Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF030	A. BUILDING. _____ B. WING _____	C 04/15/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 08/24/2020. 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 4/14/21 through 4/15/21. In addition, a complaint investigation prompted by intake number LIC-20-026 and a COVID-19 focused infection control survey were conducted at that time. The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide Less commonly used abbreviations will be annotated in each deficiency	S 000		
S5002	Ch 12 Sec 6 (c) Personnel and Staffing Requirements (c) Background checks. All staff of the assisted living facility shall successfully complete, at 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 employee record review and staff interview, the facility failed to ensure a central registry check was performed for 1 of 6 sample	S5002	Chris Allen Executive Director Primrose Retirement Community, Cheyenne April 27, 2021	

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

Accepted May 14, 2021 Chris Allen was notified. Loralee Russo

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S5002	Continued From page 1 employees (CNA #1) prior to resident contact. The findings were: 1. Review of the employee file for CNA #1 showed the employee had a start date of 2/9/21 and there was no evidence a central registry check was completed prior to resident contact. 2. Interview with the administrator on 4/15/21 at 11:45 AM revealed he was aware of previous employees who did not have a completed central registry screen or background check prior to resident contact and had implemented a new process for newly hired employees which prevented them from starting work until all required documents were obtained.	S5002		
S5006	Ch 12 Sec 7 (b)(i) Assisted Living Facility (ALF) Core Services (b) Resident Assessment and Services, The staff/contract Registered Nurse (RN) shall conduct initial and, at the minimum annually, and 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 completed within forty-five (45) days prior to admission and there is no change in the	S5006		

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	ALF030	A. BUILDING: _____ B. WING _____	C 04/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1630 DOROTHY LANE CHEYENNE, WY 82009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5006	Continued From page 2 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 resident record review, and staff interview , the facility failed to ensure ALF 102 assessments were completed prior to admission for 1 of 12 sample residents (#8) reviewed. The findings were: Review of the resident record showed resident #8 admitted to the facility on 12/3/20 with a primary diagnosis of acute respiratory failure, congestive heart failure, and hypertensive kidney disease. The following concerns were identified: a. Review of the ALF 102 assessment showed it was completed on 1/18/21. b. Interview with the clinical services director on 4/15/21 at 4:36 PM revealed there was no evidence an ALF 102 assessment was completed for the resident prior to admission to the facility.	S5006		
S5007	Ch 12 Sec 7 (b)(ii) Assisted Living Facility (ALF) Core Services (b) (ii) Admission orders. A resident shall be	S5007		

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S5007	Continued From page 3 admitted only if accompanied by a history and physical completed by a physician or 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 orders 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 resident record review, and staff interview, the facility failed to ensure residents were admitted to the facility with a history and physical for 2 of 12 sample residents (#4, #10). In addition, the facility failed to ensure residents had admission orders which included tuberculosis screening, and influenza and pneumococcal immunization if required for 2 of 12 sample residents (#5, #8). The findings were:	S5007		

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S5007	Continued From page 4 1. Review of the resident record for resident #4 showed the resident admitted to the facility on 4/1/21. Further review showed there was no evidence a history and physical was completed prior to admission. 2. Review of the resident record for resident #10 showed the resident admitted to the facility on 4/12/21. Further review showed there was no evidence a history and physical was completed prior to admission. 3. Interview with the clinical services director on 4/15/21 at 2:49 PM revealed the facility did not always received a history and physical for residents prior to or at the time of admission. 4. Review of the resident record for resident #5 showed the resident admitted to the facility on 5/23/18. Further review showed there was no physician's order for tuberculosis screening or influenza and pneumococcal immunization. 5. Review of the resident record for resident #8 showed the resident admitted to the facility on 12/3/20. Further review showed the resident did not have signed admission orders, including orders for tuberculosis screening and influenza and pneumococcal immunization, from a physician until 12/7/20. 6. Interview with the director of nursing on 4/15/21 at 4:36 PM confirmed the residents did not have orders for tuberculosis screening or influenza and pneumococcal immunization.	S5007		
S5046	Ch 12 Sec 7 (o)(iii) Assisted Living Facility (ALF). Core Services	S5046		

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PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE CHEYENNE, WY 82009

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S5046	Continued From page 5 (o) (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. (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) Residents 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)	S5046		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE CHEYENNE, WY 82005

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S5046	Continued From page 6 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. (l) 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 including staff and family members; (5.) The 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:	S5046		

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S5046	Continued From page 7 Based on resident record review and staff interview, the facility failed to ensure a record of instruction for the fire emergency plan was completed on the first date of admission for 3 of 16 sample residents (#1, #3, #5) and stored in the resident's file. The findings were: 1. Review of the resident record for resident #1 showed the resident admitted to the facility on 1/15/19. Further review showed there was no evidence the resident was instructed in the facility fire emergency plan on the day of admission. 2. Review of the resident record for resident #3 showed the resident admitted to the facility on 8/25/18. Further review showed there was no evidence the resident was instructed in the facility fire emergency plan on the day of admission. 3. Review of the resident record for resident #5 showed the resident admitted to the facility on 5/23/18. Further review showed there was no evidence the resident was instructed in the facility fire emergency plan on the day of admission. 4. Interview with the DON on 4/15/21 at 2:49 PM revealed fire evacuation instructions on the first date of admission were performed by the administrator and should be in the resident file the administrator kept in his office. 5. Interview with the administrator on 4/15/21 at 3:55 PM revealed fire evacuation instructions on the first date of admission were performed by the DON and would be kept in the resident's record.	S5046		
S5048	Ch 12 Sec 9 (a)(i) Contractual Svcs Provided Outside ALF Auth	S5048		

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S5048	Continued From page 8 (a) 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. (i) Components of the outside service(s) contract: (A) Who will provide service(s); (B) What service(s) will be provided; (C) When the service(s) will be provided; (D) Where the service(s) will be provided; (E) How the service(s) will be provided; and This State Rule and Regulation is not met as evidenced by: Based on observation, resident record review, and staff and resident interview, the facility failed to ensure contractual agreements were provided for 4 of 4 sample residents (#1, #3, #7, #10) who received services from an entity outside the facility. The findings were: 1. Observation on 4/14/21 at 10:20 AM showed resident #1 had a caregiver in his/her apartment who was not an employee of the facility. Interview with the resident at that time revealed the caregiver assisted with some activities of daily living which the facility was unable to provide. Review of the resident's record showed the	S5048		

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S5048	Continued From page 9 resident did not have a service contract for the services provided by the outside entity. 2. Review of a list of residents provided by the facility on 4/14/21 showed resident #3 received services from an outside entity. Review of the resident's record showed the resident did not have a service contract for the services provided by the outside entity. 3. Review of a list of residents provided by the facility on 4/14/21 showed resident #7 received services from an outside entity. Review of the resident's record showed the resident did not have a service contract for the services provided by the outside entity. 4. Review of a list of residents provided by the facility on 4/14/21 showed resident #10 received services from an outside entity. Review of the resident's record showed the resident did not have a service contract for the services provided by the outside entity. 3. Interview with the DON on 4/15/21 at 2:16 PM revealed the facility did not have service contracts for residents who received assistance from outside entities.	S5048		

PROVIDER'S PLAN OF CORRECTION

Date:	**May 7, 2021**
Provider:	**Primrose Retirement Community of Cheyenne** **1530 Dorothy Lane** **Cheyenne, WY 82009**
Provider/ CLIA Number:	**ALF030**
Survey Completed:	**April 15, 2021**

S5002 Personnel and Staffing Requirements

The administrator received a successful Wyoming Department of Family Services Central Registry Screening on April 22, 2021, for the one staff member identified in the survey as having not had a screening completed prior to direct resident contact. Going forward, the facility administrator has implemented a new hire checklist for each candidate to prevent a new hire from starting work at Primrose prior to the receipt of a successful central registry screening by the facility. Additionally, the facility administrator audited all current employee files and found no other employees missing the Central Registry screening.

S5006 Assisted Living Facility Core Services – ALF 102

The Director of Nursing will ensure that an ALF 102 will be completed for all new admissions prior to admission to the facility and implemented a new admissions checklist on May 1, 2021, to ensure that this takes place for all new admissions going forward. This corrective action will be evaluated by the facility's Quality Assurance team on a monthly basis to ensure 100% compliance.

S5007 Assisted Living Facility Core Services – Admission Orders

The Director of Nursing will ensure that all new residents to the facility will have a history and physical completed by a physician within 90 days prior to admission to the facility. The Director of Nursing implemented a new admission checklist on May 1, 2021, to ensure that this takes place for all new admissions going forward. This corrective action will be evaluated by the facility's Quality Assurance team on a monthly basis to ensure 100% compliance.

The Director of Nursing will ensure that all new residents to the facility will have physicians' orders for a tuberculosis screening and pneumococcal immunization prior to admission to the facility. The Director of Nursing implemented a new admission checklist on May 1, 2021, to ensure that requisite physicians' orders are received for all new admissions going forward prior to admission. This corrective action will be evaluated by the facility's Quality Assurance team on a monthly basis to ensure 100% compliance.

S5046 Assisted Living Core Services – Fire Safety

The facility administrator has implemented a process to instruct all new admissions of the facility's fire emergency plan on the day of admission and to document evidence of training in the resident file. The facility administrator has implemented a new admission checklist to ensure that the required evidence of training is obtained and retained on admission. Additionally, the facility's fire evacuation instructions will be deployed to all residents at the monthly resident meeting on May 12, 2021, and incorporated into monthly education on fire safety at each monthly resident meeting going forward to ensure that 100% of our residents are provided and reminded of the facility's fire evacuation procedures.

S5048 Contractual Services Provided – Third-Party Contracts

The Director of Nursing has obtained outside services contracts for all third-party services provided for all current residents. The contracts include who is providing services; what services are provided; when services are provided; where services are provided; and how services are provided. The Director of Nursing has implemented an audit process to ensure that new contracts will be completed for all new outside services for residents. The Director of Nursing has also implemented an education process to ensure that any new admission discloses outside services so that required contracts can be obtained and incorporated in the resident's assistance plan upon admission.

Please contact me at (307) 634-1530 or christopher.allen@primroseretirement.com if you have any questions or concerns. Thank you.

Sincerely,

Christopher W. Allen
Executive Director
Primrose Retirement of Cheyenne