Healthcare Licensing and Surveys

PRINTED: 09/28/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF022	A. BUILDING: _____ B. WING _____	C 09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE MANOR INC	830 NORTH MAIN STREET BUFFALO, WY 82834

(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 in conjunction with a licensure survey by the Office of Healthcare Licensing and Surveys on 9/11/17 through 9/12/17. The survey was prompted by complaint intakes LIC-16-031 and LIC-17-019 The following common abbreviations are used throughout the document: CNA- Certified Nursing Assistant RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S6008	Ch 12 Sec 6 (d)(ii)(A-F) Personnel and Staffing Requirements (d) Infection Control. Written policies shall be in effect to ensure that newly hired and current employees do not spread a communicable disease that could be transmitted through usual job duties. These shall not be limited to: (ii) Tuberculin Testing. (A) Tuberculin testing must be accomplished for each employee prior to	S6008		

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

11/2/17

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Healthcare Licensing and Surveys

11/7/17 9:15am Spoke with Rene's Knight, Executive Director. PoC accepted with agreed written changes.
Penny Stevenson, RN
State Surveyor

Agape Manor, Inc. – PoC
830 N Main St.
Buffalo, WY 82834
Survey date: 09/12/2017

Tag No S5008 **10/25/17**

Effective 10/09/17 all current employees, including CNA#2, have either a current (within 1 yr of hire) TB test or current risk assessment on file.

All current employee files will be reviewed by Resident Care Director and Executive Director to ensure all requirements have been met by November 10, 2017.

As of 09/23/17 the new policy was put into place, employees were educated about the new policy during an employee meeting in addition to signing the new Low risk assessment (when required). Each new employee will be informed of the policy upon hire in addition to the request for an initial TB test.

The Resident Care Director will ensure policy is being followed by reviewing each current employee folder bi-annually (June and January of each year).

Results of employee file audit will be supplied to the ~~Executive Director,~~ QA Committee PS bi-annually (June and January of each year), for a quality assurance review.

** As of 09/23/17 Agape Manor, Inc. applied to WY Dept of Health to become a low risk facility. All employees upon hire need a two-step TST (skin test) at Public Health. Upon negative result – no annual testing afterward.

Tag No S5010 **9/27/17**

All current employees, including RN#1, CNA#2, and CNA#3, that require licenses have proof of current licensure in their employee files.

All current employee files will be reviewed by Resident Care Director and Executive Director to ensure all requirements have been met by November 10, 2017.

As of 09/25/17 all employees were educated about the new policy during an employee meeting in addition to the reminder to supply proof of licensure upon renewal.

All current employee files will be reviewed annually, January 2 - January 15 to ensure they are in compliance with all State and Federal requirements.

The Resident Care Director will review the policy bi- annually (Jan and June) to ensure compliance.

Results of the RCD's policy review will be supplied to the ~~Executive Director,~~ QA Committee PS bi-annually (June and January of each year), for a quality assurance review.

Tag No S5054 **11/04/17**

Incident reports have been filed or supplied to OHCL on the three incidents cited.

Resident Care Director has reviewed all current resident files to insure all incidents have been reported.

Agape Manor shall report all accidents, injuries, incidents, illness and allegations of abuse, neglect or exploitation to the resident's family or responsible party and be documented in the resident's records. All 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). The facility's investigation of the incident shall be reported to the Licensing Division and the Long Term Care Ombudsman within (5) working days.

Documentation to support the facility reporting the situation and follow up will also be present in the resident records.

All nursing staff received a copy of the new P&P on Incidents/Accidents.

Reporting will be the responsibility of the Resident Care Director and/or a licensed nurse on staff.

Resident Care Director will review all current resident charts bi-annually (January and June of each year) to insure all required incidents are being reported to the OCHL.

Results of the RCD's audit will be supplied to the ~~Executive Director~~ QA Committee PS, bi-annually (June and January of each year), for a quality assurance review.

Tag No S5066 **10/27/17**

Effective 09/28/17 the Agape Manor, Inc. Grievance Policy has been edited to include the guidelines for written reports, submission to the appropriate state agency and recordation of resolutions.

Reporting will be the responsibility of the Resident Care Director and/or a licensed nurse on staff.

The Grievance Policy will be reviewed annually during each Quality and Assurance assessment unless need arises prior to that time.

Staff and residents have been informed of the revised policy via resident council and staff meetings. Staff have been required to read and initial the new policy.

The Executive Director will review the reporting, resolution, and reporting process at each occurrence to verify effect and thoroughness of the Grievance Policy process.

Tag No S5074 **07/21/18**

Effective 10/15/2017 the Dietary manager will provide the State Health Surveyor with monthly progress reports, via email, relating to his CDM licensure. The contracted Registered Dietician will insure paperwork is being done as required, progress on CDM course is being made and Dietary Manager is performing job as required.

The Executive Director will verify reporting is being made on a monthly basis. Estimated completing ~~06/2018~~ 7/21/18 PS

All future Dietary managers will meet or exceed state requirements.

The Executive Director will verify all applicants meet or exceed state requirements during the application process.

Dietary manager has been enrolled in University of North Dakota CDM course since 07/21/17 and has an expected completion date of 07/21/18.

Tag No S5076 **09/25/17**

Effective 09/12/17 the Dietary manager has cleaned the stainless steel tables and continues to monitor the condition of all kitchen equipment and tools. All broken or cracked utensils have been discarded and replaced with new tools.

Dietary manager has met with each Dietary employee individually and reviewed State Rules and Regulation and safe food handling practices in accordance with the current edition of the Food Code (USPHS).

Dietary manager will monitor condition of equipment on a weekly basis and request replacements of any cracked or damaged tools or equipment. Kitchen manager will hold monthly meetings with Dietary staff and incorporate In-Service lessons associated with safe food handling practices in accordance with the current edition of the Food Code (USPHS).

Dietary Manager will provide the Executive Director with all results of each meeting and the Executive Director will be responsible for ensuring meetings are held and the above referenced content is included. The Executive Director will also perform weekly spot checks in the kitchen to verify safe handling practices are being met.

Results of meeting minutes and weekly Spot checks will be provided bi-annually (each June and January) to the QA Committee for a quality assurance review. PS

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S5008	Continued From page 1 employment and annually thereafter. (B) Employees having known positive skin tests shall provide a certificate of noninfectiousness, recommendations, if any, for treatment, and evidence they have complied with such recommendations. (C) Individuals provide documentation of negative skin test administered within the last twelve (12) months do not require a follow-up (D) Individuals who have not had a skin test or who do not have written proof of skin test results, shall have an intradermal Mantoux using 5TU PPD. This shall be accomplished via the two (2) step procedure. If the first test is negative and the employee is asymptomatic, the employee may engage in resident contact prior to the results of the second skin test. (I) A negative reaction requires no follow-up. (II) A positive reaction (10mm in duration suing 5TU PPD) requires a referral to a physician for x-ray and certification of noninfectiousness and appropriate treatment if needed. Follow up shall comply with the recommendations of the attending physician. (E) If symptoms occur, a new certificate of noninfectiousness is required. (F) No person with an airborne, contagious or infectious disease shall be employed until a work release is obtained. (I) The facility shall prohibit employees	S5008		

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S5008	Continued From page 2 with a communicable disease or infected skin lesions from direct contact with residents and their food, if direct contact will transmit a disease. (II) The facility shall require staff to follow universal precautions when performing direct resident care. This State Rule and Regulation is not met as evidenced by: Based on employee record review and staff interview, the facility failed to ensure staff members were free from communicable disease, including tuberculosis (TB), for 1 of 4 employee records reviewed (CNA #2). The findings were: Review of the employee record for CNA #2 showed a date of hire of 2/15/13. Further review showed a TB test had been completed on 2/22/15. Further review showed no evidence a TB test or screening had been completed since that time. Interview with the resident care director on 9/12/17 at 2:53 PM confirmed that a TB test or screening for CNA #2 had not been completed this year.	S5008		
S5010	Ch 12 Sec 6(e)(ii)(A-L) Personnel And Staffing Requirements (e) Personnel Policies and Records. (ii) A record for the manager and each employee shall be maintained and contain at a minimum the following information:	S5010		9/27/17

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S5010	Continued From page 3 (A) Name, current address and telephone number; (B) Social Security Number; (C) Education; (D) Work experience, documentation of reference checks; (E) Date of employment (F) Position in the assisted living facility (job description); (G) Documentation of tuberculin testing; (H) Orientation checklist; (I) I-9, (Employment Eligibility Verification); (J) W-4 (Employee's Withholding Allowance Certificate); (K) Licensure, Certification, or Credentials; (e.g., RN, LPN, CNA; and (L) Documentation of all completed background and Central Registry background check with no offenses. This State Rule and Regulation is not met as evidenced by: Based on employee record review and staff interview, the facility failed to ensure employee personnel records contained all of the required components including current licensure and documentation of tuberculin (TB) testing for 3 of 4	S5010		

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S5010	Continued From page 4 employees reviewed (RN#1, CNA #2, CNA #3). The findings were: 1. Review of the employee record for RN #1 showed a date of hire of November 2015. Continued review showed evidence of a nursing license which expired in 12/2016. Further review showed no evidence of current licensure was contained in the employee's record. 2. Review of the employee record for CNA #2 showed a date of hire of February 2013. Continued review showed evidence of a CNA certification which expired in 12/2014. Further review showed no evidence of a current certification was contained in the employee's record. In addition, review of the employee record showed a TB test was completed on 2/22/15. Further review showed no evidence a current TB test was contained in the employee's record. 3. Review of the employee record for CNA #3 showed a date of hire of March 2017. Continued review showed no evidence of current CNA certification was contained in the employee's record. 4. Interview with the resident care director on 9/12/17 at 2:53 PM confirmed the licenses/certifications were not printed out and placed in the employee record.	S5010		
S5054	Ch 12 Sec 7 (e)(i)(A-K) Assisted Living Facility (ALF) Core Services (e) Resident Records and Reports. Each resident's records shall be current, organized and maintained in individual folders which shall be made available to the resident, the Licensing	S5054		11/4/17

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S5054	Continued From page 5 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 include personal clothing. (D) All accidents, injuries, incidents,	S5054		

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S5054	Continued From page 6 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 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	S5054		

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S5054	Continued From page 7 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, review of the Office of Healthcare Licensing and Surveys incident log, and resident, family, and staff interview, the facility failed to report incidents which affected 3 sample residents (#3, #14, #20) who had reportable incidents. The findings were: 1. Review of the medical record for resident #3 showed s/he had a fall at the facility on 7/6/16	S5054		

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S5054	Continued From page 8 and again on 8/21/16. The following concerns were identified: a. Review of the "Incident/Accident Report" form dated 7/6/16 and timed 10 AM, revealed the resident tipped his/her wheelchair off a curb while participating in a fire drill. Review of nurse's notes dated 7/9/16, not timed, showed the resident requested to see a doctor "today" due to left hip pain. Review of a physician note dated 7/9/16 showed the resident presented to the emergency department complaining of hip pain. Further, the note showed "[resident] states any movement of the left hip whatsoever is very painful. [Resident] has not been ambulatory since the injury." Review of a nurse's note dated 7/10/16, not dated, showed the resident had a diagnosis of "closed intratrochanteric fx [fracture] of left hip." b. Review of the "Incident/Accident Report" dated 8/21/16 and timed 4:40 PM showed the resident was attempting to transfer from his/her recliner using his/her walker. Further, the report showed the resident fell between the recliner and wheelchair. Review of a nurse's note dated 8/21/16, not timed, showed the resident was found on the floor in his/her room. In addition, the resident complained of back pain following the fall and was transported to the hospital via ambulance. Review of a hospital discharge summary dated 9/6/16 showed the resident had a "recent fracture of T-7 vertebral body due to fall." 2. Review of the medical record for resident #14 showed s/he was admitted July of 2015. The following concerns were identified: a. Review of the "resident care notes" dated 1/11/17, and timed 7 PM, showed the resident was given the wrong medications. Further, the nurse was notified and advised that vital signs be taken to monitor for drop in blood pressure and pulse. Review of the "medication error report"	S5054		

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S5054	Continued From page 9 dated 1/11/17 showed the nurse signed the report on 1/12/17. b. Interview on 9/12/17 at 1:55 PM with resident #14 and his/her family member revealed the resident had loaned money to a staff member for a down payment on a vehicle. In addition, the family member stated s/he notified the management of the facility about the loan and allowed them time to "fix the issue." Further, s/he confirmed the resident was fully reimbursed by the facility and the employee was no longer working at the facility. Interview with the resident care director on 9/12/17 at 2:55 PM revealed she was aware the incident had happened, but it was taken care of by the executive director. 3. Review of the medical record for resident #20 revealed s/he was admitted on 1/12/15. The following concerns were identified: a. Review of a nurse's note dated 9/29/15, not timed, showed the resident fell and complained of hip pain; the resident was transported to the hospital and diagnosed with a hip fracture that required repair. b. Interview with CNA #1 on 9/12/17 at 10:40 AM revealed the resident had a "rice bag" s/he used for pain relief. Further, she stated "a couple of months ago", the resident placed the rice bag in his/her microwave and warmed it to the point the bag burned in the microwave and caused the fire alarm to sound in the facility. In addition, she stated the resident had moved out of the facility in June 2017 to be with family. c. Interview with the resident care director on 9/12/17 at 2:53 PM revealed the fire department had responded to the fire alarm at the facility. 4. Review of the Office of Healthcare Licensing and Survey incident log showed no reporting of the incidents related to residents #3, #14, and	S5054		

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S5054	Continued From page 10 #20. 5. Interview with the resident care director on 9/12/17 at 2:53 PM confirmed the facility had not reported the incidents to the licensing division. Further, she revealed she was unaware of the requirement to report those types of incidents.	S5054		
S5066	Ch 12 Sec 7 (g)(iv) Assisted Living Facility (ALF) Core Services (g) Grievance Procedure. The written grievance procedure shall establish a system of receiving, reviewing, and alleviating concerns, complaints and allegations of resident rights violations, and poor service provided to include, but not limited to: (iv) The facility shall provide written reports of the grievances and resolutions to the Ombudsman and the Licensing Division within ten (10) days after the grievance is filed.. This State Rule and Regulation is not met as evidenced by: Based on staff interview and review of facility policies and procedures, the facility failed to ensure the grievance policy contained all required elements. The findings were: Review of the "Grievance Policy and Procedure", dated 5/17/16, showed it contained methods for residents and family members to voice grievances and detailed how the agency would respond. However, the policy failed to include written reports of the grievances and resolutions should be provided to the Ombudsman and	S5066		10/27/17

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S5066	Continued From page 11 Licensing Division within 10 days. Interview with the resident care director on 9/12/17 at 2:53 PM confirmed the procedure did not include all required elements.	S5066		
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 and review of enrollment information, the facility failed to ensure the dietary manager was qualified. The findings were: Interview with the dietary/kitchen manager on 9/12/17 at 10:15 AM revealed he was enrolled in a qualifying dietary manager program through the University of North Dakota. Review of the enrollment information showed the manager was enrolled on 7/21/17. The expected completion date was 7/21/18, 1 year from enrollment.	S5074		7/21/18
S5076	Ch 12 Sec 7 (j)(v) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition.	S5076		9/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF022	A. BUILDING: _____ B. WING _____	C 09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE MANOR INC	830 NORTH MAIN STREET BUFFALO, WY 82834

(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
S5076	Continued From page 12 (v) Individuals with food preparation responsibilities shall be in good health and shall practice safe food handling techniques in accordance with the current edition of the Food Code published by the U.S. Public Health Service, Food and Drug Administration. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a sanitary environment was maintained in 1 of 1 food preparation/storage areas (kitchen). The findings were: 1. Observation in the kitchen showed the following concerns: a. On 9/12/17 at 11:30 AM cook #1 was placing items onto resident meal trays, which included buns. With her bare hands, the cook touched the buns to open them. During the service process the cook left the service area and handled the door to the freezer on 3 occasions, touched her face, apron, the counter and drawers, and with no hand hygiene continued to handle the food and equipment for resident meals. b. Observation on 9/12/17 at 9:50 AM showed 2 stainless steel storage tables that had an accumulation of food and debris. c. Observation on 9/12/17 at 10:10 AM showed 2 spatulas with cracks and fissures in the plastic and broken edges. d. Interview with the dietary/kitchen manager on 9/12/17 at 12:37 PM verified the need for handwashing after handling the refrigerator/freezer doors and leaving the service area. He confirmed the identified equipment was old and needed to be replaced. In addition, he verified the storage tables were in need of cleaning.	S5076		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S5076	Continued From page 13 2. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 3. According to Food Code 2013, U.S. Public Health Service: 3-301.11 Preventing Contamination from Hands. "(A) FOOD EMPLOYEES shall wash their hands as specified under § 2-301.12. (B) Except when washing fruits and vegetables as specified under §3-302.15 or as specified in ¶¶ (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT."	S5076		