Healthcare Licensing and Surveys

RECEIVED
MAR 23 2018
Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF27	A. BUILDING: ______ B. WING ______	02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONDELL HEIGHTS RETIREMENT COMMUNIT	106 E MAIN STREET NEWCASTLE, WY 82701

(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 licensure survey was conducted by Healthcare Licensing and Surveys from 2/21/18 to 2/22/18.	S 000		
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 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	S5054		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: DianeBaird Hudson   TITLE: Director   (X6) DATE: 3/14/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF27	A. BUILDING: _____ B. WING _____	02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONDELL HEIGHTS RETIREMENT COMMUNIT	106 E MAIN STREET NEWCASTLE, WY 82701

(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
S5054	Continued From page 1 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, 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;	S5054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF27	A. BUILDING: _____ B. WING _____	02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONDELL HEIGHTS RETIREMENT COMMUNIT	106 E MAIN STREET NEWCASTLE, WY 82701

(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
S5054	Continued From page 2 (l) 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 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;	S5054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF27	A. BUILDING: _____ B. WING _____	02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONDELL HEIGHTS RETIREMENT COMMUNIT	106 E MAIN STREET NEWCASTLE, WY 82701

(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
S5054	Continued From page 3 (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, policy and procedure review, and staff interview the facility failed to ensure 1 of 1 incidents (involving resident #2) reviewed which required reporting was reported to the appropriate entities. The findings were: Review of the record for resident #2 showed a nursing note dated 2/24/17 and timed at 3:45 PM which described a fall. The note showed the resident had fallen in his/her room on 2/23/17 and as a result was taken to the emergency room where fractures were identified. The resident was admitted to the swing bed unit and returned on 3/25/17 to the assisted living facility after rehabilitation. Interview with the administrator on 2/22/18 at 9:15 AM verified the fall with injury had not been reported to the licensing division or to the long term care ombudsman. Review of the undated policy and procedure for medical emergency showed, "If the situation is deemed a medical emergency requiring outside assistance...The Licensing Division will be notified by telephone or fax within one day...Notice of transfer and Incident Form with the result of the investigation will be copied to the Licensing Division and the Long Term Care Ombudsman within five days."	S5054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF27	A. BUILDING: _____ B. WING _____	02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONDELL HEIGHTS RETIREMENT COMMUNIT	106 E MAIN STREET NEWCASTLE, WY 82701

(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
S5074	Continued From page 4	S5074		
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 observation, the facility failed to employ a qualified dietary manager. The findings were: Observation on 2/21/18 at 3:40 PM showed a cook working in the kitchen, interview with cook #1 at that time revealed there was not a dietary manager. Interview with the facility manager on 2/21/18 at 5:55 PM verified there was not a qualified dietary manager, and he was the one who placed the food orders and oversaw menus and meals. He stated they had not been successful at finding an already qualified manager, and he was thinking of enrolling in a course.	S5074		
S5077	Ch 12 Sec 7 (j)(vi) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (vi) The kitchen and dining area shall be kept clean and sanitary in accordance with standards	S5077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF27	A. BUILDING: _____ B. WING _____	02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONDELL HEIGHTS RETIREMENT COMMUNIT	106 E MAIN STREET NEWCASTLE, WY 82701

(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
S5077	Continued From page 5 established in the current edition of FDA Food Code. The dining area shall provide suitable furniture and adequate space to comfortably seat all residents. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure food safety techniques were followed and sanitary conditions in the kitchen and dish-room were maintained. The findings were: 1. Observation on 2/21/18 at 4:40 PM showed cook #1 was preparing the evening meal. Interview with cook #1 at that time revealed the temperature of food items was taken to ensure they were heated and held at appropriate levels, however, there was no record kept. According to Food Code 2013, U.S. Public Health Service: 3-202.11: "(D) TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked to a temperature and for a time specified under §§ 3-401.11 3-401.13 and received hot shall be at a temperature of 57oC (135oF) or above." 2. Observation on 2/21/18 at 4:46 PM showed a dispensing system was used to fill buckets with a quaternary sanitizer solution. The dish machine was also equipped with a system to automatically dispense a chlorine sanitizer. Interview with the facility manager on 2/22/18 at 9:20 AM verified there was no testing of these solutions to ensure the concentrations were effective except when the chemical company came to provide service every 6 months. According to Food Code 2013, U.S. Public Health Service: 4-501.116 "Concentration of the	S5077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF27	A. BUILDING: _____ B. WING _____	02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONDELL HEIGHTS RETIREMENT COMMUNIT	106 E MAIN STREET NEWCASTLE, WY 82701

(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
S5077	Continued From page 6 SANITIZING solution shall be accurately determined by using a test kit or other device." 3. Observation on 2/21/18 at 4:40 PM showed shell eggs were available in a refrigerator, interview with cook #1 at that time revealed these were used to cook and serve eggs at breakfast. She verified several residents liked their eggs with runny yolks and pasteurized shell eggs were not something they used. According to Food Code 2013, U.S. Public Health Service: 3-401.11 "(D) A raw animal FOOD such as raw EGG... soft cooked EGGS... may be served or offered for sale upon CONSUMER request or selection in a READY-TO-EAT form if: (1) As specified under 3-801.11(C)(1) and (2), the FOOD ESTABLISHMENT serves a population that is not a HIGHLY SUSCEPTIBLE POPULATION;" According to Food Code 2013, U.S. Public Health Service definitions: "Highly susceptible population" means PERSONS who are more likely than other people in the general population to experience foodborne disease because they are: (1) Immunocompromised; preschool age children, or older adults; and (2) Obtaining FOOD at a facility that provides services such as custodial care, health care, or assisted living, such as a child or adult day care center, kidney dialysis center, hospital or nursing home, or nutritional or socialization services such as a senior center. 4. Observation on 2/21/18 at 4:46 PM showed the kitchen had a build-up of debris around the edges of the floor and the walls. In addition to the grime on the walls, there were areas where the paint	S5077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF27	A. BUILDING: _____ B. WING _____	02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONDELL HEIGHTS RETIREMENT COMMUNIT	106 E MAIN STREET NEWCASTLE, WY 82701

(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
S5077	Continued From page 7 was peeling/flaking off. This damage was specifically evident around the 3-compartment sink area. Observation at that time also showed the dish room had similar concerns with the walls around the dish machine; they were damaged with peeling paint. 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." 5. Interview with the Administrator and the facility manager on 2/22/18 at 10:15 AM confirmed they were not aware of the need for pasteurized shell eggs. Further, they verified documentation was not kept for food temperatures or sanitizer concentrations.	S5077		

Mondell Heights Retirement Community
106 E. Main Street, Newcastle, WY 82701
307-941-1919
Fax-307-460-7007

Updated Plan of Correction for February 22, 2018 Program Survey

S5054 Chapter 12 Section 7 (e)(i)(A-J) Assisted Living Core Services

The facility will report the necessary incidents to the Licensing Division and Ombudsman in keeping with Sect 7 (e)(i)(D) by the Director:

1. For the resident found in the survey to have been affected, the required incidents will be identified, logged and reported on the state system by April 26, 2018.
2. The corrective action for all residents who have been or may be affected in the future, incidents will be identified and logged by April 26, 2018.
3. Systemic changes made to assure this deficient practice does not recur include:
    a. Providing training or upgrading knowledge of the incident reporting system and requirements to the RN and any others deemed necessary by April 26, 2018;
    b. For each incident requiring outside assistance or resulting in the resident being transferred to another healthcare facility the following procedures will be enacted by the RN or Director:
        i. Review the internal Incident Report Form and investigate the incident;
        ii. Complete an incident report on the HLS Incident Database System;
        iii. Document in the resident file;
        iv. Document on the MHRC Resident Appointment Calendar; and
        v. Be responsible for the follow up mandatory contacts.
4. The Quality Enhancement Team will review the Incident Log at quarterly meetings to identify trends or problems requiring policy changes. The Team will audit a sample of incidents for compliance annually.

S5074 Ch 12 Sec 7 (j)(iii)(A) ALF Core Services.

The facility will maintain appropriate day to day responsibilities for food production and management of the dietary services by:

1. Appointing an Interim Culinary Coordinator to supervise the day to day responsibilities March 20, 2018;
2. Enroll an existing employee in a CDM program to serve Mondell Heights Culinary Services to be completed by May of 2019. A quarterly update on progress will be provided to HLS. (An extension of time will be required for this item to May 1, 2019)

CH 4/27/18 9:19 AM Talked with Diane Baird Hudson, Director and accepted POC, with an Extended POC for CDM. The DOC for S5054 is 4/26/18 the extended POC is 5/2019

Mondell Heights Retirement Community
106 E. Main Street, Newcastle, WY 82701

307-941-1919
Fax-307-460-7007

Updated Plan of Correction for February 22, 2018 Program Survey

S5077 Ch 12 Sec 7(j)(vi) ALF Core Services. Kitchen and Dining Area Kept Clean and Sanitary

The facility will provide for food to be produced according to Food Code 2013, US Public Health Service by the Interim Culinary Coordinator:

1. Providing culinary staff with training on taking and recording temperatures of food before distribution to residents.
    a. The temperatures will be taken and recorded by the culinary staff preparing the meals.
    b. The records will be maintained by the Interim Culinary Coordinator until there is a CDM;
    c. The records will be reviewed at the quarterly Quality Enhancement Team meeting. Appropriate retraining or other changes will be prescribed by the QE Team.

2. Providing culinary staff with training on testing and recording the sanitizing solution used to disinfect surfaces in food service area and the chlorine sanitizer in the dishwasher:
    a. Testing will be completed and documented not less than one time per week by the culinary staff responsible for dishwashing.
    b. The records will be maintained by the Interim Culinary Coordinator / CDM;
    c. The records will be reviewed at the quarterly Quality Enhancement Team meeting. Appropriate retraining or other changes will be prescribed by the QE Team.

3. Culinary staff provided with and trained by the Interim Culinary Coordinator to use pasteurized shell eggs for any egg served with a runny yolk by 3/2/18;
    a. Review by observation of breakfast and monitoring egg ordering by the Interim Culinary Coordinator will be reported to the Quarterly QE Team.

4. The kitchen and dishroom will be brought to a clean and grimefree condition by scraping, priming and painting with a durable scrubbable paint by April 22, 2018;
    a. A mandatory cleaning schedule will be implemented and documented by culinary staff;
    b. The records will be maintained by the Interim Culinary Coordinator / CDM;
    c. The records will be reviewed at the quarterly Quality Enhancement Team meeting. Appropriate retraining or other changes will be prescribed by the QE Team.