PRINTED: 06/27/2018
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF009	A. BUILDING: _____ B. WING _____	C 06/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ABSAROKA	2401 COUGAR AVENUE CODY, WY 82414

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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 6/12/18 through 6/13/18. Also reviewed in the course of the survey was complaint #LIC-18-028. The following common abbreviations are used throughout the document: RN: Registered Nurse ALF: Assisted Living Facility CNA: Certified Nursing Assistant HWD: Health and Wellness Director Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5020	Ch 12 Sec 7 (b)(i)(A) 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. (i) The completion of the ALF 102. (A) The current version of the ALF 102 is the designated screening tool. The form may be	S5020	A - The facility will ensure ALF102 is completed by staff RN minimum annually and when there is change in resident condition. B – A completed ALF102 has been updated by facility RN on Resident #6, #13, #18, #28, #29, #34, #39. In addition a new ALF 102 has been completed on remaining facility residents to comply with minimum annual requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelly Braunig TITLE: Executive Director (X6) DATE: 7-24-18

STATE FORM 6899 X2BW11 If continuation sheet 1 of 6

7/25/18-10:45 Am I spoke with the Executive Director to inform her the plan of correction was accepted. Tim Lord

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S5020	Continued From page 1 updated and/or revised periodically by the Program Division. Providers will be notified of changes in the form. The following guidelines apply to the ALF 102; (I) The ALF 102 is only valid if completed within forty-five (45) days prior to admission and there is no change in the resident's condition. (II) The ALF 102 must be completed and signed by an RN. (III) The ALF 102 may be completed telephonically; however, it must be verified in person by an RN. (IV) A new ALF 102 shall be completed at least annually, and when there is a change in the resident's condition. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure ALF 102 assessments were completed annually for 7 of 8 sample residents ((#6, #13, #18, #28, #29, #34, #39). The findings were: 1. Review of the medical record for resident #6 showed the ALF 102 was not dated or signed. 2. Review of the medical record for resident #13 showed the ALF 102 was last completed on 9/22/16. 3. Review of the medical record for resident #18 showed the ALF 102 was last completed on 9/21/16.	S5020	C - Health and Wellness Director will assign the staff RN the month of May each year to complete an annual ALF102 on each resident in facility. In addition to capture ALF102 completion on change of condition and annually, HWD will create and monitor weekly a spreadsheet signed by nurses when ALF102 is completed upon change of condition along with our care plans. D – The Executive Director will add to quarterly Quality Assurance meeting form a section to ensure that ALF102 has been completed on any change of conditions if this happens prior to annual review. 2nd quarter QA meeting form will include annual ALF102 due on all residents. The HWD will be required to bring along the new weekly monitoring tool / spreadsheet to all QA meetings signed by RN and HWD that ALF102 documents have been completed annually and with all change of conditions to support our care plans.	

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S5020	Continued From page 2 4. Review of the medical record for resident #28 showed the ALF 102 was last completed on 9/21/16. 5. Review of the medical record for resident #29 showed the ALF 102 was last completed on 9/22/16. 6. Review of the medical record for resident #34 showed the ALF 102 was last completed on 9/22/16. 7. Review of the medical record for resident #39 showed the ALF 102 was last completed on 8/16/16. 8. Interview with the executive director and the HWD on 6/13/18 at 10:20 AM revealed the facility did not complete ALF 102s annually, as they were not aware of this requirement.	S5020	The Health and Wellness Director (HWD) will coordinate an in-service with staff RN's to ensure state requirements of completing ALF102 is communicated and the weekly monitoring tool is used. E – Date of Completion: July 31, 2018	
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	A – The facility will ensure RN Assessment is completed by staff RN minimum annually and when there is change in resident condition or upon any significant change in the resident's mental or physical condition. B – A completed RN assessment has been updated by facility RN on Resident #6, #13, #18, #28, #29, #34, #39. In addition a new resident assessment has been completed by staff RN to comply with minimal annual requirements.	

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S5023	Continued From page 3 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 RN completed a resident assessment annually and with a change of condition for 7 of 8 sample residents (#6, #13, #18, #28, #29, #34, #39). The findings were: 1. Review of the medical record for resident #39 showed no evidence an RN completed an annual assessment of the resident. Further, review of the "Resident Log" notes indicated the resident had a "change of condition" on 9/20/17. 2. Review of the medical record for resident #6 showed no evidence an RN completed an annual assessment of the resident. 3. Review of the medical record for resident #13 showed no evidence an RN completed an annual assessment of the resident. 4. Review of the medical record for resident #18 showed no evidence an RN completed an annual assessment of the resident. 5. Review of the medical record for resident #28 showed no evidence an RN completed an annual assessment of the resident. 6. Review of the medical record for resident #29 showed no evidence an RN completed an annual assessment of the resident.	S5023	C - Health and Wellness Director will assign the staff RN the month of May each year to complete minimum annually a full assessment on each resident in facility. . In addition to capture RN assessment completion on change of condition, HWD will create and monitor weekly a spreadsheet to ensure the assessment paperwork is completed upon change of condition by RN that goes along with our care plan updates. D - The Executive Director will add to quarterly Quality Assurance meeting form a section to ensuring RN assessments have been completed on any change of conditions or changes in resident's mental or physical condition if happens prior to annual review. 2nd quarter QA meeting form will include the annual assessments due. The HWD will be required to bring along the new weekly monitoring tool / spreadsheet to all QA meetings signed by RN and HWD that assessment documents have been completed annually and with all change of conditions to support our care plans.	

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S5023	Continued From page 4 7. Review of the medical record for resident #34 showed no evidence an RN completed an annual assessment of the resident. 8. Interview with the executive director and HWD on 6/13/18 at 10:20 AM revealed the facility did not conduct an assessment of residents annually or with a change of condition, as they were not aware it was required.	S5023	The Health and Wellness Director (HWD) will coordinate an in-service with staff RN's to ensure state requirements of completing assessments is communicated and the weekly monitoring tool is used. E – Completion date: July 31, 2018	
S5073	Ch 12 Sec 7 (j)(ii) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (ii) There must be organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome and sanitary in accordance with the rules. The dietetic service must ensure that food prepared is nutritionally adequate in accordance with the Dietary Reference Intakes (DRI) for adults. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview the facility failed to ensure food was properly labeled and dated in 1 of 1 food preparation area (Kitchen). The findings were: 1. Observation of the "True" refrigerator on 6/13/18 at 9:54 AM showed the following: a. A plastic bag labeled "shredded mozzarella cheese" which was not dated. b. A block of sliced yellow cheese wrapped in plastic wrap, which was not labeled or dated.	S5073	A – The facility will ensure that food is properly labeled and dated in food preparation area. B – The Dining staff has properly completed labels with dates on shredded mozzarella, blocks of yellow cheese, pizza shells and all carafes with liquid in them. C – Dining Services Director has ordered and restocked food labels and completed an in – service with his cook staff regarding the requirements for labeling and dating food packages. Dining Director has also ordered and updated helpful charts on used by product information to ensure proper labeling and used by dates. Dining Director will use a daily Pre Shift Meeting Form adding labels are audited and checked daily for proper usage times.	

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S5073	Continued From page 5 2. Observation of the walk-in cooler on 6/13/18 at 9:57 AM showed the following: a. A package labeled "4 pizza shell" dated "use by 6/5." 3. Observation of the "True" refrigerator/freezer combo near the oven showed the following: a. A carafe of white liquid which was not labeled or dated. 4. Interview with cook #1 on 6/13/18 at 10:15 AM revealed all the food in the kitchen storage areas was available for resident consumption and should have been labeled and dated with a use-by date.	S5073	D – Dining Services Director will monitor proper labeling by continuing in-service trainings annually. Contracted Dietician will be contacted by Dining Director to include on monthly and quarterly inspections. The Dining Director will be required to bring his daily Pre shift meeting form to QA to ensure proper labeling and will have these forms checked by Dietician upon her visit. E – Completion Date: July 15, 2018	