RR 5/28/14

RECEIVED
WY Dept of Health
MAY 28 2014
Healthcare Licensing and Surveys

Hand-Delivered VAH

PRINTED: 05/09/2014
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
	ALF030	A. BUILDING: ~~Healthcare Licensing and Surveys~~ B. WING	04/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE CHEYENNE, WY 82009

(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
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 number of resident's personal physician, dentist, ophthalmologist or optometrist; (VI) Medicare number of other medical insurance identifying data;	S5054	**S5054** The facility will ensure that all medical records for residents, who require outside services, contain a copy of the signed service agreement between the resident and the outside entity. This will be accomplished by: A) Director of Nursing will contact outside oxygen entities to request a signed copy of the service agreement for Residents #2, #3, and #6. B) Director of Nursing or designee will perform monthly chart audits to ensure all residents, who require assistance from an outside entity, have a signed copy of the service agreement in their medical record. C) Director of Nursing will add: Signed Copy of Resident/Outside Entity Agreement Received, to the Resident Orientation Checklist that is completed on resident admission. DON or designee will request a signed copy of the service	5/30/14

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

EXECUTIVE DIRECTOR 5-27-14

accepted by Landee Rees 5/28/14

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF030	A. BUILDING: _____ B. WING _____	04/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE CHEYENNE, WY 82009

(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
S5054	Continued From page 1 (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. (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.	S5054	agreement upon admission to the facility. D) Director of Nursing will add the plan of correction into Quality Assurance and will ensure that plan is achieved and sustained by reviewing and evaluating at the monthly Quality Assurance meetings. E) Corrective actions will be completed by May 30, 2014 by Director of Nursing or designee.	

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF030	A. BUILDING: _____ B. WING _____	04/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE CHEYENNE, WY 82009

(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
S5054	Continued From page 2 (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. This State Rule and Regulation is not met as evidenced by: Based on observation, medical record review, review of the facility list of residents requiring outside services, and staff interview, the facility failed to ensure the medical record had a copy of outside service agreements concerning oxygen	S5054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF030	A. BUILDING: _____ B. WING _____	04/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE CHEYENNE, WY 82009

(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
S5054	Continued From page 3 for 3 of 3 residents (#2, #3, #6). The findings were: Observations of residents #2, #3, and #6 during the survey from 4/24/14 at 10:40 AM through 4/25/14 at 1:35 PM showed each had oxygen delivered from portable tanks via nasal cannula. Review of the facility document titled, "Residents requiring outside services" showed residents #2, #3, and #6 received oxygen services from outside organizations. Review of the medical record for the residents showed each had physician's orders for oxygen. However, the medical record review showed the facility failed to obtain a copy of agreements with outside entities to provide the oxygen. Interview with the DON on 4/25/14 at 10:30 AM confirmed the facility failed to obtain a copy of the agreements for oxygen services for residents #2, #3, and #6.	S5054	**S5074** The facility will ensure that Dining Services Director receives ServSafe Certification in order to comply with S5074. This will be accomplished by: A) Facility has purchased a ServSafe manual for Dining Services Director and was received on 4/24/14. B) Executive Director will follow-up with Dining Services Director weekly to ensure progress is moving forward. C) Upon completing the manual, Dining Services Director will take the on-line exam for ServSafe Certification. D) Corrective action for completing and receiving ServSafe Certification is June 25th 2014.	6/25/14
S5074	Ch 12 Sec 7 (j)(iii)(A) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (iii) Food service supervision: (A) Day to day responsibilities for food production and management of the dietary services shall be assigned to a person with nutrition and food service management experience equivalent to that of a Certified Dietary Manager. This State Rule and Regulation is not met as evidenced by: Based on staff interview and review of personnel file, the facility failed to ensure the qualifications were met for the dietary manager. The findings	S5074		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF030	A. BUILDING: _____ B. WING _____	04/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE CHEYENNE, WY 82009

(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
S5074	Continued From page 4 were: Interview with the dietary manager on 4/25/14 at 11:10 AM revealed he had been in the position of dietary manager since the facility opened in December of 2013. Previous to this position, the manager had worked in the food service industry for 16 years. Further interview showed he was not certified and was not enrolled in any dietary manager certification program. The dietary manager planned to meet the equivalency based on his experience and certification in ServeSafe (a nationally recognized food safety program). The interview revealed the manager had received a ServeSafe manual on 4/24/14. However, he confirmed he had not taken the ServeSafe test and had no specific date as to when he would take the test. Review of the managers personnel file confirmed he was not certified as a dietary manager, and did not have ServeSafe certification.	S5074	**S5094** The facility will ensure that on the first day of admission, each resident will be instructed in the proper action of the fire emergency plan, including the location of all of the exits. A record of this instruction will be in each resident chart. This will be accomplished by: A) Director of Nursing or designee will review with Residents #1, #2, #3, #4, #5, and #6 the Fire Emergency Plan and obtain resident signature using the new Fire Safety Education form to ensure all safety information has been provided to these residents. B) Director of Nursing or designee will perform monthly chart audits to	5/30/14
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	S5094		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF030	A. BUILDING: _____ B. WING _____	04/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE CHEYENNE, WY 82009

(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
S5094	Continued From page 5 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. (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;	S5094	ensure all residents have been instructed in the Fire Emergency Plan on day of admission and resident signatures have been obtained. C) Director of Nursing will attach the new Fire Safety Education form to the Resident Orientation checklist that is completed on resident admission. This form will contain: Emergency Procedures for a Fire, Emergency Procedure for a Tornado, Evacuation Plan, and Location of Exits. Director of Nursing or designee will review this form with residents on the first day of admission to instruct on the Emergency Plan and will obtain resident signature. D) Director of Nursing will add this plan of correction to Quality Assurance and will ensure that plan is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF030	A. BUILDING: _____ B. WING _____	04/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE CHEYENNE, WY 82009

(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
S5094	Continued From page 6 (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 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 and staff interview, the facility failed to ensure a record of resident education concerning the fire emergency plan was documented in the resident record for 6 of 6 open sample residents (#1, #2, #3, #4, #5, #6). The findings were: Review of the medical records for residents #1, #2, #3, #4, #5, and #6 revealed no documentation	S5094	achieved and sustained by reviewing/evaluating at the monthly Quality Assurance meetings. E) Correction actions will be completed by May 30, 2014 by Director of Nursing or designee.	

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF030	A. BUILDING: _____ B. WING _____	04/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE CHEYENNE, WY 82009

(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
S5094	Continued From page 7 to show residents were educated concerning the facility fire emergency plan. Interview with the director of nursing on 4/25/14 at 10:30 AM confirmed the facility did not document resident education concerning the facility fire emergency plan.	S5094		