STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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
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 the Office of Healthcare Licensing and Surveys on 11/15/17 through 11/16/17. Also reviewed in the course of the survey were complaint intakes LIC-16-007 and LIC-17-026. The following common abbreviations are used throughout the document: ALF- Assisted Living Facility CNA- Certified Nursing Assistant CSD- Clinical Services Director RN- Registered Nurse Less commonly used abbreviations will be annoted in each deficiency.	S 000		
S5020	Ch 12 Sec 7 (b)(i)(A) 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. (i) The completion of the ALF 102. (A) The current version of the ALF 102 is	S5020	S5020 The facility will ensure that the Executive Director and the Clinical Service Director (RN) conducts weekly QA Audits of resident records to ensure ALF 102 assessments are signed and dated. This will be accomplished by the following: A). Resident #9's ALF 102 was reviewed on 11/20/2017. Resident passed away in hospice outside the community on 11/21/17. Every Wednesday the Executive Director and Clinical Services Director (RN) will perform QA Audits of care plans held from the month prior. A reproducible QA audit form will be utilized to ensure compliance with state regulations. Results of the QA audits will be reported to the Quality Assurance team quarterly to ensure continued compliance.	12/31/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 12/15/17

Accepted POC with Jeff Shahan on 12/20/17

POC 1/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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
S5020	Continued From page 1 the designated screening tool. The form may be updated and/or revised periodically by the Program Division. Providers will be notified of changes in the form. The following guidelines apply to the ALF 102; (I) The ALF 102 is only valid if completed within forty-five (45) days prior to admission and there is no change in the resident's condition. (II) The ALF 102 must be completed and signed by an RN. (III) The ALF 102 may be completed telephonically; however, it must be verified in person by an RN. (IV) A new ALF 102 shall be completed at least annually, and when there is a change in the resident's condition. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure ALF 102 forms were were signed and dated for 1 of 10 sample residents (#9) with a change of condition. The findings were: 1. Review of a "Nursing/Progress Note" dated 9/24/17 and untimed showed resident #9 required surgery for a "blood clot" and was hospitalized. The following concerns were identified: a. Review of a "Nursing/Progress Note" dated 10/31/17 and timed 3:50 PM showed the resident returned to the facility following hospitalization and acute rehabilitation. b. Review of the resident's ALF 102 assessments showed an ALF 102 dated 3/16/17	S5020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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
S5020	Continued From page 2 and an ALF 102 that was not signed or dated. c. Interview with the CSD on 11/17/17 at 8:30 AM revealed the ALF 102 that was not dated or signed was completed when the resident returned from the hospital and reflected the resident's level of care. Further, she confirmed the ALF 102 should have been signed and dated.	S5020	S5054 The facility will ensure that the Clinical Services Director (RN), and Assistant Clinical Services Director (RN) will utilize a QA Audit tool to review all incidents requiring an initial nurses note. This will be accomplished by the following: A). Clinical Services Director (RN) has provided education to staff on proper documentation of initial falls on 11/17/17 on all residents including resident #6. A staff sign in roster and agenda will be kept on file for proof of education. B). Upon submitting incidents into the State System Clinical Services Director (RN), and Assistant Clinical Services Director (RN), will complete a Fall Close Out Audit ensuring an initial incident note has been entered into the patient's chart, and monitoring whether additional information is required for follow up to the state. Results of the QA audits will be reported to the Quality Assurance team quarterly to ensure continued compliance.	12/31/17
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	S5054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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 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; (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.	S5054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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 4 (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. (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	S5054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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 5 responsibilities, if applicable. This State Rule and Regulation is not met as evidenced by: Based on medical record review, staff interview, and review the State Agency incident logs, the facility failed to ensure medical records were complete and accurate for 1 of 10 sample residents (#6) who had incidents, accidents, or illness. The findings were: Review of a "Nursing/Progress Note" dated 10/11/17 and untimed showed resident #6 had complaints of bilateral flank pain and was transferred to the hospital for evaluation. Review of a "Nursing/Progress Note" dated 10/14/17 and untimed showed the resident returned from the hospital with a diagnosis of "broken ribs." The following concerns were identified: a. Review of the State Agency incident logs showed the resident had a fall on 10/6/17 and was transferred to the hospital for evaluation and treatment. A CT scan and X-ray were performed and had no findings. b. Review of the "Nursing/Progress notes" between 8/11/17 and 10/7/17 showed no evidence of a fall on 10/6/17. c. Review of "Nursing/Progress Notes" from 10/7/17 to 10/11/17 showed no evidence of any incident that occurred which may have resulted in rib fracture. d. Interview with the CSD on 11/17/17 revealed the rib fracture was the result of the fall on 10/6/17 and a note for the fall should have been made in the resident's record. Further, the facility should have updated the report to the State Agency when they identified the rib fracture.	S5054		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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
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 record review, resident interview, and staff interview, the facility failed to ensure documentation of response for 1 of 1 sample resident (#5) who verbalized a grievance. The findings were; 1. Interview with resident #5 on 11/15/17 at 9:45 AM revealed the resident had reported concerns to the facility related to not having hot water for showers. The resident revealed s/he had to use another room for showers unless s/he got up at 5 AM. As a result, the resident stated s/he only took a shower about 1 time per week. 2. Review of the shower records for resident #5 for September, October, and November 2017 showed the resident received showers on 9/20/17, 9/27/17, 10/4/17, 10/7/17, 11/1/17, and 11/8/17. Further, the resident refused showers on 9/16/17, 10/21/17, and 11/4/17. 3. Interview with the administrator on 11/17/17 at 8:30 AM revealed the facility was aware of cold water concerns as a mixing valve had been identified as being damaged and he was aware	S5064	S5064 The facility will ensure that the Executive Director and Clinical Services Director (RN), will utilize a grievance process and a reproducible resident grievance log. This will be accomplished by the following: A). Residents were educated by the Executive Director on the grievance process and how to utilize the new grievance form. Education took place on 11/22/2017 and, 11/27/2017 during the resident food council and resident council meetings. Staff education will be on 12/20/2017. Grievance resolution was communicated to resident #5 on 12/3/2017. Outside contractor will replace mixing valve for hot water on 12/12/2017. B). Grievance log was created and implemented by Executive Director and Clinical Services Director (RN) to monitor all grievance's and resolutions. Grievance log will be reviewed by Quality Assurance team monthly to ensure continued compliance and resolution to all grievances.	12/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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
S5064	Continued From page 7 that a resident did have to use the shower in another room as a result. Further interview revealed the facility did not document resident grievances or resolution to grievances.	S5064	S5077 The facility will ensure that all the kitchen equipment is clean and in proper working condition. This will be accomplished by the following: A). Dining Services Director has added ice machine cleaning to the morning and afternoon cook duties. Dining Service Director cleaned the ice machine removing build up and debris on 11/16/2017. Executive Director will ensure compliance through weekly dinning service audits. Dining service audits will be reported to the Quality Assurance team monthly. B). Dining Services Director has added water carafe inspections to the monthly dining task list. Existing water carafes that were damaged with cracks and fissures have been disposed of. Executive Director will ensure compliance through weekly dinning service audits. Dinning service audits will be reported to the Quality Assurance team quarterly.	12/31/17
S5077	Ch 12 Sec 7 (j)(vi) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (vi) The kitchen and dining area shall be kept clean and sanitary in accordance with standards established in the current edition of FDA Food Code. The dining area shall provide suitable furniture and adequate space to comfortably seat all residents. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure kitchen equipment and serving utensils were clean and in good repair in 1 of 1 food preparation area (kitchen). The findings were: 1. Observation on 11/15/17 at 9:38 AM showed the ice machine had build-up of debris on the inside of the ice storage compartment. Further, observation at that time showed 2 areas of the steam table cabinets that had the protective formica broken off which exposed the underlying wood and created a surface which could not be cleaned effectively. 2. Observation on 11/15/17 at 9:55 AM showed 11 of 16 water carafes were damaged with cracks and fissures on the inside. 3. Interview with the administrator on 11/17/17	S5077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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
S5077	Continued From page 8 revealed he was not aware of any of the identified areas and confirmed the damaged steam table and water carafes could not be cleaned effectively. 4. According to Food Code 2013, U.S. Public Health Service 4-101.11 " Materials that are used in construction of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT may not be allowed the migration of deleterious substances or impart colors, odors, or tastes to FOOD and under normal use conditions shall be: (A) Safe; (B) Durable, CORROSION-RESISTANT, and nonabsorbent (C) Sufficient in weight and thickness to withstand repeated WAREWASHING; (D) Finished to have a SMOOTH, EASILY CLEANABLE surface; and (E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. "	S5077	C). An outside contractor was obtained and stainless steel countertops were delivered on 12/15/2017 and will be installed on 12/22/2017. All counter tops will be inspected for chips, and cracks weekly by the Executive Director during the weekly Dining Services Audit. Results of the audit will be reported to the Quality Assurance Team quarterly.	
S5082	Ch 12 Sec 7 (k)(i) Assisted Living Facility (ALF) Core Services (k) Transfer and Discharge. (i) Residents shall receive a thirty (30) day written notice prior to any facility initiated transfer or discharge, unless the resident imposes an imminent danger to self and/or others or the resident's level of care exceeds that which can be provided by an assisted living facility. Residents shall have the right to object to the request, except where undue delay might jeopardize the health, safety or well-being of the resident or others. The notice shall include contact information for the Long Term Care Ombudsman.	S5082	S5082 The facility will ensure that 30 day transfer or discharge notice will be issued to resident per state regulations. This will be accomplished by: A). Clinical Services Director will communicate with the Executive Director the patient's that require a 30-day notice for transfer or discharge. All 30 day notices will be issued by the Executive Director of the community. B). All transfers and discharges will be reviewed weekly during the Service Level Meetings to ensure proper notice is given. A reproducible audit form has been created and will be submitted to the Quality Assurance team quarterly to ensure continued compliance.	12/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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
S5082	Continued From page 9 This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to issue a discharge notice to 1 of 2 sample residents (#11) who was discharged from the facility. The findings were: 1. Review of a "Nursing/Progress Note" dated 2/18/17 and untimed showed resident #11 was sent to the hospital related to "changing mental status." The following concerns were identified: a. Review of a "Nursing/Progress Note" dated 3/13/17 and untimed showed the resident was evaluated for discharge from the hospital and the facility was working on changing dialysis times so the resident could return. No further notes were dictated in the "Nursing/Progress Notes." Further, there was no evidence the resident was issued a transfer or discharge notice from the facility. b. Review of a discharge summary dated 3/30/17 showed the resident was discharged from the facility because s/he was "beyond the scope of care for assisted living." c. Interview with the administrator on 11/17/17 at 8:30 AM revealed the facility did not issue a discharge notice when the resident was hospitalized and determined to be above the level of care the facility could provide.	S5082	S5091 The facility will ensure the resident areas remain clean and in good repair. This will be accomplished by the following. A). An outside contractor has been obtained and a bid has been completed to repair the facilities carpet on North 1st floor, South 1st floor and South 2nd floor in the identified areas. Work will commence January 1, 2018 and will end on January 3, 2018. B). Community Maintenance Director will ensure the corner wall near the staff room, left exit door window frame, elevator door and frame, the recreational room lower left door, door frame at the wellness center, doors to rooms 104, 106, 110, 116, 117, 128, 139 will be repaired and painted to cover exposed areas.	1/15/18
S5091	Ch 12 Sec 7 (n)(ii)(A-AA) Assisted Living Facility (ALF) Core Services (n) Furnishings, Buildings, Physical Plant. (ii) Sleeping rooms shall be homelike, well lighted, ventilated and equipped in compliance with the requirements below:	S5091		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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
S5091	Continued From page 10 (A) All windows shall have drapes, curtains, shades or blinds to assurance privacy; (B) Beds (if provided by the facility) shall be at least standard size in width (39"), and shall be equipped with comfortable, clean mattresses and pillows. Mattresses shall be professionally renovated or replaced as needed. Extra long beds shall be used to accommodate tall residents. Rollaway-type beds, cots, and folding beds shall not be used unless the resident brings these items from home for personal use; (I) Two residents may, by consent of both parties; or by approval of the appropriate responsible party, be permitted to use one bed no smaller than double size, and occupy a single-bed sleeping room. (C) Cabinet or bedside table; (D) Non-combustible wastebasket; (E) Chair; and (F) If common closets are utilized by two (2) or more residents, dividers shall be provided for separation of each resident's clothing. All closets shall be equipped with doors. Free-standing closets shall be deducted from the square footage in the sleeping room. (G) The size and arrangement of the residents' beds, furnishings, possessions or equipment shall allow the resident to gain fire emergency access to windows and doors, and access to toilet room. Multiple-bed rooms shall have at least three (3) feet between beds.	S5091	C). Community Maintenance Director will ensure that hand rails adjacent to 115, and 119 on the south hall on the first floor will be repaired and repainted to correct damaged areas. Doors, carpet, and handrails will be placed on the TELS system for monthly maintenance checks to ensure areas are maintained and in good condition. Results of the monthly audit will be submitted to the Quality Assurance team quarterly for review to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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
S5091	Continued From page 11 (H) Residents shall be encouraged to bring personal items and furniture to their rooms, (e.g., beds, chairs, and pictures); (I) There shall be at least one (1) bedside screen per double room available to provide resident privacy when needed; (J) There shall be an adequate supply of hot and cold water available at each lavatory, bathtub/shower, kitchen sink, dishwasher, and laundry equipment. Hot water for bathing, and resident handwashing, and laundry should be no hotter than one hundred and twenty (120°) degrees Fahrenheit. (K) All plumbing shall be maintained in good repair and according to the requirements of the Uniform Plumbing Code; (I) Private water systems shall be safe, potable, and have an adequate supply. Testing shall be done monthly and records of tests shall be retained at the facility. (II) Private water systems shall be tested and found safe and potable before Licensure is granted. (L) Fireplaces shall be securely screened and glassed in; (M) The facility shall be maintained so that it is free of hazards, such as loose or broken window glass, loose or cracked floors or floor coverings, or cracked or loose plaster on wall or ceilings; (N) At least one primary grade level entrance to the building shall be freely accessible for wheelchairs; (O) Each resident shall have his individual comb, toothbrush, towels, and wash cloths; (P) Clean drinking glasses shall be available for the residents. Common drinking	S5091		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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
S5091	Continued From page 12	S5091		

cups are prohibited;

(Q) Bathrooms shall have soap and toilet paper. The facility shall provide paper towels or a blow dryer for hands, or rack space adequate for each resident using the bathroom to hang his/her personal towel. Use of a common towel is prohibited.

(R) Provisions shall be made for privacy in all bath and toilet rooms;

(S) Automatic deodorizers or aerosol fresheners shall not be used except in bathrooms; and

(T) Residents shall not use a common bar of soap. The facility shall provide either soap dispensers or individual bars of soap for each resident.

(U) Housekeeping.

(I) Housekeeping practices and procedures shall be employed to keep the home free from offensive odors, accumulations of dirt, and dust.

(II) Floors shall be maintained and clean.

(III) Polish of floors shall provide a non-slip finish.

(IV) Throw or scatter rugs shall not be used. Non-slip mats may be used.

(V) Covered containers with tight lids shall be used for garbage storage.

(W) The facility shall be maintained free of insects and rodents. All windows shall be screened. All exit doors opening inward shall have a screen door.

(X) Linens and laundry.

(I) Laundry service for linen and residents' personal clothing shall be provided. The manager shall take measures to ensure that residents' clothing is not lost or misplaced while laundering.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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
S5091	Continued From page 13 (II) All linen shall be bagged or placed in a hamper before being transported to the laundry area. (III) Bed linen shall be changed as necessary but at least weekly. Additional blankets or pillows shall be provided. Rubber or water protective sheets shall be used if indicated. (IV) Two (2) complete changes of clean bed linen shall be on hand for each licensed bed. (1.) Torn, worn, or unclean bed linen shall not be used. (V) All bleaches, detergents, disinfectants, and other cleaning agents shall be separated from medicines and foods. (VI) Soiled linen shall not be transported through, sorted, processed, or stored, in kitchens, food preparation areas, or food storage areas. (Y) The heating system shall be inspected yearly, before the heating season, and maintained according to manufacturer's instructions. (Z) Portable space heaters shall not be used (e.g. electric or kerosene) (AA) Equipment Maintenance and Testing. (I) The devices, equipment, systems, conditions, arrangements, levels of protection, or any other features that are required for compliance with the provisions of the Life Safety Code shall be permanently maintained for the building housing the facility. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 5 of 6 resident areas (North 1st floor, North 2nd floor, South 1st floor,	S5091		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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
S5091	Continued From page 14 South 2nd floor, and the Dining area) were clean and in good repair. The findings were: 1. Observation of the North 1st floor on 11/16/17 at 3 PM showed the following concerns: a. The carpet was not secured to the floor in multiple locations and 2 carpet seams were pulling apart. b. The door frame at the wellness center had multiple exposed areas of underlying material on the lower 3 1/2 feet. c. The lower 6 inches of the entrance doors at apartments 128 and 139 were damaged, which exposed underlying material. 2. Observation of the South 1st floor on 11/15/17 at 1:58 PM showed the following: a. The lower 6 inches of the door frames of apartments 104, 106, 110, 116, 117 had chipped off paint, which exposed underlying material and created a surface that could not be clean effectively. b. In the hall between apartment 102 and 104 there was a 3 inch hole in the carpet. c. Observation on 11/15/17 at 1:57 PM showed the hand rails to the left of apartment 119 and 115 in the South 1st floor hallway were damaged and exposed the underlying wood, which created a surface that could not be cleaned effectively. 3. Observation of the main dining area on 11/15/17 at 1:59 PM showed the following concerns: a. The corner of the wall near the staff room was damaged and exposed the underlying material on the lower 4 inches. b. The left exit door window frame had multiple damaged areas that exposed the underlying material.	S5091		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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
S5091	Continued From page 15 4. Observation of the North 2nd floor on 11/15/17 at 10:20 AM showed the following concerns: a. The elevator door and frame revealed multiple damaged areas which exposed the underlying material. b. The recreation room lower left door had damaged metal edging. 5. Observation of the South 2nd floor on 11/15/17 at 10:25 AM revealed the following concerns: a. There was a gap in the carpet seam in the south side hall by the center stairs. 6. Interview 11/17/17 at 9:45 AM with the maintenance supervisor confirmed the concerns.	S5091		