Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF024	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF BUFFALO	1 NORTH KLONDIKE 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. A revisit survey was conducted on 2/19/25 through 2/20/25 for all previous deficiencies cited on 12/5/24. Also reviewed in the course of the survey was complaint intakes LIC-25-026 and LIC-25-030. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5020	Ch 12 Sec 7 (e) 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;	S5020		

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S5020	Continued From page 1 (C) Individual admission form. This 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 number of resident's personal physician, dentist, ophthalmologist or optometrist; (VI) Medicare number or 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 of safety of a resident shall be provided to the Licensing Division immediately (within one business day). Reporting shall be done by	S5020		

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S5020	Continued From page 2 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 the 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 personal funds 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 of Medicare except for applicable deductible and coinsurance amounts. (F) A signed copy of the resident's rights;	S5020		

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S5020	Continued From page 3 (G) The resident's assessment and individualized assistance plan; (H) Copies of al 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. (ii) The resident shall be assured of confidential treatment of all information in the record, and the resident's written consent (or the consent of the guardian) shall be required for the release of information to persons not otherwise authorized for receive it. (iii) All residents' records shall be retained in a physically secure area for a minimum of six (6) years after the resident has left the facility and may be disposed of, by shredding or burning, after that time. (iv) In the event of dissolution of the facility, the manager shall notify the Licensing Division as to the location of all residents' records. (v) All records shall be protected from damage by fire, water and other hazards. (vi) All entries in each resident's record shall be made in ink, signed and dated.	S5020		

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S5020	Continued From page 4 This State Rule and Regulation is not met as evidenced by: Based on medical record review, staff and resident interview, and state survey agency incident database review, the facility failed to report allegations of financial exploitation for 3 of 5 sample residents (#1, #2, #3) reviewed for incidents. The findings were: 1. Interview with resident #1 on 2/19/25 at 3:09 PM revealed CNA #1 had recently been arrested for taking money and other financial information from residents. Resident #1 revealed the CNA had taken blank checks from the resident's check book and used them to obtain money. The resident revealed the CNA had cashed 3 checks and each were written in the amount of $500. The resident revealed her daughter notified local law enforcement before the resident was aware the incident had occurred. Review of the resident's medical record showed no evidence of an incident report or investigation. 2. Interview with resident #2 on 2/19/25 at 3:55 PM revealed CNA #1 took pictures of her bank cards; however, s/he was not aware of any missing funds. Review of the resident's medical record showed no evidence of an incident report or investigation. 3. Interview with resident #3 on 2/19/25 at 4 PM revealed CNA #1 had taken picture of the resident's bank card and used the information to make purchases and withdraw money. The resident revealed the CNA had taken "about $3000" and the resident was working with his/her bank's fraud department to have it returned. The resident revealed s/he had asked the facility to	S5020		

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S5020	Continued From page 5 contact law enforcement. Interview with the resident on 2/20/25 at 8:49 AM revealed s/he had reported it to the police and the bank. Review of the resident's medical record showed no evidence of an incident report or investigation. 4. Review of the state survey agency incident database showed the facility had not reported any incidents in December 2024, January 2025, or February 2025. 5. Interview with the facility manager on 2/19/25 at 4:33 PM revealed she was aware resident money had been stolen and law enforcement provided the facility with a copy of a no trespass order for CNA #1. The manager revealed she was not aware of how much money had been stolen and when she asked the facility owner about reporting the stolen money, he said they didn't need to. 6. Interview with the facility manager on 2/20/25 at 9:07 AM revealed law enforcement came to the facility on 12/20/24 to talk to resident #1. When the facility manager asked why they needed to speak to the resident, she was told it didn't involve the facility. The facility manager further revealed she found some checks in a file for a resident the following Monday, she notified law enforcement, and CNA #1 was arrested for forgery. The facility manager confirmed the facility owner said they did not need to report the incident.	S5020		

Buffalo

Survey Date: February 21, 2024

Corporate office Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by Willow Creek Community, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. The POC shall only be a required effort to respond to the unsubstantiated and subjectively biased allegations alleged in the survey document. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by Willow Creek Community of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Willow Buffalo 2/21/24

Deficiency: Manager Qualifications (S5000)

- Regulatory Requirement: The facility manager must pass an open book test on Assisted Living Facility Licensure and Program Rules with a score of 85% or higher.
- Plan of Correction:
    - Corrective Action: The facility manager will retake the Assisted Living Manager Test, ensuring the test is submitted to the state survey agency for grading. The manager will achieve a passing score of 85% or greater.
    - Monitoring: Upon completion, the manager's test results will be documented and kept in the personnel file, with the submission and receipt of results confirmed with the state licensing authority.
    - Completion Date: Within 10 days of receiving the statement of deficiencies.

Deficiency: Background Checks (S5002) (S5004)

- Regulatory Requirement: All staff must successfully complete a State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check and Department of Family Services (DFS) Central Registry screening before direct resident contact.
- Plan of Correction:
    - Corrective Action: Background checks and DFS Central Registry screenings will be completed immediately for all staff who did not undergo these checks before resident contact.
    - Preventative Action: The facility will revise its onboarding process to ensure no staff member has resident contact before the completion of required background checks and screenings.

10/23/24- 1:30 pm- Spoke with owner, Eric McMillan, POC Accepted & agreed upon changes. Alleged date of compliance is 10/30/24.

- Monitoring: Human Resources will maintain an audit system to ensure compliance with background check requirements for new hires. Monthly reviews will be conducted to verify compliance.
- Completion Date: All required screenings and checks will be completed within 30 days.

Deficiency: Maintenance and Environmental Safety (S5005)

- Regulatory Requirement: The facility must maintain a safe and clean environment for residents, including repairs to damaged linoleum.
- Plan of Correction:
  - Corrective Action: The damaged linoleum in the kitchen area will be repaired or replaced immediately to prevent trip hazards and ensure a clean, safe environment.
  - Preventative Action: A routine maintenance inspection schedule will be implemented to identify and address facility repair needs proactively.
  - Monitoring: Weekly maintenance checks will be conducted by the facility's maintenance staff, and a report will be submitted to the Director of Nursing (DON) or designee to ensure ongoing compliance with safety standards.
  - Completion Date: Repairs will be completed within 14 days.

Deficiency: Medication Assistance (S5018)

- Regulatory Requirement: An RN must assess each resident's ability to self-administer medication. This assessment was not completed for several residents.
- Plan of Correction:
  - Corrective Action: The RN will conduct medication self-administration assessments for all residents to determine their ability to safely self-administer medications.
  - Preventative Action: A protocol will be established to ensure that all new residents receive an RN assessment for medication self-administration upon admission. The protocol will also ensure regular re-assessments every two months or upon changes in the resident's condition.
  - Monitoring: The DON or designee will audit resident files monthly to verify that assessments are up to date and properly documented.
  - Completion Date: All resident assessments will be completed within 30 days.

Deficiency: Medication Storage (S5019)

- Regulatory Requirement: Medications requiring refrigeration were improperly stored alongside food items in the kitchen.
- Plan of Correction:
  - Corrective Action: All medications requiring refrigeration will be moved to a dedicated medication refrigerator in the office to prevent contamination with food.

- Preventative Action: Staff will be retrained on proper medication storage procedures, including temperature monitoring and segregation of medications from food.
- Monitoring: The temperature of the medication refrigerator will be checked daily, with results logged and reviewed by the DON or designee. Weekly audits will ensure proper storage practices are followed.
- Completion Date: Storage corrections will be completed within 7 days.

Deficiency: Resident Activities Program (S5021)

- Regulatory Requirement: The facility must provide a structured activities program to enhance residents' physical, psychosocial, and spiritual well-being. No organized activities were being offered.
- Plan of Correction:
  - Corrective Action: A dedicated activities coordinator will be appointed to develop and implement a structured activities program, including social, physical, and recreational activities tailored to residents' interests and abilities.
  - Preventative Action: A monthly activities calendar will be created, distributed, and posted in common areas. Resident feedback will be incorporated into the program.
  - Monitoring: The activities coordinator will submit weekly reports on program participation and resident engagement to the DON or designee, and the effectiveness of the activities program will be reviewed during monthly QAPI meetings.
  - Completion Date: A fully implemented activities program will be in place within 30 days.

Deficiency: Grievance Procedure (S5022)

- Regulatory Requirement: The facility must have a written grievance procedure in place and post it in a conspicuous location.
- Plan of Correction:
  - Corrective Action: The facility's written grievance procedure will be updated, posted in a prominent location, and distributed to all residents. Staff will be retrained on how to handle grievances in accordance with this procedure.
  - Monitoring: The DON or designee will review the grievance log monthly to ensure all grievances are properly documented and addressed in a timely manner.
  - Completion Date: The updated grievance procedure will be posted within 7 days.

Completion Timeline:

- Immediate actions will be completed within 7-14 days, depending on the severity of the deficiency.
- Follow-up audits and assessments will continue for three months to ensure sustained compliance.

Date of compliance via telephone was 10/30/24.

10/23/24 - 1:30 PM - Spoke with Eric McMillan. Plan to be accepted with agreed upon changes.

Responsible Party: Manager or designee will be responsible for overseeing all corrective actions, implementing system changes, and conducting regular audits to ensure compliance with state regulations.

DOC: 10/30/24

_____ _____

Eric McMillan, President Date