PRINTED: 10/[illegible]/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
	ALF822	A. BUILDING: _____ B. WING _____	C 09/26/2018

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

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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 06/26/2001 A licensure survey was conducted by Healthcare Licensing and Surveys on 9/24/18 through 9/25/18. Also reviewed in the course of the survey was complaint intake LIC-18-037. The following common abbreviations are used throughout the document: ALF: Assisted Living Facility CNA: Certified Nursing Assistant RN: Registered Nurse 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 file review and staff interview, the facility failed to ensure required	S5006		

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys

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

10/26/18

STATE FORM [illegible] C2SM11 [illegible] continuation sheet 1 of 19

Accepted with changes. Changes made based on call with Renee Knight EDC 11/5/18 @ 10:30 am
DOC = 11/2 1.0

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OCT 24 2018
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S5006	Continued From page 1 background checks were completed for 1 of 4 employee files reviewed (CNA #1) prior to direct resident contact. The findings were: 1. Review of the personnel file for CNA #1 showed no evidence the Department of Criminal Investigation (DCI) background check was completed. In addition the Department of Family Services (DFS) registry screen showed a finding of neglect dated 9/6/18. 2. Interview with the administrator on 9/25/18 at 2:22 PM confirmed the DCI background check was not completed, and the finding of neglect from DFS.	S5006		
S5022	Ch 12 Sec 7 (b)(iii)(A-B) 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. (iii) The Registered Nurse shall make an initial assessment of the resident's needs, which describes the resident's capability to perform ADLs and notes all significant impairments in functional capability. (A) Initial assessment. A current assessment shall be maintained in each resident's file. (B) The assessment shall include at least the following information:	S5022		11/12/18

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S5022	Continued From page 2 (I) Medically defined conditions and prior medical history; (II) Physical status; (III) Sensory and physical impairments; (IV) Nutritional status and requirements; (V) Special treatments and/or procedures; (VI) Mental and psychosocial status; (VII) Discharge potential; (VIII) Dental condition; (IX) Activities potential; (X) Rehabilitation potential; and (XI) Medication regimen. (1.) Documentation of resident's ability to self-medicate. This State Rule and Regulation is not met as evidenced by: Based on resident and staff interview, medical record review, and policy and procedure review, the facility failed to ensure the ability to self-medicate was assessed for 8 of 10 sample residents (#1, #2, #3, #5, #6, #7, #8, #9) who received medications from non-licensed staff. The findings were: 1. Review of the "Care Plan" for resident #1, last updated on 7/11/18, showed under the	S5022		

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S5022	Continued From page 3 medications section "Res [resident] will pick up medications at 8am from the nurse office, 8pm med's [sic] will be delivered to res. apt [apartment]." Review of the "assessment and Service Plan" dated 6/2018 showed the resident required staff to order, store and distribute medications. Further review showed no evidence an assessment was completed to determine if the resident was able to safely self-medicate. 2. Review of the physician assessment dated 8/30/18 showed resident #2 had diagnoses which included dementia and adult failure to thrive. In addition, the physician assessment showed the resident was alert to self, and normally confused. Review of the medical record showed no evidence an assessment was completed to determine if the resident was able to safely self-medicate. 3. Review of the physician assessment dated 6/12/17 showed resident #3 had a primary diagnosis of memory loss. Review of the nursing assessment dated 6/17/17 showed the resident was "At times not orientated to time, poor ST [short term]/LT ([long term] memory, history memory impairment." Further review showed no evidence an assessment was completed to determine if the resident was able to safely self-medicate. 4. Review of the physician assessment dated 8/31/18 showed resident #5 had diagnoses which included stroke and status post deep brain stimulator placement. Further review showed no evidence an assessment was completed to determine if the resident was able to safely self-medicate. 5. Review of the "Care Plan" for resident #6, last	S5022		

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S5022	Continued From page 4 updated 6/1/18, showed the resident required "medication administration by staff." Review of the "Assessment and Service Plan" dated 5/30/18 showed the resident required staff to order, store and distribute medications. Further review showed no evidence an assessment was completed to determine if the resident was able to safely self-medicate. Interview with CNA #3 on 9/24/18 at 9:05 PM revealed the resident was confused and unable to identify his/her medications. 6. Review of the "Care Plan" for resident #7, last updated 6/10/18, showed under the medication section "Res. will pick up medications at 8am from the nurse office, 8pm meds will be delvrd [delivered] to res. apt." Review of the "assessment and Service Plan" dated 10/11/17 showed the resident required staff to order, store and distribute medications. Further review showed no evidence an assessment was completed to determine if the resident was able to safely self-medicate. Interview with CNA #3 on 9/24/18 at 9:15 PM revealed the resident had "dementia' and was confused. Further, the resident required "total assist" with care. Interview with the resident on 9/24/18 at 2:25 PM revealed s/he was not aware what medications s/he took. 7. Review of the "Care Plan" for resident #8, last updated 3/16/18, showed under the medication section "Res. will get med's @ [at] 8a & [and] 5p from nurse office." Review of the "Assessment and Service Plan" dated 3/12/18 showed the resident required staff to order, store and distribute medications. Further review showed no evidence an assessment was completed to determine if the resident was able to safely self-medicate.	S5022		

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S5022	Continued From page 5 8. Review of the "Care Plan" for resident #9, last updated on 7/11/18, showed under the medications section "Res [resident] will come to nurse office to get am medications to ensure med's [sic] are taken on time and correctly." Review of the "Assessment and Service Plan" dated 7/7/18 showed the resident required staff to order, store and distribute medications. Further review showed no evidence an assessment was completed to determine if the resident was able to safely self-medicate. Interview with CNA #3 on 9/24/18 at 9:15 PM revealed CNAs "administer" the resident's medications. 9. Interview with the nurse manager on 9/25/18 at 1:48 PM revealed self administration assessments were only completed on residents who were independent with medication administration. 10. Review of the policy titled "Medication Management Policy" received from the facility on 9/25/18 showed "...(II.) After appropriate resident assessment, the Certified Nursing Assistant shall utilize knowledge of Resident's rights, legal and ethical concepts, communication skills, safety, and infection control while...(II.) We will employ a licensed nurse to perform the following:...E. Review self administered medications at least 60-62 days for change and appropriateness of resident to self administer..."	S5022		
S5030	Ch 12 Sec 7 (c)(iii) Assisted Living Facility (ALF) Core Services (c) Resident Rights. The facility shall adopt and follow a written policy of resident rights. The policy shall be posted in a conspicuous place, and there shall be documentation in the resident's	S5030		11/8/18

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S5030	Continued From page 6 record that the resident read, or management explained, the policy. This policy shall not exclude, take precedence over, or in any way abrogate the legal and constitutional rights enjoyed by all adult citizens and shall include, but is not limited to the following: (iii) Free from physical or chemical restraints not required to treat the resident's medical symptoms. No chemical or physical restraints will be used except by order of a physician; This State Rule and Regulation is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to ensure residents were free from physical or chemical restraints for 1 of 10 sample residents (#5). The findings were: Observation on 9/24/18 at 2:51 PM showed resident #5 was seated in a fabric-padded rocking chair in his/her room, with a TABs alarm (alarm used to notify staff if residents are attempting to get up without assistance) attached to his/her clothing. Observation on 9/25/18 at 12:40 PM showed the TABs alarm was attached to the rocking chair while the resident was out of the room. The following concerns were identified: a. Review of physicians orders showed no evidence of an order for TABs alarm use. b. Interview with nurse manager on 9/25/18 at 2:22 PM confirmed the resident should not have had a tabs alarm on.	S5030		
S5052	Ch 12 Sec 7 (d)(iv)(A) Assisted Living Facility (ALF) Core Services (d) Medications.	S5052		10/25/18

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S5052	Continued From page 7 (iv) Medication assistance. (A) The staff shall be responsible for providing necessary assistance to residents deemed capable of self-medicating, but are unable to do so because of a functional disability, in taking oral medications. Non-licensed staff can only assist with oral medications. Medication assistance may include: (I) Reminding resident to take medications; (II) Removing medication containers from storage; (III) Assisting with removal of cap; (IV) Assisting with the removal of a medication from a container for residents with a disability which prevents independence in this act; (V) Observing the resident take the medication; and (VI) Documentation of observation. This State Rule and Regulation is not met as evidenced by: Based on staff and resident interview, resident record review, and policy and procedure review, the facility failed to ensure CNAs only assisted residents with medications who were capable of self-administration but hampered by a functional disability for 3 of 10 sample residents (#4, #6,#7). The findings were: 1. Interview with the nurse manager on 9/25/18 at 1:48 PM revealed the pharmacy packaged	S5052		

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S5052	Continued From page 8	S5052		

resident medications based on medication administration times and the medication packages were reviewed by the RN. The nurse manager confirmed facility CNAs obtained resident medications from the medication storage area and ensured they were given to the appropriate resident. The following concerns were identified:

a. Further interview with the nurse manager on 9/25/18 at 1:48 PM revealed the facility only completed medication self-administration assessments on those residents who were independent with medication.

b. Review of the medication error reports from 4/8/18 through 9/9/18 showed 15 missed doses, 1 wrong dose, and 1 wrong resident. Description of the errors included "were found in another resident's room," "slipped my mind in the confusion/busyness," "accidentally gave to another resident," "missed dose," and "pack found in shadow box not given."

c. Interview with the CNA #2 on 9/24/18 at 9:06 PM stated the facility had a 3-point check system in place where the pharmacy checked the medications and combined the medications into packets for each resident. The RN checked all the medications, verified the medications were correct, put a note on each box for each resident, and indicated when the medications were to be given. The CNA looked at the name on the box and checked the time to give the medications. Narcotics were included in the packet if scheduled. As needed (PRN) narcotics were given by CNAs when requested by the resident.

d. Review of the physician assessment dated 4/27/17 showed resident #4 had diagnoses which included rheumatoid arthritis, and peripheral neuropathy. Review of the resident self-administration guideline dated 8/26/17 showed the resident could not tell the nurse what

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S5052	Continued From page 9 s/he took medications for. e. Review of the "Care Plan" for resident #6 last updated 6/1/18 showed the resident required "medication administration by staff." Review of the "Assessment and Service Plan" dated 5/30/18 showed the resident required staff to order, store and distribute medications. Further review showed there was no evidence an assessment was completed to determine if the resident was able to safely self-medicate. Interview with CNA #3 on 9/24/18 at 9:05 PM revealed the resident was confused and unable to identify his/her medications. f. Review of the "Care Plan" for resident #7 last updated 6/10/18 showed under the medication section "Res. will pick up medications at 8am from the nurse office, 8pm meds will be delvrd [sic] to res. apt." Review of the "Assessment and Service Plan" dated 10/11/17 showed the resident required staff to order, store and distribute medications. Further review showed there was no evidence an assessment was completed to determine if the resident was able to safely self-medicate. Interview with CNA #3 on 9/24/18 at 9:15 PM revealed the resident had "dementia' and was confused. Further, the resident required "total assist" with care. Interview with the resident on 9/24/18 at 2:25 PM revealed s/he was not aware what medications s/he took. g. Review of the policy titled "Medication Management Policy" received from the facility on 9/25/18 showed "...(II.) After appropriate resident assessment, the Certified Nursing Assistant shall utilize knowledge of Resident's rights, legal and ethical concepts, communication skills, safety, and infection control while...(II.) We will employ a licensed nurse to perform the following:...E. Review self administered medications at least 60-62 days for change and appropriateness of resident to self administer..."	S5052		

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S5094	Ch 12 Sec 7 (o)(iii)(A-E) Assisted Living facility (ALF) Core Services (o) Evacuation Capability, Emergency Procedures, and Fire Safety. (iii) Fire Safety. (A) Portable fire extinguishers shall be installed, inspected, and maintained according with NFPA 10, Standard for Portable Fire Extinguishers. (I) State of Wyoming certified individuals shall inspect and service the extinguishers. All extinguishers shall have a tag or label securely attached that indicate the month and year the maintenance was performed and that identifies the person performing the service. (B) Readily available and clearly readable telephone numbers for emergency contacts shall be located near all telephones. (C) Clearly readable floor diagrams reflecting the actual floor arrangement showing the exit locations and evacuation routes shall be posted in conspicuous places. Each resident shall be instructed with its use on the first day of admission. (D) Resident training for the fire emergency plan shall be in accordance with the Life Safety Code Operating Features sections. (I) On the first day of admission, each resident shall be instructed in the proper action of the fire emergency plan, including the location of all the exits. A record of this instruction shall be in each resident file.	S5094		10/25/18

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S5094	Continued From page 11 (E) Fire exit drills shall be conducted in accordance to the Life safety Code Operating Features sections. The minimum number of drills, as amended, shall be held at least twelve (12) times per year on a monthly basis with a minimum of one drill conducted each quarter on each shift. Fire exit drill records over a two-year period shall be available upon request at the facility. (I) The facility shall be responsible for recording fire exit drills on an evaluation form that include at least the following: (1.) Date of drill; (2.) Time of day; (3.) Type of drill (Practice, Announced, Surprise); (4.) Residents who participated including staff and family members; (5.) Time required (minutes and seconds) to evacuate all residents (including staff) from the occupied areas to a point of assembly as defined in the Life Safety Code; (6.) List of anyone, including staff and family members, who did not evacuate in the required time allowed by the evacuation capability rating of the facility. Evacuation capability rating for each facility shall be listed on the form; (7.) Comments on the factors that contributed to each individual's inability to evacuate successfully and any corrective actions	S5094		

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S5094	Continued From page 12 recommended; and (8.) Signature and date of the person completing the form. 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 a record of instruction of the fire emergency plan was available in the medical record for 8 of 10 sample residents (#1,#2, #3, #4, #5, #6, #7, #8). The findings were: 1. Review of the resident record for resident #1 showed the resident admitted to the facility on 6/9/14. Further review showed there was no evidence the facility provided instructions for the fire emergency plan on the first day of admission. 2. Review of the resident record showed resident #2 was admitted on 8/30/18. Further review showed there was no evidence the facility provided instructions for the fire emergency plan on the first day of admission. 3. Review of the resident record showed resident #3 was admitted on 6/15/17. Further review showed there was no evidence the facility provided instructions for the fire emergency plan on the first day of admission. 4. Review of the resident record showed resident #4 was admitted on 5/1/17. Further review showed the resident room orientation included fire alarm/escape route and was initialed; however, there was no date. There was no	S5094		

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S5094	Continued From page 13 evidence the facility provided instructions for the fire emergency plan on the first day of admission. 5. Review of the resident record showed resident #5 was admitted on 8/31/18. Further review showed there was no evidence the facility provided instructions for the fire emergency plan on the first day of admission. 6. Review of the medical record for resident #6 showed the resident admitted to the facility on 6/1/18. Further review showed there was no evidence the facility provided instructions for the fire emergency plan on the first day of admission. 7. Review of the medical record for resident #7 showed the resident admitted to the facility on 10/5/17. Further review showed there was no evidence the facility provided instructions for the fire emergency plan on the first day of admission. 8. Review of the medical record for resident #8 showed the resident admitted to the facility on 3/16/18. Further review showed there was no evidence the facility provided instructions for the fire emergency plan on the first day of admission. 9. Interview with the administrator on 9/25/18 at 2:08 PM revealed the facility does not document instruction provided to residents on the fire procedures. 10. Review of the policy titled "Fire Alarm-Evacuation of Building" dated 2/15/10 showed "...All residents shall be trained in the proper actions to take in the event of a fire..."	S5094		
S5095	Ch 12 Sec 8 (a)(i) Services Which Cannot Be Provided by Level I	S5095		11/8/18

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 09/25/2018

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

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S5095	Continued From page 14 Services which cannot be provided by the Level I Assisted Living Facility staff. (a) The following services cannot be provided: (i) Continuous assistance with transfer and mobility; This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, resident record review, and review of the CNA assignment work-sheets, the facility to ensure 1 of 8 sample residents (#5) were not provided continuous assistance with transfer/mobility. The findings were: 1. Observation on 9/25/18 at 8 AM showed resident #5 had swelling and bruising which was purple in color noted to his/her left upper face. Continued observation showed staff assisted the resident to ambulate, with a walker, toward the dining room while the staff member held a gait belt around the resident's waist. Observation at 8:45 AM showed the resident ambulated with a walker in the hall while a staff member held a gait belt around the resident's waist. Observation at 12:30 PM showed the resident ambulated with a walker toward the dining room while a staff member held a gait belt around the resident's waist. The following concerns were identified: a. Review of a fall risk assessment dated "9/18" showed the resident had a score of 22. Further, the assessment indicated a "Total score of 10 or above represents HIGH RISK." b. Review of an "Incident/Accident Report" dated "9/23" and timed 9 AM showed the resident was "found on floor between bathroom [and] bedroom, walker laying on it's side, incon	S5095		

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S5095	Continued From page 15 [incontinent] of urine, nightgown very wet; mouth [and] nose bleed." There was no evidence the resident was assessed for continued appropriateness of assisted living placement. c. Observation on 9/24/18 at 2:51 PM showed resident #5 was seated in a fabric padded rocking chair in his/her room, with a TABs alarm (alarm used to notify staff if resident's are attempting to get up without assistance) attached to his/her clothing. d. Review of an ALF 102 dated 9/24/18 showed, "...6. Dressing and Personal Grooming - c. Significant assistance or cuing needed on a regular basis. ...9. Mobility - b. Able to transfer and/or ambulate with minimal or standby assistance..." e. Review of the assignment work-sheet titled "CNA's 6AM - 2PM" and "2 PM - 10 PM" received from the facility on 9/25/18 showed resident #5 required "1 person assist - ambulate to all meals." f. Interview with CNA #3 at 9:45 PM revealed resident #5 required total assistance with care. g. Interview with the nurse manager on 9/25/18 at at 2:22 PM revealed she was unsure why the resident had a TABs alarm in use.	S5095		
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	S5100		11/8/18

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S5100	Continued From page 16 evidenced by: Based on observation, resident record review and staff interview, the facility failed to ensure residents were appropriately placed for 1 of 1 sample residents (#1) whose wandering jeopardized the health and safety of the resident. The findings were: 1. Review of the care plan titled "Safety", last revised on 7/15/18, showed resident #1 required monitoring related to "wandering & [and] confusion." The following concerns were identified: a. Observation on 9/25/18 at 12:45 PM showed a security coded exit door by the resident's room was propped open with a large rock. No staff were observed in the area. b. Review of a "Resident Care Note" entry dated 8/5/18 and untimed showed the resident left the facility and traveled to a former residence. The resident notified a previous neighbor that s/he was lost and the neighbor took the resident to the hospital. A former staff member saw the resident outside the facility and notified the facility the resident had left. After notification, the facility contacted local law enforcement regarding the resident's elopement. c. Review of an incident report dated 8/4/18 showed the resident "wandered from the facility" and was taken by a former staff member to the emergency department. The resident had told a neighbor s/he was "lost." d. Review of a "Resident Care Note" entry dated 5/15/18 and untimed showed "Spoke [with] daughter [name] and reviewed [resident's name] wandering and elopement..." e. Review of the "Assessment and Service plan" dated 6/2018 showed "...C. Current and Past Behavioral Issues...Does resident have any behavioral issues present?...wandering..."	S5100		

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S5100	Continued From page 17 f. Interview with the nurse manager and administrator on 9/25/18 at 2:18 PM revealed resident #1 "does well when [s/he] isn't confused" and s/he had been placed on "frequent checks every hour."	S5100		
S5107	Ch 12 Sec 9 (a)(i-v) Contractual Svcs Provided Outside ALF Auth Contractual Services Provided Outside Assisted Living Facility Authority. Residents in an assisted living facility may receive services from an outside entity for care beyond that provided for or specified in the Assisted Living Program Administration Rules. These services must be arranged by the appropriate professional and be incorporated into the resident's assistance plan. The resident's choice of providers must be honored. (a) Components of the outside service(s) contract: (i) Who will provide service(s); (ii) What service(s) will be provided; (iii) When the service(s) will be provided; (iv) Where the service(s) will be provided; (v) How the service(s) will be provided, and This State Rule and Regulation is not met as evidenced by: Based on resident record review, staff interview, and policy and procedure review, the facility failed to ensure a contract was in place with all	S5107		11/8/18

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S5107	Continued From page 18 required parties for 2 of 2 sample residents (#2, #5) who received outside services. The findings were: 1. Review of the medical record showed resident #2 received one on one services from an outside service as of 8/30/18. Further review showed no contract between the facility, the resident, and the service to identify delineation of services and responsibilities. 2. Review of a 8/31/18 physician's order showed resident #5 was to receive physical therapy. Further review showed no contract between the facility, the resident, and the service to identify delineation of services and responsibilities. 3. Interview with the nurse manager on 9/25/18 at 1:21 PM confirmed the facility did not have a copy of the contract for either resident's outside services. 4. Review of the policy titled "outside Contractual Responsibilities" dated 5/17/16 showed "...The resident and/or their family member will communicate with the outside contractor to establish the details of the services to be provided. Upon arrival Agape Manor, Inc. will request the outside contractor fill out a form detailing the services they are providing, to whom the services are provided, and where the services are to be provided..."	S5107		

Agape Manor, Inc. **09/25/18** **P1 of4**

5006

All employees including employee #1 will have the required background checks (DCI and DFS central registry) completed.

A check list will be used to ensure all new employees have these items completed prior to resident contact.

The staff responsible for ensuring the files will be provided education related to the background checks.

The department managers and ED will review the files for completeness and any incomplete files will corrected and discussed in QA each March and September.

Date of completion: 11/09/18

5022

Resident assessments for ability to self-medicate has been completed for residents #1, #2, #3, #6, #7, #8, #9. Resident #5 was discharged on 10/01/18. The completed assessments will be included in the resident record.

All resident records will be reviewed to ensure self-admin of medication assessments are completed. This requirement will be added to the new admission paperwork for nursing and education to nurses **will be provided.**

Audits of the resident records will be conducted by the nurse manager or ED every 60 days and will be discussed in QA quarterly.

Date of completion: 11/12/18

5030

All residents including #5 will be free from physical and chemical restraints not required to treat the **resident's medical symptoms. No chemical or physical restraints will be used except by order of a physician.**

A checklist was created for a one time use of verifying there are no other restraints being used within **the facility.**

All staff training will be provided 11/08/18 and will include use of physical or chemical restraints.

Nurse Manager will continually include use of physical or chemical restraints as a training topic semi-**annually during staff meeting.**

Date of completion 11/08/18.

Agape Manor, Inc. 09/25/18 P2 of 4

5052

Residents #4, #6, #7 as well as all residents have had assessments completed for their ability to self-administer medications. Based on these assessments needed changes will be made to the resident care plans.

Education was provided to all nursing staff related to medication errors and scope of practice. This included steps for providing medication assistance rather than administration for CNAs. In addition, education was provided related to the need for PRN narcotics/medications to be assessed/provided by the on-call RN.

For residents who are deemed safe to self-administer medications, there will be a review done by the nurse every 60-62 days to ensure continued appropriateness.

Random audits will be completed by the nurse manager to ensure staff are providing medication assistance per the guidelines. Any issues or errors will be corrected immediately and reports of the audits will be provided/discussed in quarterly QA meetings.

Date of Completion: 10/25/18

S5094

All medical records including residents #1 thru #8 will include a signed copy of the Resident Policy and Procedure signature sheet, verifying they have been instructed on the Fire Emergency Plan and evacuation routes. #2, #3, #4, #6, #7 Resident #5 was discharged on 10/1/18.

Effective 10/12/18 all residents including #1 thru #8, with the exception of #5, who discharged on 10/01/18, participated in a surprise fire emergency drill and successful evacuation.

All new residents will have documentation in their medical files confirming the facility is providing instruction or fire emergency and means of evacuation on the first day of admission.

Audits of the resident records will be conducted by the nurse manager or ED every 60 days and will be discussed in QA quarterly.

Date of Completion: 10/25/18

Agape Manor, Inc. **09/25/18** **P3 of 4**

S5095

Resident #5 was assessed and given a 30 day discharge notice on 09/25/18 as inappropriate and beyond ALF Level 1 care.

RN will review all residents with form ALF 102 Functional Screening for Assisted Living Facilities upon admission, change of conditions, and annually. CNA #3 is not capable nor is it within her scope of practice to assess or diagnose resident abilities. Care plans will be updated to reflect CNA **responsibilities and ALF Level 1 scope of practice. Medical terminology will be reviewed at quarterly CNA meetings.**

Nurse Manager will review resident files annually to ensure reviews by RN are being completed.

Audits of the resident records will be conducted by the nurse manager or ED every 60 days and will be **discussed in QA quarterly.**

Effective 10/22/18 care plans will be updated to reflect CNA responsibilities and ALF Level 1 scope of practice. Medical terminology will be reviewed at CNA meeting on 11/08/18.

Date of completion 11/08/18

S5100

11/5/18

A Re-evaluation/assessment for resident #1 was completed. The resident was determined to be safe for the level of care.

No exit door in the facility will be propped open at anytime. Staff will revisit building policies at the **upcoming meeting on 11/08/18.**

When a resident appears to be experiencing a higher than base level of confusion the residents Care plan will be updated immediately to include documentation and checks every hour to evaluate level of **confusion and potential for redirection.** resident will be assessed and

RN will review residents upon admission, change of conditions, and annually.

Audits of the resident records will be conducted by the nurse manager or ED every 60 days and will be **discussed in QA quarterly.**

Date of completion 11/08/18

S5107

All residents including, resident #2 and #5 will have a signed contract for any outside services in their medical file. The contract will be between the facility, the resident, and the service to identify delineation of services and responsibilities.

All resident files will have been reviewed, a checklist generated, and all required Outside Services contracts completed and filed in the resident file.

Audits of the resident records will be conducted by the nurse manager or ED every 60 days and will be discussed in QA quarterly.

Date of completion 11/08/18