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Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF019	A. BUILDING: _____ B. WING _____	07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNDANCE ASSISTED CARE	108 ABBY LANE SUNDANCE, WY 82729

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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 7/11/18 through 7/12/18. The following common abbreviations are used throughout the document: RN: Registered Nurse DON: Director of Nursing ALF: Assisted Living Facility CNA: Certified Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5006	Ch 12 Sec 6 (c) Personnel and Staffing Requirements (c) Background checks. All staff of the assisted living facility shall successfully complete, at a minimum, a State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check and a Department of Family Services Central Registry Screening before direct resident contact. This State Rule and Regulation is not met as evidenced by: Based on employee record review and staff	S5006		

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Wayne Johnson 9/03/18 owner

10/12/18-2:52 PM - I spoke with Linda Johnson and informed her the POC was accepted.

Tim Evans

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S5006	Continued From page 1 interview, the facility failed to ensure background checks were completed for 4 of 4 employees (employee #1, employee #2, employee #3, and employee #4). The census was 14. The findings were: 1. Review of the employment file for employee #1 showed the employee had a start date of 5/23/18. Further review showed there was no DCI criminal background check completed. 2. Review of the employment file for employee #2 showed the employee had a start date of 3/29/17. Further review showed there was no DCI criminal background check completed. 3. Review of the employment file for employee #3 showed the employee had a start date of 8/14/15. Further review showed there was no DCI criminal background check completed. 4. Review of the employment file for employee #4 showed the employee had a start date of 5/19/09. Further review showed there was no DCI criminal background check completed. 5. Interview with the facility manager on 7/12/18 at 2:30 PM revealed she was not aware DCI criminal background checks were required to be completed.	S5006	**S5006** **1 Employee #1,#2,#3 and #4 will have completed background checks by 8-31-18** **2 All records will be reviewed for any additional deficiencies in the completion of the background checks and any additional deficiencies will be corrected.** **3. Management Staff will be instructed as to the current state requirement.** **4 The quality assurance system will be adjusted to include monitoring of reported The personnel and staffing requirements will be updated to include the fingerprint background check.** **5. The completion of this corrective action will be established by 08-31-2018**	
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	S5023		

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S5023	Continued From page 2 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 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 assessment was completed no less than once every 12 months for 3 of 8 sample residents (#1, #12, #13). The findings were: 1. Review of the medical record for resident #1 showed the resident admitted to the facility on 4/24/17 and an annual RN assessment was not completed. 2. Review of the medical record for resident #12 showed the resident admitted to the facility on 8/1/13 and the only RN assessment was dated 8/1/13. 3. Review of the medical record for resident #13 showed the resident admitted to the facility on 9/1/16 and the RN only assessment was dated 9/1/16. 4. Interview with the facility manager on 7/12/18 at 1:32 PM revealed RN assessments were not	S5023	**S5023** **1 Employee #1, #12 and #13 will have completed annual assessments by 8-31-18 The survey and corrective actions will be posted for all residents and employees to review.** **2 All records will be reviewed for any additional deficiencies in the completion of the background checks and any additional deficiencies will be corrected.** **3. Management and Staff will be instructed as to the current state requirement. The Nursing assessment procedure will be completed to include annual assessments for all residents.** **4 The quality assurance system will be adjusted to include monitoring of the requirements which will be updated.** **5. The completion of this corrective action will be established by 08-31-2018**	

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S5023	Continued From page 3 completed annually or with a significant change in resident condition, and she was not aware these assessments were required.	S5023		
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 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	S5054	**S5054** **1. Resident #11 will have a completed incident accident report and the corrective actions will be posted for all residents and employees to review.** **2. Staff will be instructed as to the policy that has been established and all records will be reviewed for any additional deficiencies and any additional deficiencies will be corrected.** **3. Elopements will be included in incident accident reports. Management and Staff will be instructed as to the current state requirement. The Nursing assessment procedure will be updated.** **4 The quality assurance system will be adjusted to include monitoring of the requirements which will be updated.** **5. The completion of this corrective action will be established by 08-31-2018**	

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S5054	Continued From page 4 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; (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.	S5054		

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S5054	Continued From page 5 (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; (J) Copy of all ALF 102's; and (K) Copy of outside contractual responsibilities, if applicable.	S5054		

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S5054	Continued From page 6 This State Rule and Regulation is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure all accidents or incidents affecting residents health, welfare, or safety were reported to the Licensing Division for 1 of 2 sample residents (#11) with incidents of elopement. The findings were: 1. Review of a "Nurse's Notes" entry for resident #11 dated 7/5/18 and timed 4:15 PM showed "A young man came and stated that [resident's name] was walking through yards so I had him point out where. I saw resident walking without his walker on the other side of the block. I grabbed the wheelchair [and] went to pick [him/her] up. [The resident] stated [s/he] was glad to see me cause [s/he] didn't know how much further [s/he] could walk. When asked what happened [s/he] stated that [s/he] went out the door for a little walk [and] got lost. RN notified. [S/he] also did not have [his/her] glasses." 2. Interview with the facility manager on 7/12/18 at 1:32 PM revealed the facility did not complete an incident report or report to the Licensing Division because there was no injury; however, it was confirmed that the resident was off the facility grounds and could not return to the facility without assistance. 3. Review of the policy titled "Incidents/Accidents" last revised 7/2017 showed "...Any incident/Accident that affect the resident's health or wellbeing, the incident must be faxed to the Wyoming State Health Department and area ombudsman within 24 hours of incident. Followed up by an In-House investigation report, to be	S5054		

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S5054	Continued From page 7 completed by the manager and summary and plan of correction sent to the Wyoming State Health Department within five (5) days of the Incident/Accident..."	S5054	S5064 1 Resident #3 will have direct contact with the manger who in turn will take responsibility for involving others who can help. If the manager is unable to direct the desired change then the resident may direct his/her grievance to the resident counsel or owner. A verbal or written response will be given to the resident. The survey and corrective actions will be posted for all residents and employees to review. 2 All records will be reviewed for any additional deficiencies in the concern for residents rights and any additional deficiencies will be corrected. 3. Management Staff will be instructed as to the current state requirement. A grievance log will be created to comply with the applicable standard. Each grievance shall be summarized with a completion date. 4 The quality assurance system will be adjusted to include monitoring of reported concerns. 5. The completion of this corrective action will be established by 08-31-2018	
S5064	Ch 12 Sec 7 (g)(ii) 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: (ii) Documentation of the provider's response to verbal and written resident grievances; This State Rule and Regulation is not met as evidenced by: Based on observation, resident and staff interview, and policy and procedure review, the facility failed to ensure documentation of grievance resolution for 1 of 1 sample resident (#3) who voiced a grievance. The census was 14. The findings were: 1. Interview with resident #3 on 7/11/18 at 2:36 PM revealed the resident had reported concerns with his/her phone to the manager. The resident said s/he was told "we are getting a new one" and the phone concern had not been corrected. 2. Interview with the facility manager on 7/12/18 at 1:32 PM revealed she was aware of the concern related to the telephone and further revealed there was no documentation of the concern or any resolution. The manager was unsure when the resident voiced the concern	S5064		

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S5084	Continued From page 8 about the phone, but revealed it had been more than 10 days. 3. Review of the policy titled "Grievance Resolution" last revised 7/2017 showed "Grievances that cannot be easily resolved or have not been resolved to a resident's satisfaction should be dealt with in the following manner. The resident should direct his/her concern or problem to the manager, who will, in turn, take responsibility for involving others who can help. If the manager is unable to effect the desired change or resolve the matter to the resident's satisfaction, the resident may direct his/her grievance to the resident council or owner. A prompt response will be given to the resident verbally and if desired, in writing..."	S5084	S5067 1 a. The grievance policy and procedures book will be posted for all residents and employees to review. A grievance log will be created to comply with the applicable standard. Each grievance shall be summarized. 2. Staff will be instructed as to the policy established and all records will be reviewed for any additional deficiencies in the concern for residents rights and any additional deficiencies will be corrected.	
S5067	Ch 12 Sec 7 (g) Assisted Living Facility (ALF) Core Services (g) Grievance Procedure. The written grievance procedure shall be posted in a conspicuous place within the facility. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure the grievance policy was posted in a conspicuous location in the facility. The census was 14. The findings were: 1. Observation on 7/12/18 at 12:45 PM showed the grievance procedure was posted on a cork board outside the nursing office; however, it was covered by other documents on the board. 2. Interview with the facility manager on 7/12/18	S5067	3. The grievance procedure will be made clearly visible to all residents 4 The quality assurance system will be adjusted to include monitoring of reported concerns. 5. The completion of this corrective action will be established by 08-31-2018	

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S5067	Continued From page 9 at 1:32 PM revealed she was unsure how facility residents would be aware of the procedure for filing grievances. 3. Review of the policy titled "Grievance Resolution" last revised 7/2017 showed "Grievances that cannot be easily resolved or have not been resolved to a resident's satisfaction should be dealt with in the following manner. The resident should direct his/her concern or problem to the manager, who will, in turn, take responsibility for involving others who can help. If the manager is unable to effect the desired change or resolve the matter to the resident's satisfaction, the resident may direct his/her grievance to the resident council or owner..."	S5067	S5073 1 Pasteurized eggs shall be purchased and used where soft cooked eggs are being prepared or the facility will no longer serve soft cooked eggs. The survey and corrective actions will be posted for all residents and employees to review. 2. Staff will be instructed as to the policy established. 3. Management Staff will be instructed as to the current state requirement. Pasteurized eggs will be used to prevent the growth of bacteria where applicable. 4. The quality assurance system and cooks dietary procedures and requirements will be adjusted to include monitoring of the requirements which will be updated. e. The completion of this corrective action will be established by 08-31-2018	
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, staff interview, and policy and procedure review, the facility failed to ensure food was prepared and served in safe manner in 1 of 1 food preparation area (kitchen). The	S5073		

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S5073	Continued From page 10 census was 14. The findings were: 1. Observation on 7/12/18 at 11:12 AM showed the facility used non-pasteurized eggs for cooking. 2. Interview with the facility manager on 7/12/18 at 11:16 AM revealed the facility made fried eggs for residents and confirmed the staff did not check the temperature of the egg yolks. Further, she was not aware pasteurized shell eggs could be purchased. 3. Review of the policy titled "Food Safety" last revised on 7/2017 showed "...Food will be serviced in such a way as to prevent growth of bacteria..." 4. According to Food Code 2017, U.S. Public Health Service: 3-401.11 "(D) A raw animal FOOD such as raw EGG, raw FISH, raw-marinated FISH, raw MOLLUSCAN SHELLFISH, or steak tartare; or a partially cooked FOOD such as lightly cooked FISH, soft cooked EGGS, or rare MEAT other than WHOLE-MUSCLE, INTACT BEEF steaks as specified in (C) of this section, 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;" 5. According to Food Code 2017, 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:	S5073		

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S5073	Continued From page 11 (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.	S5073		
S5100	Ch 12 Sec 8 (a)(vi) Services Which Cannot Be Provided By Level I Services which cannot be provided by the Level I Assisted Living Facility staff. (a) The following services cannot be provided: (vi) Care of resident whose wandering jeopardizes the health and safety of 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 residents were appropriately placed for 2 of 2 sample residents (#1, #11) whose wandering jeopardized health and safety. The findings were: 1. Review of a "Nurse's notes" entry for resident #1 dated 7/2/18 and un-timed showed "[resident's name] went to hospital at 630ish [sic], had fallen by fence at [business name]. Sheriff's office called to inform that [s/he] was being taken to the hospital..." The following concerns were identified: a. Review of a "Nurse's Notes" entry dated 7/2/18 and un-timed showed "[Resident's name] came back from the hospital at 9:45. [S/he] has 1	S5100		

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S5100	Continued From page 12 cut to the bridge of [his/her] nose, and is wearing a neck brace. [S/he] has a small chip to C1 or C2, but the doctor thought it was an old injury..." b. Review of a "Nurse's Notes" entry dated 7/6/18 and timed 10 PM showed Resident displayed confusion multiple times throughout the day..." c. Review of a "Nurse's Note" entry dated 6/7/18 and timed 1:15 PM showed "CNA went to check on resident [and] couldn't find [him/her] inside the building so I walked around and found [him/her] in between the air conditioning units..." d. Review of a "Nurse's Notes" entry dated 6/23/18 showed "Today I had a phone conversation [with] [resident's name] daughter [name] We visited about [resident's name] progressive dementia. [Resident's name] is incontinent of bowel and bladder 100% of the time, states [s/he] does not know when [s/he] has to go or if [s/he's] going..." e. Review of the medical record showed the resident was placed on 1 hour checks related to incident on 7/2/18. f. Review of the incident log showed the 7/2/18 incident was considered an elopement and the resident was not on facility property at the time of the fall. 2. Review of a "Nurse's Notes" entry for resident #11 dated 7/5/18 and timed 4:15 PM showed "A young man came and stated that [resident's name] was walking through yards so I had him point out where. I saw resident walking without his walker on the other side of the block. I grabbed the wheelchair [and] went to pick [him/her] up. [the resident] stated [s/he] was glad to see me cause [s/he] didn't know how much further [s/he] could walk. When asked what happened [s/he] stated that [s/he] went out the door for a little walk [and] got lost. RN notified.	S5100	**S5100** **1 Resident #1 and #11 will be immediately addresses to ensure the safety of the resident and the survey and corrective actions will be posted for all residents and employees to review.** **2. Staff will be instructed as to the policy established. All records will be reviewed for any additional deficiencies in monitoring residents actions.** **3. Residents who exceed the level of care provided by the facility will be informed in a care conference with representatives of the resident to discuss careful transition to a higher level of care when appropriate and documentation of the process will be made to ensure the safety of the resident. Management and Staff will be instructed as to the current state requirement.** **4 The quality assurance system will be adjusted to include monitoring of the requirements which will be updated.** **5. The completion of this corrective action will be established by 08-31-2018**	

PRINTED: 07/25/2018
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
	ALF019	A. BUILDING: _____ B. WING _____	07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNDANCE ASSISTED CARE	108 ABBY LANE SUNDANCE, WY 82729

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S5100	Continued From page 13 [S/he] also did not have [his/her] glasses." 3. Interview with the facility manager on 7/12/18 at 1:32 revealed the facility does not monitor residents following incidents; however, they placed resident #1 on 1 hour checks after the elopement incident because the resident was not appropriate for assisted living level of care. Further, the facility did not consider the incident with resident #11 an elopement because the resident was not injured; however, it was confirmed that the resident was off facility property and could not return to the facility independently.	S5100		