Healthcare Licensing and Surveys

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 05/22/2023

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 08/24/2020. Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001. 0000 Statement A licensure survey was conducted by Healthcare Licensing and Surveys from 5/16/23 through 5/22/23. Also reviewed in the course of the survey was complaint intake LIC-23-022.	S 000		
S5022	Ch 12 Sec 7 (g) Assisted Living Facility (ALF) Core Services (g) Grievance Procedure. (i) 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: (A) Resident's method to express and document grievances; (B) Documentation of the provider's response to verbal and written resident grievances; (C) List of agencies, with address and telephone numbers for residents to contact if grievances are not addressed satisfactorily (e.g. State Long Term Care Ombudsman and the Department of Health, Office of Licensing and Surveys); and	S5022		

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S5022	Continued From page 1 (D) 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. (ii) The written grievance procedure shall be posted in a conspicuous place within the facility. This ELEMENT is not met as evidenced by: Based on review of facility records, resident representative interview, staff interview, observation, and review of facility policy the facility failed to document receipt and response to resident grievances for 1 of 7 sample residents (#3), and failed to submit required reports to the Ombudsman. In addition, the facility failed to post the written grievance procedure in a conspicuous place. The findings were: 1. Review of facility records on 5/16/23 showed grievance records were not available. 2. Interview with the facility resident care director on 5/16/23 at 8:45 AM revealed the facility had not received any grievances in a long time. 3. Interview with the representative for resident #3 on 5/17/23 at 10 AM revealed a grievance concerning missing medications had been verbally communicated to the facility resident care director on 3/13/23. 4. Interview with regional ombudsman #1 on 5/12/23 at 2:40 PM revealed their agency had received no communications from the facility in the last year. 5. Observation of the facility on 5/16/23 at 9:30 AM showed the grievance procedure was not posted or available to the residents.	S5022		

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S5022	Continued From page 2 6. Interview with Nurse #1 on 5/17/23 at 9:15 AM confirmed there was no public posting of the grievance procedures. 7. Review of the undated policy titled "Wyoming Ombudsman Program" showed "5. Copies of written concerns and grievances and their findings will be maintained by the resident care director files." 8. Interview with the resident care director on 5/19/23 at 9 AM revealed the facility assumed making information on how to contact the Ombudsman available was sufficient and did not need a detailed explanation.	S5022		
S5060	Ch 4 Sec 5 (j)(e) Licensure (j) (E) The Assisted Living Facility shall post the survey results in a manner conducive for public view. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview the facility failed to post survey results in a manner conducive for public review. The facility census was 17. The findings were: 1. Observation of the facility on 5/16/23 showed survey results were not available for public review by residents, their families, or the general public. 2. Interview with nurse #1 on 5/17/23 at 9:15 AM revealed the survey results were not readily available. Later nurse #1 was able to produce the document and revealed it had been located in the resident care director's locked office, in a file	S5060		

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S5060	Continued From page 3 cabinet. Further interview revealed the survey results were not available unless specifically requested.	S5060		

S5022

The facility will be certain to document receipt and response to resident/family grievances and submit required reports to the Ombudsman. The facility will also ensure posting of the grievance procedure in a conspicuous place.

Effective 07/15/23 a Grievance Policy and Procedure will be posted in a conspicuous place within the facility, all grievances will be resolved, responded to in writing, recorded in a Grievance Log, and reported to the Ombudsman and the Licensing Division within (10) days of the receipt of the grievance.

A written response will be supplied by 07/15/23 to the Ombudsman, Licensing Division and Resident's (#3) Representative in reference to the 03/13/23 verbal grievance regarding missing medications.

The Executive Director will be responsible for all matters relating to the Grievance Policy and the Grievance Log including but not limited to; investigating, resolving, responding in writing, reporting to the Ombudsman and Licensing Division and recording on the Grievance Log.

A quarterly review of the Grievance Log by the Executive Director and Nurse Manager will be completed and initialed on the Grievance Log to ensure no incidents have been overlooked.

This issue will be monitored for completion until resolved.

in QAPI 0/3

S5060

The facility will ensure that survey results are available for public review by residents, their families, and/or the general public.

Effective 07/15/23 the most recent survey results will be pinned to a cork board within the front entryway of the facility.

The Executive Director will be responsible for posting the results of each survey upon receipt from the Licensing Division.

A task with the heading "Posted Survey Results" will be add to the Maintenance Quarterly checklist to ensure the results are still attached to the cork board. If missing, the Executive Director will be responsible for replacing.

The Executive Director is responsible for ensuring the completion of the Maintenance Quarterly checklist at the completion of each quarter.

This issue will be monitored for completion until resolved.

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6/19/23 - This revised POC accepted w. th agreed to changes by Renee Knight, Administrator, and Tony Madden, State Health Surveyor - 3