STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF017	A. BUILDING _____ B. WING _____	C 07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ASSISTED LIVING	950 HOMESTEAD AVENUE RIVERTON, WY 82501

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S 000	Opening Comments Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 12/12/2007 Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001 A licensure survey was conducted by Healthcare Licensing and Surveys on 7/11/18 to 7/12/18. Also reviewed during the survey were complaint intakes LIC-17-018 and LIC-17-037. The following common abbreviations are used throughout this document: CNA- certified nurse aide LPN- licensed practical nurse NA- nurse aide PPD- purified protein derivative; tuberculosis skin test Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5003	Ch 12 Sec 6 (b)(iii) Personnel And Staffing Requirements (b) Staffing. (iii) The assisted living facility shall not employ an individual as a nurse assistant who is not currently certified by the Wyoming State Board of Nursing. Certification must be verified by the manager of the assisted living facility. This State Rule and Regulation is not met as evidenced by:	S5003	The facility will not employ any person as a nurse assistant that is not currently certified by the Wyoming state Board of Nursing Certification will be verified by the administrator prior to person being schedule on the floor. Facility compliance will be met by:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah E. Gallatin | TITLE: RN, ADM | (X6) DATE: 8/3/18

POC accepted. Message left for Deborah Gallatin, Administrator on 8/21/18 @ 8:55 a.m.
DOC = 8/31/18
Janell G

Healthcare Licensing and Surveys

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S5003	Continued From page 1 Based on personnel file review, staff interview, and review of e-mail documentation, the facility failed to ensure a nurse aide had a graduate nurse aide (GNA) permit issued by the Wyoming Board of Nursing for 1 of 1 nurse aides (NA #1). The findings were: 1. Review of the personnel file for NA #1 revealed she was issued a certificate of completion for the Nursing Assistant Training, Competency, and Evaluation Program (NATCEP) on 2/5/18. Further review of the file showed no evidence the NA had a GNA permit issued by the Wyoming Board of Nursing. 2. During an interview on 7/12/18 at 2:26 PM the manager stated the employee started working as a nurse aide in the facility on 3/29/18. She stated the employee was scheduled to take her test on 7/28/18. 3. Review of an e-mail from the manager, dated 7/17/18, showed she had no further documentation to provide when asked if the nurse aide had a GNA permit. 4. Review of the Nurse Practice Act, 33-21-132 Temporary permit, showed "...(c) The board may issue a temporary permit to practice nursing or nurse assisting to a graduate of an approved nursing or nursing assistant education program, pending the results of the first board approved national nursing licensure or certification examination offered after graduation...The temporary permit shall be surrendered in event of failure of the licensure or certification examination. A new graduate holding a temporary permit shall practice only the direction and supervision of a registered professional nurse. A temporary permit for such a request shall be	S5003	No person(s) will be hired or allowed to work as an N.A. without temporary permit from the Wyoming State Board of Nursing. Administrator will verify all permits and licensure prior to hire and annually. Copies will be kept in employee files. All new graduates with temporary permits will practice only under the direction and supervision of an RN Failure of licensure or certification by employee will result in immediate removal of employee from schedule by administrator. N.A #1 has been removed from nursing schedule.	7/23/18 7/23/18 7/23/18 7/23/18 7/23/18

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S5003	Continued From page 2 issued only one (1) time." In addition, according to 33-21-145, Violation; penalties, "...(a) No person shall: (i) Engage in the practice of nursing or nurse assisting as defined in this act without a valid, current license, certificate or temporary permit, except as otherwise permitted under this act or the Nurse Licensure Compact or the Advanced Practice Registered Nurse Compact..."	S5003		
S5006	Ch 12 Sec 6 (c) Personnel and Staffing Requirements (c) Background checks. All staff of the assisted living facility shall successfully complete, at a minimum, a State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check and a Department of Family Services Central Registry Screening before direct resident contact. This State Rule and Regulation is not met as evidenced by: Based on review of personnel files and staff interview, the facility failed to ensure DCI background checks and DFS central registry screenings were completed prior to resident contact for 3 of 3 employees (CNA #1, NA #1, certified dietary manager) reviewed. The findings were: 1. Review of personnel files revealed the following concerns: a. CNA #1 was hired 5/15/17. Further review showed the DFS central registry screening was completed 5/22/17 and the DCI background check was completed 5/26/17. b. NA #1 was hired 12/4/16 (in the dietary department). However, the DFS central registry	S5006	Criminal and DFS backgrounds will be conducted on all new employees prior to the start of employment. Compliance will be met by: At the time of job offer, person will complete the required forms to allow backgrounds to be conducted. Administrator will copy forms, place copies in a designated file, and send originals to appropriate agencies. When backgrounds are returned and no concerns identified. Originals will be placed in employee file, and copies will be destroyed. Only at this time will the new hire be authorized by administrator to be scheduled to work. Certified Dietary manager's DFS background was received and placed in her file.	07/31/18 07/31/18 07/31/18 07/16/18

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S5006	Continued From page 3 screening was not completed until 12/19/16 and the DCI background check was not completed until 12/27/16. c. The certified dietary manager was hired 9/11/17. There lacked evidence of a DFS central registry screening. 2. During an interview on 7/12/18 at 1 PM the manager stated she called DFS and they have a record of doing the screening, but confirmed there was no documentation in the employee's file. In addition, she confirmed DCI background checks and DFS screenings were not always done prior to resident contact.	S5006	Administrator of the facility will ensure all tuberculin testing and/or physician evaluations with follow up plans are completed and placed in employee files for all new hires and annually.	7/31/18
S5008	Ch 12 Sec 6 (d)(ii)(A-F) Personnel and Staffing Requirements (d) Infection Control. Written policies shall be in effect to ensure that newly hired and current employees do not spread a communicable disease that could be transmitted through usual job duties. These shall not be limited to: (ii) Tuberculin Testing. (A) Tuberculin testing must be accomplished for each employee prior to employment and annually thereafter. (B) Employees having known positive skin tests shall provide a certificate of noninfectiousness, recommendations, if any, for treatment, and evidence they have complied with such recommendations. (C) Individuals provide documentation of negative skin test administered within the last twelve (12) months do not require a follow-up	S5008	All employee files will be audited for TB compliance. All employees will be educated to state regulations on TB testing. All TB testing will be conducted in August starting in 2018 and annually thereafter. Employees will be responsible for self scheduling of test and obtaining results. Results of testing or physician's statement of no active disease with follow up recommendations, will be due by the 31st of August. If results or statements are not received by this date, employee will be removed from schedule.	7/24/18 7/31/18 8/31/18 8/31/18

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S5008	Continued From page 4 (D) Individuals who have not had a skin test or who do not have written proof of skin test results, shall have an intradermal Mantoux using 5TU PPD. This shall be accomplished via the two (2) step procedure. If the first test is negative and the employee is asymptomatic, the employee may engage in resident contact prior to the results of the second skin test. (I) A negative reaction requires no follow-up. (II) A positive reaction (10mm in duration suing 5TU PPD) requires a referral to a physician for x-ray and certification of noninfectiousness and appropriate treatment if needed. Follow up shall comply with the recommendations of the attending physician. (E) If symptoms occur, a new certificate of noninfectiousness is required. (F) No person with an airborne, contagious or infectious disease shall be employed until a work release is obtained. (I) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents and their food, if direct contact will transmit a disease. (II) The facility shall require staff to follow universal precautions when performing direct resident care.	S5008	All new employees must provide results of testing or physician's statement with follow up recommendations within the last twelve (12) months. No new employee will be scheduled for work without TB testing results. Administrator will be responsible to ensure compliance is met through employee list, utilizing check off when results are provided during August, then annually thereafter. LPN #1 testing will be completed. CNA #1 provided statement from physician regarding treatment Received ending 9/14/17. C.N.A. #1 will follow up physician for recommendations. Administrator will ensure all documentation is employee's files. Certified Dietary Manager testing will be completed.	7/31/18 8/31/18 8/06/18 8/31/18 7/31/18 8/06/18

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S5008	Continued From page 5 This State Rule and Regulation is not met as evidenced by: Based on review of personnel records and staff interview, the facility failed to ensure annual tuberculin (TB) testing was completed for 3 of 3 employees (LPN #1, CNA #1, certified dietary manager) reviewed. The findings were: 1. Review of personnel files revealed the following concerns: a. LPN #1 was hired 9/12/12. Review of the personnel file showed the last PPD was completed on 3/22/17. b. CNA #1 was hired 5/15/17 and her last PPD was completed on 3/9/17. c. The certified dietary manager was hired 9/11/17 and her last PPD was completed on 1/13/16. 2. During an interview on 7/12/18 at 1 PM the manager stated she had no further documentation of TB testing and stated it appeared they were late.	S5008		
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	S5020	Facility will ensure that all ALF 102 assessments are completed at admission, annually, and with significant change. Compliance will be met by:	

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S5020	Continued From page 6 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 review of resident records and staff interview, the facility failed to ensure the ALF 102 was completed at least annually for 2 of 4 sample residents (#3, #4). The findings were: 1. Review of the resident record showed resident #3 had an ALF 102 dated 11/10/16. 2. Review of the resident record showed resident #4 had an ALF 102 dated 6/4/16. 3. During an interview on 7/12/18 at 1 PM the manager stated she was unable to find any additional ALF 102 forms for either resident.	S5020	All resident charts will be audited for ALF compliance by administrator or designee. Administrator or designee will review all resident overflow charts for missing ALFs. Administrator will complete new ALFs on all residents that have missing forms. All resident charts will have a designated area, identified with tab for filing of ALFs. On completion of ALFs, copy of original will be placed in a binder and kept in Administrator's office. Original will be filed in Resident chart. Administrator or designee will develop running schedule for completion of ALFs. Administrator will complete ALFs on admission, with significant change and annually. Administrator or designee will conduct audits of all resident charts for ALF compliance, monthly x 6 month, if no concerns found, audits will be conducted annually thereafter.	8/10/18 8/10/18 8/10/18 8/10/18 8/10/18 8/10/18 7/31/18
S5088	Ch 12 Sec 7 (I)(i)(A-D) Assisted Living Facility (ALF) Core Services	S5088	New ALFs have been completed	8/10/18

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S5088	Continued From page 7 (l) Quality Improvement. (i) The facility shall have an active quality improvement program to ensure effective utilization and delivery of resident care services. (A) A member of the facility's staff shall be designated to coordinate the quality improvement program. (B) The quality improvement program shall encompass a review of all services and programs provided for all residents. The program shall have: (I) A written description; (II) Problem areas identified; (III) Monitor Identification; (IV) Frequency of monitoring; (V) A provision requiring the facility to complete annually a self assessment survey of compliance with regulations; and (VI) A satisfaction survey shall be provided to the resident, resident's family, or resident's responsible party at least annually. (C) Problems identified during the annual survey or the quality improvement process shall be addressed with appropriate written corrective actions. (D) The quality improvement program shall be re-evaluated at least annually.	S5088	on residents #3 and #4. The facility will have an active quality improvement program to ensure utilization and delivery of resident care services. Compliance will be met by: During Resident Council, a request will be made for them to nominate a fellow resident, to represent them during Quality Improvement program. Administrator will request or assign employees to participate in Quality Improvement program. Program will be designed to determine areas of needed improvement through audits, surveys, resident interviews and complaints received. Team members will be responsible to develop plans, set goals and evaluate progress. Q.I. binder will be developed and will include (1) written description (2) problem areas identified (3) Monitor identification and (4) frequency of monitoring. Q.I program will be evaluated monthly	7/31/18 8/02/18 8/10/18 8/10/18 8/01/18

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S5088	Continued From page 8 This State Rule and Regulation is not met as evidenced by: Based on review of facility documentation and staff interview, the facility failed to have an active quality improvement program. The findings were: When asked to provide quality improvement documentation on 7/11/18 at 3:51 PM the manager stated she was unable to find her QI book. She provided evidence of a QI project for resident shopping dated 2/11/15. She was unable to provide evidence of the written description of the QI program, including problem areas identified, monitor identification, and frequency of monitoring. In addition, she was unable to provide evidence of any QI activities since 2015. Furthermore, she stated the facility did not complete an annual self assessment survey of compliance with the regulations.	S5088	x 6 months to ensure program is addressing all facility and resident concerns. First evaluation. Meetings will be conducted monthly while concerns are are being addressed, then quarterly thereafter. Facility self-survey will be conducted annually. Policies: Employee files: Resident charts:	8/29/18 8/10/18 7/25/18 7/23/18 8/10/18
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;	S5089	Facility will ensure that a policy is in place regarding resident care in the event of a power outage. Compliance will be met by:	

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S5089	Continued From page 9 (D) Medication management; (E) Emergency are of residents (including 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:	S5089		

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S5089	Continued From page 10 Based on policy review and staff interview, the facility failed to develop policies related to power outages. The findings were: 1. During an interview on 7/11/18 at 3:54 PM the manager stated the facility had a power outage last year. She stated power was out in the whole town. She stated residents were concerned, and since then the facility had purchased an emergency generator. 2. Review of the facility's policies showed no policy regarding resident care in the event of a power outage.	S5089	Administrator will develop a policy addressing steps to be taken to ensure resident care and safety in the event of a power outage. Policy will include but not limited to: (1) Actions to be taken by staff, at the time of outage. (2) Ongoing actions by staff throughout outage. (3) Expectations and coverage of generator. (4) Persons to be contact when outage occurs. All staff will be provided education on Power Outage policy.	8/10/18 8/15/18
S5094	Ch 12 Sec 7 (o)(iii)(A-E) Assisted Living facility (ALF) Core Services (o) Evacuation Capability, Emergency Procedures, and Fire Safety. (iii) Fire Safety. (A) Portable fire extinguishers shall be installed, inspected, and maintained according with NFPA 10, Standard for Portable Fire Extinguishers. (I) State of Wyoming certified individuals shall inspect and service the extinguishers. All extinguishers shall have a tag or label securely attached that indicate the month and year the maintenance was performed and that identifies the person performing the service. (B) Readily available and clearly readable telephone numbers for emergency contacts shall be located near all telephones.	S5094		

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S5094	Continued From page 11 (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; (2.) Time of day; (3.) Type of drill (Practice, Announced, Surprise); (4.) Residents who participated	S5094		

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S5094	Continued From page 12 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 review of resident records and staff interview, the facility failed to ensure the resident was instructed on the fire emergency plan on the first day of admission for 2 of 4 sample residents (#2, #3). The findings were: 1. Review of the resident record showed resident #2 was admitted on 6/15/18. Further review showed the resident signed a form dated 6/20/18 that showed s/he was instructed in the fire emergency plan. There lacked evidence the resident received the training on the day of admission. 2. Review of the resident record revealed resident	S5094	Facility will ensure that all new admits are instructed on the fire emergency plan on the first day of admission. Compliance will be met by:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF017	A. BUILDING: _____ B. WING _____	C 07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ASSISTED LIVING	950 HOMESTEAD AVENUE RIVERTON, WY 82501

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S5094	Continued From page 13 #3 was admitted on 11/12/16. Further review showed the resident signed a form dated 11/13/16 which showed the resident had received instruction on the fire emergency plan. There lacked evidence the resident had received the training on the day of admission. 3. During an interview on 7/12/18 at 2:26 PM the manager stated she usually went over the fire emergency plan on the first day, but she stated she did not document that.	S5094	Administrator will develop procedure to ensure all new admits are instructed on fire emergency procedure for residents. All nurses will be educated on the procedure to insure all new admits are instruct on fire emergency plan on first day of admission. At the time of admission assessment, nurse will provide instruction on fire safety and evacuation procedure. After instruction is provided, nurse will answer questions and provide further explanation as needed. When instruction is completed the nurse and resident will sign and date form. Signed form will be filed in resident's chart. Copy of information will be in resident's handbook. Administrator or designee will audit all new admit charts within one (1) week of admission to ensure compliance.	7/31/18 8/02/18 8/02/18 8/02/18 8/02/18

Homestead Assisted Living

Tag:	Plan of Correction Addition:
S5003	Compliance with Certification and/or licensure will be assured through audits and QI monitoring program.
S5006	Compliance with criminal and DFS background checks will be assured through audits and QI monitoring program.
S5008	Compliance with tuberculin testing and physician evaluations with follow up plans will be assured through audits and QI monitoring program.
S5020	Compliance with ALF completion will be assured through audits and QI monitoring program.
S5088	Compliance with QI program will be assured, utilizing self-surveys of policies, employee files, resident charts, resident and family surveys and communications.
S5089	Compliance with Policy and Procedure will be assured through annual self-survey of all current policies and regulation requirements, all deficiencies will be addressed in QI. Annual policy survey and compliance will be an ongoing QI issue.
S5094	Compliance with resident education on fire safety and emergency protocols will be assured through resident chart audits and QI monitoring program.

(original copy signed and dated: 08/20/2018)