held facilitated by the life enrichment director involving the facility RSA (Resident Safety Advocate), management, key staff and all residents are welcome to attend. All staff will be welcome to attend after receiving permission from the Resident Council President.	10/29/17

11/7/17

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S5032	Continued From page 9 1. Interview with residents on 9/21/17 between 2:20 PM and 2:45 PM revealed residents did not feel safe reporting concerns. Residents felt that if they filed any complaints or concerns they would lose their apartments or be retaliated against. Further, some residents reported that when they have filed concerns, the concerns were not followed up on, they were threatened with eviction and/or intimidated, or the facility management retaliated against them in some way. 2. Interview with employee #1 on 9/21/17 at 3:02 PM revealed staff have been told not to report falls or other incidents. The employee stated s/he was told not to speak with surveyors and that some staff have been informed to "shove it under the rug" in regards to incidents that have occurred. 3. Interview with employee #2 on 9/22/17 at 7:21 AM revealed it is not approved of to report grievances and the administrator told him/her not to answer surveyor questions. 4. Interview with employee #3 on 9/22/17 at 9:40 AM revealed that multiple staff have told him/her that the administrator had told them not to report incidents, and they would be immediately fired if they report any type of incidents to the state surveyors or reveal any "secrets" to them. 5. Interview with employee #4 on 9/22/17 at 11:25 AM revealed s/he has heard from staff members that the administrator wanted to "sweep things under the rug" in regards to incidents; however, the employee had not been told to do so by the administrator. 6. Interview with the administrator, CSD, and assistant CSD on 9/22/17 at 3:43 PM revealed all	S5032	B) The next resident council meeting Patty Hall, the state ombudsman, will be guest speaker. Ms. Hall will inform our residents of services available to them, resident rights in assisted living, and address any questions they may have. The Life Enrichment Director will monitor the resident council meetings notes from the previous month, ensuring any issues have been resolved. C) Education for all staff will cover in October and quarterly thereafter for one (1) year: Resident Bill of Rights, Abuse Prevention, Intervention, Reporting and Investigation policies. D) Letter of expectation will be given to all staff from management, ensuring all staff understands expectations of reporting incidents, abuse and any and all concerns to management, without fear of consequences or retaliation. The document will be signed and placed in employee's personnel file.	10/24/17 10/29/17

11/2/17

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S5032	Continued From page 10 staff are considered first responders of abuse, should report all allegations or concerns, and retaliation is not tolerated within the facility. The CSD was not aware that staff were afraid to talk to surveyors and felt it may have been the result of the previous CSD. 7. Review of the "Abuse Prevention, Intervention, Reporting and Investigating" policy dated March 2017 showed "...It is the responsibility of employees to promptly report to the Community management any incident or suspected incident of neglect or resident abuse from other residents, staff, family, or visitors including injuries of an unknown source and theft or misappropriation of resident property. All staff are mandated reporters and must comply with state and federal regulations regarding reporting suspected abuse...II. Definitions Abuse is defined as the willful infliction of injury; unreasonable confinement; intimidation; punishment with resulting physical harm, pain, or mental anguish; or deOprivation [sic] by an individual including a caretaker, or goods or services that are necessary to attain or maintain physical, mental and psychological well-being...Verbal abuse is defined as any oral, written, or gestured language that willfully includes disparaging or derogatory terms to residents or their families regardless of their age, ability to comprehend, or disability...Mental abuse is defined as, but is not limited to, humiliation, harassment and threats of punishment, or withholding of treatment or services..."	S5032	During the last resident council meeting the on discussions entailed: encouraging the residents to talk to and be open with any state surveyors, also if they might be uncomfortable to stranger they may ask staff to introduce the state surveyors. Residents were informed that there would be no consequences nor would there be any retaliation for any reporting of concerns or issues that the residents may have. This issue will be monitored by the Quality Assurance Committee until resolved. -CS	10/29/17
S5054	Ch 12 Sec 7 (e)(i)(A-K) Assisted Living Facility (ALF) Core Services (e) Resident Records and Reports. Each	S5054	The facility will report all incidents to the licensing Division.	10/29/17

10/7/17

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S5054	Continued From page 11 resident's records shall be current, organized and maintained in individual folders which shall be made available to the resident, the Licensing Division, or designated representative upon request. (i) Each folder shall include the following: (A) Information from the referring agent, if applicable; (B) History and physical performed by a physician or physician extender; (C) Individual admission form. The form shall, at a minimum, contain the following information: (I) Full name of resident and former address; (II) Date of admission; (III) Sex, race, date of birth, social security number, and former occupation; (IV) Name, home address, and telephone number of relative, friend, Power of Attorney, or guardian; (V) Name, address, and telephone number of resident's personal physician, dentist, ophthalmologist or optometrist; (VI) Medicare number of other medical insurance identifying data; (VII) A written inventory of all personal possessions; however, this inventory need not	S5054	A) Letter of expectation will be given to all staff from management, ensuring all staff understands expectations of reporting incidents, abuse and any and all concerns to management, without fear of consequences or retaliation. The document to be signed and will be placed in employee's personnel file. Staff will be educated on when to report incidents and the use of incident reports. B) CSD (Clinical Services Director), ACSD (Assistant Clinical Services Director), and management will take all reports by staff and submit required information to the licensing division. Per incident a quality assurance check list is completed for each incident to ensure each entity and agency receives notification.	

11/2/17

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	ALF006	A. BUILDING: _____ B. WING _____	C 09/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S5054	Continued From page 12 include personal clothing. (D) All accidents, injuries, incidents, illnesses, and allegations of abuse, neglect or exploitation shall be reported to the resident's family or responsible party and be documented in the individual resident records. All such occurrences shall also be reported to the appropriate entity for follow up and resolution. Reports of all incidents affecting the health, welfare or safety of a resident shall be provided to the Licensing Division immediately (within one business day). Reporting shall be done by telephone or fax. The facility's investigation of the incident shall be reported to the Licensing Division and the Long Term Care Ombudsman within five (5) working days. Documentation to support the facility reporting the situation and follow up must also be present in the resident records; (E) An accounting of all personal funds deposited with and disbursed by the facility; (I) Upon written authorization of a client, the facility must hold, safeguard, manage and account for the personal funds of the client. (1.) The facility must deposit any personal funds in excess of $100 in an interest bearing account. (2.) The facility must establish and maintain a system that assures a full and complete and separate accounting according to generally accepted accounting principles of each resident's personal funds entrusted to the facility. (3.) Upon the death of a resident with	S5054	All incidents for resident #6 and resident #8 and including all resident's will be reported to the licensing division including reports of self-harm to Wyoming Department of Health, Resident's power of attorney, Edgewood Corporate and Ombudsman, Patty Hall, and law enforcement as needed, to be done Monday through Friday and covered monthly at Safety Meeting with QA (Quality Assurance) Team. All incidents for resident #10 have been submitted to the licensing division, CSD (Clinical Services Director) and ACSD (Assistant Clinical Services Director) will ensure that they are submitted under the proper report category. Report in question is 2017-399 This issue will be monitored by the Quality Assurance Committee until resolved. -KS	

11/7/17

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S5054	Continued From page 13 a personal fund deposited with the facility, the facility must convey, within 30 days, the resident ' s funds a final accounting of those funds, to the individual or probate jurisdiction administering the resident ' s estate. (4.) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare except for applicable deductible and coinsurance amounts. (F) A signed copy of the resident's rights; (G) The resident's assessment and individualized assistance plan; (H) Copies of all applicable resident assistance contracts, signed by both parties; (I) Written acknowledgment of the receipt and explanation of all facility policies including admission/discharge policies; (J) Copy of all ALF 102's; and (K) Copy of outside contractual responsibilities, if applicable. This State Rule and Regulation is not met as evidenced by: Based on medical record review, Licensing Division log review, and staff interview, the facility failed to ensure incidents were reported to the Licensing Division for 3 of 10 sample residents (#6, #8, #10) with incidents that had the potential to affect resident health and/or safety. The	S5054		

11/28/17

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S5054	Continued From page 14 findings were: 1. Medical record review for resident #6 showed diagnoses which included Alzheimer's disease. Review of the Focus Charting Log revealed the resident made a "suicidal comment" on 8/7/17 at 1800 [6 PM]. Continued medical record review showed the facility failed to notify the Licensing Division. 2. Medical record review for resident #8 showed diagnoses which included dementia. The following concerns were noted: a. Review of a 9/8/17 note revealed: "Claiming [s/he] is going to commit suicide, [his/her] daughter is spending [his/her] money and not taking care of [him/her]...[Staff name] asked it [s/he] had plans for suicide and [s/he] said no plans. [S/he] said [s/he] wanted to commit suicide several times..." b. Review of a 9/11/17 nursing progress note revealed the following: "Resident is expressing being unhappy here and sometimes voices harming [himself/herself]..." c. Review of the Licensing Division incident log showed the facility failed to report either incident. 3. Medical record review for resident #10 showed diagnoses which included cerebral vascular accident, depression, anxiety, and hypertension. The record review revealed that the resident fell in the shower room in the presence of staff on 8/25/17 and hit his/her head. Further review showed a family member of the resident felt that the resident was pushed in the shower by staff. The following concerns were noted: a. Review of the Licensing Division incident log showed the facility failed to report the incident.	S5054		

11/8/17

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S5054	Continued From page 15 4. Interview with employee #1 on 9/21/17 at 3:02 PM revealed staff have been told not to report falls or other incidents. The employee stated s/he was told not to speak with surveyors and that some staff have been informed to "shove it under the rug" in regards to incidents that have occurred. 5. Interview with employee #3 on 9/22/17 at 9:40 AM revealed that multiple staff have told him/her that the administrator had told them not to report incidents, and they would be immediately fired if they report any type of incidents to the state surveyors or reveal any "secrets" to them. 6. Interview with employee #4 on 9/22/17 at 11:25 AM revealed s/he has heard from staff members that the administrator wanted to "sweep things under the rug" in regards to incidents; however, the employee had not been told to do so by the administrator. 7. Interview with the administrator, CSD, and assistant CSD on 9/22/17 at 3:43 PM revealed the facility failed to do incident reports or formal investigations of these incidents. It was confirmed that the incidents should have been investigated and reported.	S5054		
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	S5070	The facility will ensure that written policies and procedures relating to abuse are adhered to by educating staff relating to Resident's Dignity and Rights.	10/29/17

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S5070	Continued From page 16 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 staff and resident interview, and review of policy and procedure, the facility failed to adhere to written policies and procedures that protected residents from abuse. The census was 65. The findings were: 1. Interview with residents on 9/21/17 between 2:20 PM and 2:45 PM revealed residents did not feel safe reporting concerns. Residents felt that if they filed any complaints or concerns they would lose their apartments or be retaliated against. Further, some residents reported that when they have filed concerns, the concerns were not followed up on, they were threatened with eviction and/or intimidated, or the facility management retaliated against them in some way. 2. Interview with employee #1 on 9/21/17 at 3:02 PM revealed staff have been told not to report falls or other incidents. The employee stated s/he was told not to speak with surveyors and that some staff have been informed to "shove it under the rug" in regards to incidents that have occurred. 3. Interview with employee #2 on 9/22/17 at 7:21 AM revealed it is not approved of to report grievances and the administrator told him/her not to answer surveyor questions. 4. Interview with employee #3 on 9/22/17 at 9:40 AM revealed that multiple staff have told him/her	S5070	A) During the last resident council meeting discussions entailed: encouraging the residents to talk with and be open with any state surveyors and if they are uncomfortable speaking with strangers, they may ask staff to introduce the state surveyors. Residents were informed that there would be no consequences nor would there be any retaliation for any reporting of concerns or issues that the residents may have. B) The next resident council meeting Patty Hall, the state ombudsman, will be guest speaker. Ms. Hall will inform our residents of services available to them, resident rights in assisted living, and address any questions they may have.	

11/2/17

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S5070	Continued From page 17 that the administrator had told them not to report incidents, and they would be immediately fired if they report any type of incidents to the state surveyors or reveal any "secrets" to them. 5. Interview with employee #4 on 9/22/17 at 11:25 AM revealed s/he has heard from staff members that the administrator wanted to "sweep things under the rug" in regards to incidents; however, the employee had not been told to do so by the administrator. 6. Interview with the administrator, CSD, and assistant CSD on 9/22/17 at 3:43 PM revealed all staff are considered first responders of abuse, should report all allegations or concerns, and retaliation is not tolerated within the facility. The CSD was not aware that staff were afraid to talk to surveyors and felt it may have been the result of the previous CSD. 7. Review of the "Abuse Prevention, Intervention, Reporting and Investigating" policy dated March 2017 showed "...It is the responsibility of employees to promptly report to the Community management any incident or suspected incident of neglect or resident abuse from other residents, staff, family, or visitors including injuries of an unknown source and theft or misappropriation of resident property. All staff are mandated reporters and must comply with state and federal regulations regarding reporting suspected abuse...II. Definitions Abuse is defined as the willful infliction of injury; unreasonable confinement; intimidation; punishment with resulting physical harm, pain, or mental anguish; or de0privation [sic] by an individual including a caretaker, or goods or services that are necessary to attain or maintain physical, mental and psychological well-being...Verbal abuse is	S5070	C) Education for All-Staff will be covered in October and quarterly for one (1) year: Resident Bill of Rights to be reviewed and signed, Abuse Prevention, Intervention, Reporting and Investigation Policies, Resident Dignity, and Resident Safety Advocate Policy. Meeting will be held with staff, led by management team and facility RSA (Resident Safety Advocate) for questions and answers. Clinical services director, assistant clinical services director, and resident safety advocate will monitor quarterly for completion of incident reporting including report of abuse. This issue will be monitored by the Quality Assurance Committee until resolution. -DS	

11/2/17

Healthcare Licensing and Surveys

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S5070	Continued From page 18 defined as any oral, written, or gestured language that willfully includes disparaging or derogatory terms to residents or their families regardless of their age, ability to comprehend, or disability...Mental abuse is defined as, but is not limited to, humiliation, harassment and threats of punishment, or withholding of treatment or services..."	S5070		