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Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9019	A. BUILDING: _____ B. WING _____	06/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN LODGE LLC	110 BIRCH STREET DOUGLAS, WY 82633

(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 08/28/2001 An initial licensure survey was conducted by Healthcare Licensing and Surveys on 6/4/18 through 6/5/18. The following common abbreviations are used throughout the document: CNA - Certified Nursing Assistant EMR - Electronic Medical Record RN - Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5010	Ch 12 Sec 6(e)(ii)(A-L) Personnel And Staffing Requirements (e) Personnel Policies and Records. (ii) A record for the manager and each employee shall be maintained and contain at a minimum the following information: (A) Name, current address and telephone number; (B) Social Security Number; (C) Education;	S5010		

This plan of correction was accepted on 7/6/2018. Tonja Rothleutner was notified on 7/6/2018 at 1:22pm

Jean Yennie MT (ASCP)

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S6010	Continued From page 1 (D) Work experience, documentation of reference checks; (E) Date of employment (F) Position in the assisted living facility (job description); (G) Documentation of tuberculin testing; (H) Orientation checklist; (I) I-9, (Employment Eligibility Verification); (J) W-4 (Employee's Withholding Allowance Certificate); (K) Licensure, Certification, or Credentials; (e.g., RN, LPN, CNA; and (L) Documentation of all completed background and Central Registry background check with no offenses. This State Rule and Regulation is not met as evidenced by: Based on employee file review, and staff interview the facility failed to ensure personnel files contained all required elements for 4 of 4 employees (CNA #1, CNA #2, CNA #3, RN #1) reviewed. The findings were: 1. Review of the employee file for CNA #1 showed it failed to include a job description, documentation of tuberculosis testing, an orientation checklist, and verification of licensure. 2. Review of the employee file for CNA #2	S6010	The facility will ensure the completeness of the Personnel Policies and Records for every employee by doing the following: A.) CNA #1, an orientation checklist will be used to verify the employee had received the TB test, a job description and that the license was verified. B.) CNA #2, an orientation checklist will be used to verify the employee had received the TB test and a job description. C.) CNA #3, an orientation checklist will be used to verify the employee had	

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S5010	Continued From page 2 showed it failed to include a job description, documentation of tuberculosis testing, and an orientation checklist. 3. Review of the employee file for CNA #3 showed it failed to include a job description, documentation of tuberculosis testing, the I-9 (employment eligibility verification), and an orientation checklist. 4. Review of the employee file for RN #1 showed it failed to include a job description, documentation of tuberculosis testing, and verification of licensure. 5. Interview with the administrator on 6/4/18 at 2:40 PM verified the employee files did not contain all the required information.	S5010	received the TB test, a job description and that the I-9 has been verified. D.) RN #1, an orientation checklist will be used to verify the employee had received the TB test, a job description and that the license was verified. E.) An audit will be completed on all remaining employee records to ensure all required elements are present. 07/15/18 Administrator or designee will receive employee file training from an HR certified individual and will use an orientation checklist to audit the records to ensure all required elements are present for future Mountain Lodge employees. An Accuracy and Completeness of P-files PiP will be created to monitor new employee files. The Administrator or designee will audit all new employee files and the results and corrective actions taken to QAPI where necessary until resolved.	
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 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	S5020		

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S5020	Continued From page 3 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 complete the Functional Screening for Assisted Living Facilities (ALF 102) form for 6 of 7 sample residents (#1, #2, #5, #6, #7, #8) reviewed. The findings were: 1. Review of the ALF 102 for resident #1 failed to show documentation for the following: resident address, date of birth, social security number, contact person information, facility, anticipated admission date, referral source and the credentials of the staff member who filled out the form. 2. Review of the ALF 102 for resident #2 failed to show documentation for the following: anticipated admit date, referral source, and significant medical conditions including allergies. 3. Review of the medical record for resident #5 showed a note dated 6/4/18 that stated "...has home health visits for therapy." Interview with the RN #1 on 6/4/18 at 5:45 PM revealed the resident	S5020	The facility will ensure the completeness and accuracy of the Functional Screening for Assisted Living Facilities (ALF 102) for every resident by doing the following: A.) Resident #1, ALF 102 will be completed with the address, date of birth, social security, contact person information, facility, anticipated admission date, referral source and the credentials of the staff member who completed the form. B.) Resident #2, LF 102 will be completed with the anticipated admit date, referral source, and significant medical conditions including allergies. C.) Resident #5, ALF 102 will be completed to indicate the outside entities providing therapy. D.) Resident #6, ALF 102 will be completed with the address, contact information, anticipated admission date, referral source, allergies, and the credentials of the staff member who signed the form.	

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S5020	Continued From page 4 received therapy after surgery for a hip fracture. Review of the ALF 102 failed to show documentation that indicated the resident had outside entities providing therapy. 4. Review of the ALF 102 for resident #6 failed to show documentation for the following: resident address, contact information, anticipated admission date, referral source, allergies, and the credentials of the staff member who signed the form. 5. Review of the ALF 102 for resident #7 failed to show documentation for the following: resident address, contact person information, significant medical conditions, allergies, and the credentials of the staff member who signed the form. 6. Review of the ALF 102 for resident #8 failed to show documentation for the following: resident address, contact person information, allergies, and the credentials of the staff member who signed the form. 7. Interview on 6/4/18 at 2:13 PM with the administrator confirmed the ALF 102's were not fully completed.	S5020	E.) Resident #7, ALF 102 will be completed with the resident address, contact person information, significant medical conditions, allergies, and the credentials of the staff member who signed the form. F.) Resident #8, ALF 102 will be completed with the resident address, contact person information, allergies, and the credentials of the staff member who signed the form. G.) An audit will be completed on all remaining resident records to ensure the completion of the ALF 102. 07/10/18 Administrator and RN(s) will review the provide education on the importance and necessity of accurate documentation included on the ALF 102 for future Mountain Lodge residents. An ALF 102 PiP will be created to monitor new resident files. The Administrator or designee will audit all new resident files and the results and corrective actions taken to QAPI where necessary until resolved.	
S5021	Ch 12 Sec 7 (b)(ii)(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. (ii) Admission orders. A resident shall be	S5021		

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S5021	Continued From page 5 admitted only if accompanied by a history and physical completed by a physician extender within ninety (90) days prior to admission. The facility shall confirm the resident's medication regimen and special treatment orders at the time of admission. (A) Admission orders shall include an order for TB screening, influenza and pneumococcal immunization status and others for immunization if required, unless contraindicated. The facility must develop and implement policies and procedures to ensure the following: (I) Residents, or their legal representative are educated regarding the risks and benefits of these immunizations. (II) The immunizations are offered unless medically contraindicated or the resident is currently immunized. (III) If the resident is not vaccinated, the medical record must reflect the reason, such as medical contraindication or refusal. This State Rule and Regulation is not met as evidenced by: Based on medical record review, policy and procedure review, resident handbook review, and staff interview, the facility failed to ensure admission orders, including orders for tuberculosis screening, were received and confirmed for 6 of 7 sample residents (#1, #2, #5, #6, #7, #8) reviewed. The findings were: 1. Review of the medical record for resident #1 showed the resident transferred to the facility on 4/30/18 from an assisted living facility in another	S6021	This facility will ensure receipt of accurate and complete admission orders including tuberculosis screening by doing the following: A.) Resident #1, admission orders that include tuberculosis screening and the medication regimen will be obtained. The medication regimen will then be confirmed. B.) Resident #2, admission orders that include tuberculosis screening, immunization(s), and the medication regimen will be obtained. The medication regimen will then be confirmed.	

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S5021	Continued From page 6 town. A history and physical was completed by a physician on 12/16/17 (135 days prior to admission). Further review of the medical record showed no evidence admission orders had been received or the resident's medication regimen had been confirmed. 2. Review of the medical record for resident #2 showed the resident was admitted to the facility on 4/26/18 and had diagnoses which included hypothyroidism, anxiety, brief psychotic disorder, and depression. A history and physical was completed on 4/25/18, however it failed to include admission orders for the resident or include orders for tuberculosis screening or immunizations. There was no evidence the resident's medication regimen had been confirmed. 3. Review of the medical record for resident #5 showed an admission date of 4/4/18. Further review of the medical record showed no evidence admission orders were received or the resident's medication regimen confirmed. 4. Review of the medical record for resident #6 showed an admission date of 4/4/18. Further review of the medical record showed no evidence admission orders were received or the resident's medication regimen confirmed. 5. Review of the medical record for resident #7 showed an admission date of 4/4/18. Further review of the medical record showed no evidence admission orders were received or the resident's medication regimen confirmed. 6. Review of the medical record for resident #8 showed an admission date of 4/4/18. Further review of the medical record showed no evidence	S5021	C.) Resident #5, admission orders that include the medication regimen will be obtained. The medication regimen will then be confirmed. D.) Resident #6, admission orders that include the medication regimen will be obtained. The medication regimen will then be confirmed. E.) Resident #7, admission orders that include the medication regimen will be obtained. The medication regimen will then be confirmed. F.) Resident #8, admission orders that include the medication regimen will be obtained. The medication regimen will then be confirmed. G.) An audit will be completed on all remaining resident records to ensure all required elements of admission are present. This facility will obtain written admission orders that include tuberculosis screening and a full medication regime that can be verified on all existing and future resident's. 07/15/18	

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S5021	Continued From page 7 admission orders were received or the resident's medication regimen confirmed. 7. Review of the "Level 1 Admission and Discharge Criteria" policy created 11/17 showed, "...written orders must be received from the attending physician..." 8. Review of the Mountain Lodge Resident Handbook showed "...written orders must be received from the attending physician..." 9. Interview on 6/4/18 at 4:25 PM with the administrator revealed she thought admission orders were part of the history and physical and verified the facility did not have any further documentation.	S5021	Administrator will in-service the RN(s) on the regulation of written admission orders to include tuberculosis screening and medication regime for all future Mountain Lodge residents. An Admission Orders PiP will be created to monitor new resident files. The Administrator or designee will audit all new resident files and the results and corrective actions taken to QAPI where necessary until resolved.	
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	S5022		

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S5022	Continued From page 8 the following information: (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 medical record review and staff interview the facility failed to ensure an intial nursing assessment was completed by a RN on admission for 7 of 7 sample residents (#1, #2, #3 #5, #6, #7, #8) reviewed. The findings were: 1. Review of the medical records for residents #1, #2, #3, #5, #6, #7, #8 showed no evidence an	S5022	This facility will ensure completion of the initial nursing assessment by an RN be completed for resident #1, #2, #3, #5, #6, #7, and #8. An audit will be completed on all remaining resident records to ensure the completion of the nursing assessment. 07/15/18 Administrator will in-service the RN(s) on the regulation of initial nursing assessments for all future Mountain Lodge residents.	

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S5022	Continued From page 9 Initial nursing assessment was conducted by a RN. Interview on 6/4/18 at 5:45 PM with RN #1 revealed she documented a physical assessment on the back of the ALF 102 because no other means for documentation was available, however her assessment did not include all the required information. Interview with the administrator on 6//4/18 at 2:13 PM confirmed a comprehensive nursing assessment had not been completed. Further, she stated the facility's EMR was not expected to be available for use until sometime in June.	S5022	An Initial RN Assessment PiP will be created to monitor new resident files. The Administrator or designee will audit all new resident files and the results and corrective actions taken to QAPI where necessary until resolved.	
S5025	Ch 12 Sec 7 (b)(vi)(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. (vi) Resident assistance plan. (A) An RN shall develop an assistance plan for each resident. (B) Each facility shall construct its own forms for such plans, which at a minimum shall contain documentation of the following: (I) Who will provide the care/services; (II) What care/services will be provided; (III) When will care/services be provided;	S5025		

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S5025	Continued From page 10 (IV) How the care/services will be provided; (V) The expected outcome; (VI) Resident participation in development of the assistance plan to the extent of his ability to do so. A relative or other interested party may also participate; and (VII) Dated signature of the RN, the facility manager, and the resident or the resident's responsible party. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop an assistance plan of care for 7 of 7 sample residents (#1, #2, #3, #5, #6, #7, #8) reviewed. The findings were: Review of the medical record for residents #1, #2, #3, #5, #6, #7, #8 showed no evidence an assistance plan of care had been developed. Interview with the administrator on 6/4/18 at 5:15 PM verified care plans had not been created.	S5025	This facility will ensure development of assistance plan be completed for residents #1, #2, #3, #5, #6, #7, and #8. An audit will be completed on all remaining resident records to ensure the completion of the assistance plan. 07/15/18 Administrator and the RN(s) will receive training from software company on the development of assistance plans for all future Mountain Lodge residents. A Resident Assessment and Services PiP will be created to monitor new resident files. The Administrator or designee will audit all new resident files and the results and corrective actions taken to QAPI where necessary until resolved.	
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:	S5054		

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S5054	Continued From page 11 (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; (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	S5054		

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S5054	Continued From page 12	S5054		

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.

(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

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	WY9019	A. BUILDING: _____ B. WING _____	06/05/2018

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S5054	Continued From page 13 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 medical record review, and staff interview the facility failed to maintain a complete resident record for 7 of 7 residents (#1, #2, #3, #5, #6, #7, #8) reviewed and further, failed to ensure incidents were reported to the office of Healthcare Licensing and Survey for 1 of 1 (#5) resident with a major injury. The findings were: 1. Interview with the administrator on 6/5/18 at 8:45 AM revealed she had transported resident #1 to the emergency department for an acute illness on 5/26/18. The resident was then hospitalized. Review of the medical record	S5054	This facility will maintain current and organized resident records by doing the following: A.) Any accidents, injuries, incidents, illnesses, and allegations of abuse, neglect or exploitation will be reported to the resident's family or responsible party and be documented in the resident file. B.) Any fall reported to a staff member will be documented and a nursing assessment completed. The family or responsible person will be notified immediately.	

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S5054	Continued From page 14 showed no documentation of the resident's illness or notification of the resident's family or responsible party. 2. Review of the medical record for resident #3 showed a note completed by CNA #1 which documented a 4/18/18 fall in the dining room. Further review showed no evidence a nursing assessment had been completed. 3. Review of the medical record for resident #5 showed a fall event document dated 4/23/18 that detailed a resident fall and transfer to the hospital via ambulance. Further review failed to show evidence of family notification. Interview with RN #1 on 6/4/18 at 5:45 PM revealed the resident had fallen in the facility and sustained a hip fracture. Interview with the administrator on 6/4/18 at 6:12 PM confirmed the resident had sustained a hip fracture, and the injury was not reported to the Licensing Division. She stated she was unaware she was required to report major injuries to the office of Healthcare Licensing and Surveys. 4. Review of the medical record for residents #1, #2, #3, #5, #6, #7, #8 showed no evidence an inventory of personal property had been completed. 5. Interview with the administrator on 6/5/18 at 8:45 AM revealed inventory logs had not been completed and there was no system in place for documenting progress notes in individual records. In addition, she stated the facility's EMR system would not be available for use until sometime in June.	S5054	C.) Any reports of incidents affecting the health, welfare or safety of a resident shall be provided to the Licensing Division within one business day. This facility will complete an audit of all resident record to ensure the medical record is complete with all required information. 07/15/18 Administrator will in-service the staff on their requirements (duties) the resident records and reports regulation for all future Mountain Lodge residents. A Resident Record and Reports PiP will be created to monitor new resident files. The Administrator or designee will audit all new resident files and the results and corrective actions taken to QAPI where necessary until resolved.	

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S5067	Continued From page 15	S5067		
S5067	Ch 12 Sec 7 (g) Assisted Living Facility (ALF) - Core Services (g) Grievance Procedure. The written grievance procedure shall be posted in a conspicuous place within the facility. This State Rule and Regulation is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the facility failed to post the grievance procedure. The census was 8. The findings were: Observation of the facility on 6/4/18 from 10:30 AM to 2:55 PM failed to show the posted grievance procedure. Interview with the administrator on 6/4/18 at 4:50 PM confirmed the grievance procedure was not posted. Review of the grievance procedure and policy created 11/17 showed, "The written grievance procedure shall be posted in a conspicuous place within the facility."	S5067	This facility will post the written grievance procedure in a conspicuous location and notify the residents of its location. 06/30/18 Administrator will in-service the staff and residents on the location of the grievance procedure for all future Mountain Lodge residents. A Grievance Procedure PiP will be created to monitor the posting of the procedure. The Administrator or designee will complete a random audit twice monthly; the results and corrective actions taken to QAPI where necessary until resolved.	
S5073	Ch 12 Sec 7 (j)(ii) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (ii) There must be organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome and sanitary in accordance with the rules. The dietetic service must ensure that food prepared is nutritionally adequate in accordance with the Dietary Reference Intakes (DRI) for adults.	S5073		

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S5073	Continued From page 16 This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, and review of the FDA 2017 food code regulations, the facility failed to ensure food was stored in a manner that was safe for consumption in 1 of 1 kitchen and 2 of 2 resident common areas. The census was 8. The following concerns were identified: 1. Observation on 6/4/18 at 10:30 AM showed the refrigerator in the main kitchen had a plastic storage bag of peeled sliced bananas and a plastic storage bag of meat roll-ups which were unlabeled and undated. In addition the refrigerator contained a vegetable tray; a fruit tray; containers of macaroni salad, egg salad, and an unidentified white substance which were undated and unlabeled. Observation of the freezer at that time showed a plastic storage bag of mixed vegetables, a plastic storage bag of carrots, and a plastic storage bag of broccoli which were unlabeled and undated. Interview on 6/4/18 at 10:40 AM with the dietary aide revealed he was going to discard the food, but had not had time. 2. Observation of the facility on 6/4/18 showed refrigerator/freezers were available for resident use in the activity room and the theatre room. Neither appliance had a thermometer or a log sheet to monitor the temperatures. The freezer in the activity room had two containers of single serve ice cream and a frozen dinner. The refrigerator in the theater room contained a stainless steel bowl of potato salad. 3. Observation and interview with the dietary manager on 6/4/18 at 1:40 PM showed the unlabeled food was still in the kitchen's refrigerator and freezer. The dietary manager	S5073	This facility will ensure that food is stored, prepared, distributed, and served in a manner that is safe and sanitary in accordance with the rules. It will do this by: A.) An immediate audit of the refrigerators and freezers was completed to ensure only packaged, labeled, and dated items remained. B.) Any food items will be packaged, labeled, and dated before storage in any refrigerator or freezer within Mountain Lodge. C.) All refrigerators and freezers will have thermometers and a log to record temperatures. D.) Administrator and Dietary staff will receive education on the importance of discarding any unlabeled and/or undated food items. 07/10/18 Administrator will in-service all staff on the Basics for Handling Food Safely from USDA; which will include storage and temperatures. A Food Services & Nutrition PiP will be created to monitor food safety procedures and temperature logs. The Administrator or designee will complete a monthly audit and take the results and corrective actions to QAPI where necessary until resolved.	

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S5073	Continued From page 17 confirmed the food was unlabeled and undated. In addition, the dietary manager confirmed the temperature of the refrigerator/freezer appliances outside of the kitchen were not monitored. According to Food Code 2017, U.S. Public Health Service: 3-501.17 "(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (D) and (E) of this section, refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days."	S5073		
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 the facility failed to employ a qualified dietary manager. The findings	S5074		

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S5074	Continued From page 18 were: Interview with the dietary manager on 6/4/18 at 1:40 PM revealed she was enrolled in a class to become a certified dietary manager. Interview with the administrator on 6/4/18 at 4:25 PM confirmed the dietary manager was currently enrolled in the "Nutrition and Foodservice Professional Training" course through the University of North Dakota. Review of the enrollment documents showed an enrollment date of 3/23/18. The completion of the course was set for 3/30/19.	S5074	This facility will employ a Dietary Manager who is currently enrolled in the "Nutrition and Foodservice Professional Training" course. The contracted Registered Dietitian (RD) will oversee and ensure the clinical and administrative functions are performed adequately and timely. The RD will also ensure staff training in and follow safe food handling practices. A progress report will be sent to the office of Healthcare Licensing and Surveys monthly.	
S5075	Ch 12 Sec 7 (j)(iv)(A) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (iv) A minimum of three meals in a twenty-four (24) hour period shall be provided to each resident during normal dining hours. In addition, meals and between meal snacks shall be palatable, attractive in appearance, consist of a variety of foods, and shall be served at the proper temperature. (A) Menus shall be planned based on recognized national dietary standards recommended by a Registered Dietitian. Menus shall be prepared at least two weeks in advance and posted in the kitchen. Reasonable substitutions of similar nutritive value must be available to residents who refuse or/are unable to eat the food served. The daily menus shall be corrected to show the food actually served, and the corrected copy kept on file and available for inspection for one (1) year. A current dietary manual shall be approved by the Registered	S5075	A Food Service Supervision PiP will be created to monitor monthly progress and staff training. The RD or Dietary Manager will complete a monthly progress report and take the results and corrective actions to QAPI where necessary until resolved. 04/1/2019	

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S5075	Continued From page 19 Dietitian, and sufficient copies of the approved manual must be available to dietary and nursing staff in the assisted living facility. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview the facility failed to prepare menus at least two weeks in advance and post them in 1 of 1 kitchens. The census was 8. The findings were: Observation and interview with the dietary manager on 6/4/18 at 2:10 PM revealed she received 5 weeks of guidance from the dietitian and used that information to prepare the facility menus, however she only planned for 1 week at a time. The menus were kept in a drawer in the main kitchen.	S5075	This facility will keep two weeks of menus prepared and posted. 06/30/18 Administrator will in-service the dietary staff on the posted two weeks' worth of menus. A Posted Menu PiP will be created to monitor the posted menus. The Administrator or designee will complete a weekly audit and the results and corrective actions taken to QAPI where necessary until resolved.	
S5089	Ch 12 Sec 7 (m)(i)(A-R) Assisted Living Facility (ALF) Core Services (m) Facility Policies and Procedures. (I) Management shall develop policies and procedures that are available to residents and staff, including but not limited to: (A) Resident rights; (B) Disciplinary procedures surrounding substantiated cases of resident abuse; (C) Admission, transfer, bed hold days, and discharge of residents; (D) Medication management; (E) Emergency are of residents (including	S5089		

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S5089	Continued From page 20 missing resident, blizzard, water outage, etc.) (F) Fire/disaster plan; (G) Departure and return; (H) Smoking; (I) Visiting hours; (J) Activities; (K) Management of resident trust accounts; (L) Personnel policies (M) Grievance procedures; (N) Per Diem rate/charges/fees, to include a listing of what is included in the established charges; (O) Incident reports; (P) Notification of change in established per diem rates/charges/fees; (Q) Outside contractual responsibilities; and (R) Identification and notification of change in resident's condition. This State Rule and Regulation is not met as evidenced by: Based on policy and procedure review and staff interview, the facility failed to ensure all required policies and procedures were available to residents and staff. The findings were:	S5089	This facility will develop and make available to resident's a bed-hold or transfer policy. 06/30/18 Administrator will in-service the current residents on the creation and implementation of the bed-hold and transfer policies. Both policies will be added to the Resident Handbook to be provided to all current and future residents of Mountain Lodge. A Bed-hold and Transfer Policy PiP will be created to monitor the implementation of and addition to the handbook. The Administrator or designee will complete the audit and the results and corrective actions taken to QAPI where necessary until resolved.	

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S5089	Continued From page 21 Review of the facility policies failed to show evidence of a bed-hold or transfer policy. Interview with the administrator on 6/4/18 at 5:15 PM revealed the facility did not have policies for bed-hold or transfers.	S5089		
S5093	Ch 12 Sec 7 (o)(ii)(A) Assisted Living Facility (ALF) Core Services (o) Evacuation Capability, Emergency Procedures, and Fire Safety. (ii) Emergency Procedures. (A) Disaster and Emergency Preparedness. (I) The facility shall have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. A copy of the plans shall be available at all times within the facility. (1.) Emergency plans in the event of a fire shall be in accordance to the Life Safety Code Operating Feature sections. (II) The facility shall train all employees in the emergency procedures. New staff shall be trained within the first week of employment. The facility shall review the procedures with all staff at least every twelve (12) months. A training record shall be kept in each personnel file. This State Rule and Regulation is not met as evidenced by: Based on policy review, resident handbook	S5093		

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S5093	Continued From page 22 review, and staff interview the facility failed to provide detailed written plans and procedures to meet all potential emergencies. The findings were: Interview on 6/4/18 at 5:15 PM with the administrator revealed the facility did not have written plans or procedures to prepare for emergency situations. Review of the Emergency Preparedness Policy created 11/17 showed, "...The facility shall have detailed written plans and procedures to meet all potential emergencies and disasters...A copy of the plans shall be available at all times within the facility..." Review of the Mountain Lodge Resident Handbook stated "...the facility shall have detailed written plans and procedures to meet all potential emergencies and disasters...A copy of the plans shall be available at all times within the facility..."	S5093	This facility will develop plans and procedures to meet all potential emergencies likely for Mountain Lodge. 07/15/18 Administrator or designee will in-service current residents and staff on the plans and procedures to meet all potential emergencies for Mountain Lodge (ML). An Emergency Preparedness PiP will be created to monitor the development and in-services for any likely emergencies. The Administrator or designee will complete a monthly audit and the results and corrective actions taken to QAPI where necessary until resolved.	
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	S5094		

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S5094	Continued From page 23 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. (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:	S5094		

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S5094	Continued From page 24 (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 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, policy and procedure review, resident handbook review, and staff interview, the facility failed to provide written documentation of education on the fire emergency plan for 7 of 7 sample residents (#1, #2, #3, #5, #6, #7, #8) reviewed. The findings were:	S5094		

JY 7/6/18

PRINTED: 08/19/2018
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
	WY9019	A. BUILDING: _____ B. WING _____	06/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN LODGE LLC	110 BIRCH STREET DOUGLAS, WY 82633

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S5094	Continued From page 25 Review of the medical record for residents #1, #2, #3, #5, #6, #7, #8 showed no evidence the residents had been educated on the fire emergency plan. Interview with the administrator on 6/4/18 at 4:25 PM revealed she had instructed the residents upon admission, however she did not have any documentation for the resident's files. Review of the Emergency Preparedness Procedure policy dated 11/17 showed "...On the first day of admission each resident shall be instructed in the proper actions of the fire emergency plan...a record of this instruction shall be in each resident file..." Review of the Mountain Lodge Resident Handbook showed "...On the first day of admission, each resident shall be instructed in the proper action of the fire emergency plan... a record of this instruction shall be in each resident file..."	S5094	This facility will develop, in-service, and provide drills on the fire emergency plan to residents #1, #2, #3, #5, #6, #7, and #8; a record of completion will be kept in the resident file. This facility will provide training on the fire emergency plan and drill to all current resident's. Training will be provided to new residents the first day of admission. A record of completion will be kept in the resident file. 06/30/2018 Administrator or designee will in-service current residents and staff on fire emergency plan for Mountain Lodge (ML). A Fire Safety PiP will be created to monitor the drills and in-services for all current and future residents and staff. The Administrator or designee will complete a monthly audit and the results and corrective actions taken to QAPI where necessary until resolved.	
S5108	Ch 12 Sec 9 (b)(i) Contracting 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. (b) Life Safety Code Responsibilities for	S5108		

JZ 7/6/18

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S5108	Continued From page 26 Outside Contractual Services. A contract between the resident, the ALF, and all outside service providers in the ALF must be in place prior to the time of service delivery. This contract must identify the clear delineation of services. (i) The contract must specifically articulate the responsibilities of the resident, the ALF, and all service providers to comply with the Evacuation Capability, Emergency Procedures and Fire Safety requirements in these rules. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure outside service contracts were in place with all required components for 3 of 3 residents (#1, #5, #7) with outside services. The findings were: 1. Review of the medical record showed resident #1 was admitted to the facility on 4/30/18. Review of the discharge orders from the transferring assisted living facility showed the resident had diagnoses which included chronic obstructive pulmonary disease and required assistance with oxygen supplies. Interview with the administrator on 6/4/18 at 4:25 PM revealed the resident used 3 liters of oxygen via nasal cannula and an oxygen supply service was used, however no contract was available. 2. Review of the medical record for resident #5 showed a note dated 6/4/18 that stated "...has home health visits for therapy." Interview with the RN #1 on 6/4/18 at 5:45 PM revealed the resident received therapy for a hip fracture. Interview with the administrator on 6/4/18 at 4:25 PM revealed	S5108	This facility will require contracts from any provider offering services to Mountain Lodge resident's. A.) Resident #1, a contract will be prepared for the resident to receive services from the oxygen supply. B.) Resident #5, a contract will be prepared for the resident to receive home health services. C.) Resident #7, a contract will be prepared for the resident to receive services from the oxygen supply.	

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S5108	Continued From page 27 the resident used home health for therapy, however no contract was available. 3. Observation of resident #7 on 6/4/18 at 10:30 AM showed the resident using supplemental oxygen. Interview with the resident at that time revealed s/he wore oxygen in order to breathe better. Interview on 6/4/18 at 5:45 PM revealed the resident received supplemental oxygen through an outside source, however no contract was available.	S5108	Administrator or designee will require contracts from all outside providers offering services to any resident of Mountain Lodge. 07/15/2018 Administrator or designee will conduct an audit of current residents to ensure contracts are prepared if necessary. Administrator will in-service any outside service providers on resident contract requirements. An Outside Contractual Services PiP will be created to monitor the outside services received for all current and future residents. The Administrator or designee will complete a monthly audit and the results and corrective actions taken to QAPI where necessary until resolved.	

JZ 7/6/18