PRINTED: 02/22/2019
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
	ALF020	A. BUILDING: _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOMES ASSISTED LIVING	2391 MUDDY STRING RD 117 THAYNE, WY 83127

(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 Healthcare Licensing and Surveys on 2/6/19 through 2/7/19. Also reviewed in the course of the survey was complaint intake LIC-19-017.	S 000		
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 personnel file review, staff interview, and review of schedules, the facility failed to ensure a Division of Criminal Investigation (DCI) background check and a Department of Family Services (DFS) central registry screen was completed prior to resident contact for 3 of 4 employees reviewed (employees #1, #3, #4). The findings were: 1. Review of the personnel file showed employee #1 was a certified nurse aide (CNA) who was	S5006	Management will update current Orientation Checklist, to state that it is a No Resident Contact Orientation. It will also state that it is completed during business hours in unoccupied rooms and employee only spaces. There will also be added an extra signature space for date of completed orientation with no contact and one for when they have completed DCI and DFS checks and can start working with residents. To be completed by March 15,2019 And will be continually monitored through our quality assurance program. A check list will be created that will go into every employee file. With the requirements that are to be in each employee file in order for them to work. Management will insure for future employees that this check list is completed before resident contact is allowed. The ALF will ensure that all new staff will have the DCI finger prints and background check prior to resident contact upon hire. To Be completed by March 15,2019. And will be continually monitored through our quality assurance program.	

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys

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

Owner Administrator 3-9-19

STATE FORM 6899 HC5Y11 If continuation sheet 1 of 12

POC accepted. Left message for Eileen Merrill, Administrator on 4/12/19 @ 2:28 pm. DOC - 3/30/19.

Janelle Cox

RECEIVED
APR 10 2019
Healthcare Licensing and Surveys

PRINTED: 02/22/2019
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
	ALF020	A. BUILDING: _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOMES ASSISTED LIVING	2391 MUDDY STRING RD 117 THAYNE, WY 83127

(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
S5006	Continued From page 1 hired 7/9/18. Review of the staffing schedule showed employee #1 started working on 8/2/18. However, review of the DCI background check showed the results were dated 9/5/18. 2. Review of the personnel file revealed employee #3 was a CNA who was hired 5/11/18. Further review of the personnel file showed no evidence a DCI background check was completed. 3. Review of the personnel file showed employee #4 was hired 6/14/18 as a cook, and then started working as a CNA on 9/12/18. Review of the staffing schedules showed employee #4 started working on 7/18/18. However, review of the DFS central registry screen showed it was not completed until 7/19/18, and the DCI background check was not completed until 7/27/18. 4. During an interview on 2/7/19 at 12:34 PM the manager stated she thought the employee could start working prior to the DCI and DFS checks being completed if they were shadowing another employee.	S5006	Employees # 3 will be temporarily suspended from patient contact until the DCI fingerprints are done again and returned if that want to continue to work for our facility. All employees will continually be monitored through our quality assurance program.	
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.	S5008		

PRINTED: 02/22/2019
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
	ALF020	A. BUILDING: _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOMES ASSISTED LIVING	2391 MUDDY STRING RD 117 THAYNE, WY 83127

(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
S5008	Continued From page 2	S5008		

(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

(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

The facility manager will address employee # 1, # 2, # 3 about getting their TB test / verification .
TB testing or verification will be done by 3/15/2019 or employees # 1, 2, 3 will have suspended resident contact. Management will also add TB test verification to New Personnel/ New hire check list. By 3/15/2019.
And will be continually monitored through our quality assurance program.

PRINTED: 02/22/2019
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
	ALF020	A. BUILDING: _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOMES ASSISTED LIVING	2391 MUDDY STRING RD 117 THAYNE, WY 83127

(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
S5008	Continued From page 3 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. 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 tuberculin testing was completed prior to employment for 3 of 4 employees reviewed (employees #1, #2, and #3). The findings were: 1. Review of the personnel file for employee #1 revealed she was a certified nurse aide (CNA) hired 7/9/18. There lacked evidence of tuberculin testing. 2. Review of the personnel file for employee #2 revealed she was a CNA hired 4/10/18. There lacked evidence of tuberculin testing. 3. Review of the personnel file for employee #3 revealed she was a CNA hired 5/11/18. There lacked evidence of tuberculin testing. 4. During an interview on 2/7/19 at 11 AM the assistant manager confirmed the lack of documentation related to tuberculin testing.	S5008	The facility manager will address employee # 1, # 2, # 3 about getting their TB test / verifications . TB testing or verification will be done by 3/15/2019 or employees # 1, 2, 3 will have suppened resident contact. Management will also add TB test verification to New Personal/ New hire check list. By 3/15/2019.	
S5052	Ch 12 Sec 7 (d)(iv)(A) Assisted Living Facility (ALF) Cora Services (d) Medications.	S5052		

PRINTED: 02/22/2019
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
	ALF020	A. BUILDING: _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOMES ASSISTED LIVING	2391 MUDDY STRING RD 117 THAYNE, WY 83127

(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
S5052	Continued From page 4	S5052		

(iv) Medication assistance.

(A) The staff shall be responsible for providing necessary assistance to residents deemed capable of self-medicating, but are unable to do so because of a functional disability, in taking oral medications. Non-licensed staff can only assist with oral medications. Medication assistance may include:

(I) Reminding resident to take medications;

(II) Removing medication containers from storage;

(III) Assisting with removal of cap;

(IV) Assisting with the removal of a medication from a container for residents with a disability which prevents independence in this act;

(V) Observing the resident take the medication; and

(VI) Documentation of observation.

This State Rule and Regulation is not met as evidenced by:
Based on observation, resident record review, and staff interview, the facility failed to ensure certified nurse aides (CNAs) only provided medication assistance to residents who were deemed capable of self-medicating for 2 of 4 sample residents (#2, #4). The findings were:

1. Observation on 2/6/19 at 1:16 PM revealed CNA #1 brought bubble packs of medications for resident #2 to the resident, and punched the pills

PRINTED: 02/22/2019
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
	ALF020	A. BUILDING: _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOMES ASSISTED LIVING	2391 MUDDY STRING RD 117 THAYNE, WY 83127

(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
S5052	Continued From page 5 out into the resident's open hand. The resident then took the pills. Review of the resident record showed a "medical assessment and consent" (undated by physician, but reviewed by the nurse on 5/9/17) which indicated the resident was unable to administer medications by him/herself. Further review of the resident record showed no assessment to show the resident was capable of self-medicating, but needed assistance due to functional limitations. 2. Observation on 2/6/19 at 1:18 PM revealed CNA #1 brought bubble packs of medications for resident #4 to the resident, and punched the pills out into the resident's hand. The resident then took the pills. Review of the resident record showed admission physician orders dated 6/3/15 which indicated the resident was unable to administer medications by him/herself. Further review of the resident record showed no evidence the resident was capable of self-medicating, but needed assistance due to functional limitations. 3. During an interview on 2/6/19 at 3:20 PM the assistant manager confirmed a lack of documentation to show the residents were deemed capable of self-medicating. She stated the facility developed an assessment form after the last survey, but did not implement the assessment for all current residents.	S5052	Management will hold a meeting with facilities RN by 3/15/2019 to go over and review medication administration form for each resident, including resider #4. To insure that there aren't/are changes that need to be addressed. RN will sign and date bottom of medication evaluation paper of each resident annually or as needed when changes occur with each resident. Management will be sending a new Medication Assistance Evaluation form for all residents including #4 to their physicians to be re-evaluated with clarifications on self administration of medications by 3/30/2019. At which time our facility RN will review annually or when changes with resident occur to stay with in state guide lines. And will be continually monitored through our quality assurance program. Per Surveyor's information stating about an available CNA II MAC license-sure, management Is finding CNA II MAC courses for our current CNA's to obtain.	
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	S5054		

PRINTED: 02/22/2019
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
	ALF020	A. BUILDING: _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOMES ASSISTED LIVING	2391 MUDDY STRING RD 117 THAYNE, WY 83127

(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 6	S5054		

request.

(i) Each folder shall include the following:

(A) Information from the referring agent, if applicable;

(B) History and physical performed by a physician or physician extender;

(C) Individual admission form. The form shall, at a minimum, contain the following information:

(I) Full name of resident and former address;

(II) Date of admission;

(III) Sex, race, date of birth, social security number, and former occupation;

(IV) Name, home address, and telephone number of relative, friend, Power of Attorney, or guardian;

(V) Name, address, and telephone number of resident's personal physician, dentist, ophthalmologist or optometrist;

(VI) Medicare number of other medical insurance identifying data;

(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

PRINTED: 02/22/2019
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
	ALF020	A. BUILDING: _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOMES ASSISTED LIVING	2391 MUDDY STRING RD 117 THAYNE, WY 83127

(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 7	S5054		

exploitation shall be reported to the resident's family or responsible party and be documented in the individual resident records. All such occurrences shall also be reported to the appropriate entity for follow up and resolution. Reports of all incidents affecting the health, welfare or safety of a resident shall be provided to the Licensing Division immediately (within one business day). Reporting shall be done by telephone or fax. The facility's investigation of the incident shall be reported to the Licensing Division and the Long Term Care Ombudsman within five (5) working days. Documentation to support the facility reporting the situation and follow up must also be present in the resident records;

(E) An accounting of all personal funds deposited with and disbursed by the facility;

(I) Upon written authorization of a client, the facility must hold, safeguard, manage and account for the personal funds of the client.

(1.) The facility must deposit any personal funds in excess of $100 in an interest bearing account.

(2.) The facility must establish and maintain a system that assures a full and complete and separate accounting according to generally accepted accounting principles of each resident's personal funds entrusted to the facility.

(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

PRINTED: 02/22/2019
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
	ALF020	A. BUILDING: _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOMES ASSISTED LIVING	2391 MUDDY STRING RD 117 THAYNE, WY 83127

(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 8	S5054		

resident ' s estate.

(4.) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare except for applicable deductible and coinsurance amounts.

(F) A signed copy of the resident's rights;

(G) The resident's assessment and individualized assistance plan;

(H) Copies of all applicable resident assistance contracts, signed by both parties;

(I) Written acknowledgment of the receipt and explanation of all facility policies including admission/discharge policies;

(J) Copy of all ALF 102's; and

(K) Copy of outside contractual responsibilities, if applicable.

This State Rule and Regulation is not met as evidenced by:
Based on review of the Healthcare Licensing and Surveys (HLS) incident database, staff interview, and review of incident reports, the facility failed to report incidents affecting the health, welfare, or safety of a resident to HLS for 3 of 3 incidents reviewed. The findings were:

1. Review of the HLS database prior to survey on 2/5/19 at 11:37 AM revealed the facility had not

PRINTED: 02/22/2019
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
	ALF020	A. BUILDING: _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOMES ASSISTED LIVING	2391 MUDDY STRING RD 117 THAYNE, WY 83127

(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 9 reported any incidents in the past year. 2. On 2/6/19 at 3 PM the facility provided the surveyor with incident reports since October 1, 2018. Review of the incidents showed the following incidents should have been reported to HLS: a. On 10/19/18 resident #6 was taken to the emergency room by ambulance for bleeding. b. On 10/24/18 resident #5 allegedly eloped and was by the road in front of the facility. c. On 12/27/18 resident #3 fell in his room and staff were unable to assist him up. He was transported to the emergency room via ambulance. 3. During an interview on 2/6/19 at 1:39 PM the assistant manager confirmed the incidents were not submitted to HLS. She stated there was a problem with the computer and they were having problems submitting to the electronic incident database.	S5054	Management will submit incident forms on 3/9/2019 for residents #6, #5, #3. Management will contact data base on 3/15/2019 to see if there were any further electronic issues and that they did or didn't receive incident forms. Management will insure that the incident reports will be submitted and will follow up with the data base after the next incident occurs to insure that the issues are/were resolved. And will be continually monitored through our quality assurance program.	
S5088	Ch 12 Sec 7 (l)(i)(A-D) Assisted Living Facility (ALF) Core Services (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	S5088		

PRINTED: 02/22/2019
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
	ALF020	A. BUILDING: _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOMES ASSISTED LIVING	2391 MUDDY STRING RD 117 THAYNE, WY 83127

(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
S5085	Continued From page 10	S5085		

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.

This State Rule and Regulation is not met as evidenced by:
Based on review of quality improvement documentation and staff interview, the facility failed to complete an annual self assessment survey of compliance with the regulations. The findings were:

1. Review of the quality improvement binder showed no evidence the facility had conducted a self assessment survey of compliance with the regulations in the past year. The binder did

PRINTED: 02/22/2019
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
	ALF020	A. BUILDING: _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOMES ASSISTED LIVING	2391 MUDDY STRING RD 117 THAYNE, WY 83127

(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
S5088	Continued From page 11 contain an "Assisted Living Self Assessment" form, but it was blank. 2. During an interview on 2/7/19 at 12:34 PM the manager stated they had not completed a self assessment survey to determine compliance with the regulations.	S5088	Management will hold a meeting on 3/20/2019 for our Annual Self Survey and then a yearly meeting to follow in December to conduct Our Annual Self Survey to make sure that they stay in compliance per state regulations. It will be put in with the facilities Quality Assurance Survey. And will be continually monitored through our quality assurance program.	