PRINTED: 04/14/2021
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
	ALF028	A. BUILDING: _____ B. WING _____	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN PLAZA ASSISTED LIVING	4154 TALON DRIVE CASPER, WY 82604

(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 3/31/21. In addition, a COVID-19 focused infection control survey was conducted. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5008	Ch 12 Sec 6 (d)(ii) 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) Require tuberculin testing, or screening as appropriate; This State Rule and Regulation is not met as	S5008		

5/3/21 - POC approved by Micah Sneed, DOC 5/14/21. Micah Sneed

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S5008	Continued From page 1 evidenced by: Based on employee file review, staff interview, and policy review, the facility failed to ensure tuberculin (TB) testing or screening was completed upon hire for 1 of 3 employee files reviewed (#1). The findings were: 1. Review of the file for employee #1 showed she was a CNA with a hire date of 2/26/21. The file lacked information to show any TB testing or screening had been completed. 2. Interview with the executive director on 3/31/21 at 3:22 PM confirmed TB testing was not completed for these employees upon hire. She further stated employees #2 and #3 had been hired but not placed on the schedule yet, as they were awaiting fingerprint results. 3. Review of the 3/25/21 policy and procedure titled "Employee Health, including Tuberculin Testing and Communicable Disease." Showed "1. The Wellness Program Director (R.N.) will perform all tuberculin test (TB) testing for employees at [the facility] unless they can substantiate a prior (TB). 2. All employees must submit to a Mantoux method tuberculin test, prior to employment unless proof is submitted that the test has been administered within the last 12 months..."	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	S5020		

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S5020	Continued From page 2 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 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 record, staff interview, and policy and procedure review, the facility failed to ensure assessments were completed as required for 2 of 5 sample residents (#5, #6). The findings were: 1. Review of the resident record showed resident #5 admitted to the facility on 2/8/21 with a primary diagnosis of dementia, and was transferred to the secured dementia care unit on 3/10/21. The following concerns were identified:	S5020		

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S5020	Continued From page 3 a. Review of the Form ALF 102 screening assessment failed to identify the resident's needs and abilities for "Medication Self Management." Further review showed there was no date of the screening or identification of a registered nurse who completed the screening. b. Review of the resident record showed the resident had a significant decline in cognition, resulting in his/her placement in the secured dementia care unit. Further review showed a significant change assessment had not been completed following the identification of a significant change. 2. Review of the resident record showed resident #6 admitted to the facility on 7/30/20 for severe dementia and following an event of syncope (fainting or passing out). Review of the Form ALF 102 screening assessment failed to show the date of completion for the screening or identification of a registered nurse who completed the screening. 3. Interview with the executive director on 3/31/21 at 4:05 PM revealed there was no additional documentation to show who completed the ALF 102 screening or the date of screening completion. Further interview revealed resident #5 did have a significant decline in cognition, and that a new assessment would have been necessary when that decline was identified. 4. Review of the Level 1 Admission and Discharge Criteria policy with a review date of 3/25/21 showed, the move-in process included "Admissions to the community are accepted after all...physician's orders...nursing assessments (ALF102) have been met..." 5. Review of the Level 2 Resident assessment	S5020		

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S5020	Continued From page 4 policy and procedure with a review date of 3/25/21 showed, "A registered nurse (RN or other with RN sign-off) will conduct an initial assessment, and at minimum, and annual assessment (ALF 102). An accurate, standardized, reproducible assessment of each resident's functional capacity, medication review and physical assessment will be conducted per year, unless indicated more often by resident's medical condition(s)."	S5020		
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 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	S5021		

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S5021	Continued From page 5 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, policy and procedure review, and staff interview, the facility failed to ensure tuberculin (TB) screening was completed for 1 of 2 newly admitted sample residents (#5). The following concerns were identified: 1. Review of the resident record showed resident #5 was admitted to the facility on 2/8/21, with evidence of completed pneumococcal and influenza vaccinations. However, further review failed to show completion of the necessary TB screening. 2. Interview with the executive director on 3/31/21 at 4:05 PM revealed the facility did not receive confirmation from the resident's primary care physician for the TB screening. As a result, the facility had not completed the screening at the time of the survey. 3. Review of the Level 1 Admission and Discharge Criteria policy with a review date of 3/25/21 showed, the move-in process included "...All resident admission orders shall include an order for TB screening, influenza, and pneumococcal immunization status and resulting orders for immunizations if required, unless	S5021		

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S5021	Continued From page 6 contraindicated."	S5021		
S5041	Ch 12 Sec 7 (c)(xiv) Assisted Living Facility (ALF) Core Services (c) Resident Rights. The facility shall adopt and follow a written policy of resident rights. The policy shall be posted in a conspicuous place, and there shall be documentation in the resident's record that the resident read, or management explained, the policy. This policy shall not exclude, take precedence over, or in any way abrogate the legal and constitutional rights enjoyed by all adult citizens and shall include, but is not limited to the following: (xiv) Expect the cooperation of the provider in achieving the maximum degree of benefit from those services which are made available by the facility; This State Rule and Regulation is not met as evidenced by: Based on resident record review, and staff interviews, the facility failed to ensure advanced directives decisions/documents were completed for 1 of 5 sample residents (#5). The findings were: 1. Review of the resident record showed resident #5 was admitted to the facility on 2/8/21, and was transferred to the facility's dementia care unit on 3/10/21. The following concerns were identified= a. Review of the record showed the resident had a "Provider's Orders for Life Sustaining Treatment (POLST)" form, dated 2/8/21. However, the form was not completed and failed to include whether or not the resident would like	S5041		

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S5041	Continued From page 7 to receive cardiopulmonary resuscitation (CPR) or not. b. Review of the resident evaluation dated 2/8/21 failed to show an identified code status for the resident upon admission. c. Interview with the executive director on 3/31/21 at 3:05 PM revealed the resident did not have any other advance directives on file, and there was no official code status determined by the facility at the time of survey.	S5041		
S5053	Ch 12 Sec 7 (d)(v)(A) Assisted Living Facility (ALF) Core Services (d) Medications. (v) Medication Administration (A) An RN shall be responsible for the supervision and management of all medication administration as required by the Wyoming Nurse Practice Act, and the Wyoming Board of Nursing Rules and Regulations. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, and resident record review, the facility failed to ensure appropriate medication supervision during 1 of 3 medication observations affecting resident #5. The findings were: 1. Review of the resident record showed resident #5 was admitted to the facility on 2/8/21, but was then moved to the secured dementia care unit on 3/10/21 due to concerns with impaired cognition and exit-seeking behaviors. The following concerns were identified: a. Observation on 3/30/21 at 4:40 PM showed	S5053		

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S5053	Continued From page 8 RN #1 gave the resident a small cup with pills, which the resident began taking one at a time. During this period, the nurse continued to sort and administer medications for other residents and did not maintain observation to ensure the resident consumed all medications. b. Review of the resident evaluation dated 3/31/21 showed the resident "Has occasional confusion and some difficulty recalling details. Needs occasional prompting or orientation...Requires employee assist/administer medications up to 3x per day with more than 4 medications per pass." c. Interview with the executive director on 3/31/21 at 4:05 PM revealed the nurse was expected to watch the resident consume medications until all were consumed, especially when providing medications to residents with dementia.	S5053		
S5072	Ch 12 Sec 7 (j)(i) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (i) Assisted Living Facilities that choose to admit residents who need therapeutic or mechanically modified diets must employ or contract with a Registered Dietitian who shall approve written menus and dietary modifications, approve special diet needs, plan individual diets, and provide guidance to dietary staff in areas of preparation, service, and monitoring. The frequency of visits is determined by the residents' needs and the competency of the dietary staff but must include at least a monthly onsite review of dietary services. This State Rule and Regulation is not met as	S5072		

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S5072	Continued From page 9 evidenced by: Based on staff interview, and resident record review, the facility failed to ensure a registered dietitian (RD) was employed or contracted with to provide guidance and planning related to a special diet for 1 of 1 residents (#1) who had a mechanically modified diet. The findings were: Review of the 3/25/21 physician history and physical showed resident #1 had diagnoses that included dysphasia. The physician did not address the diet texture. Review of a 3/31/21 facility "Special Diets" list identified the resident as receiving a mechanical soft diet. Review of a speech therapist note included in the resident chart from a hospital admission dated 1/7/21 showed, the resident was on a "Level 4 (puree)/Level 3 (moderately thick) diet." The therapist's note also showed swallowing strategies for the resident to follow. The following concerns were identified: a. Interview with dietary managers #1 and #2 on 3/31/21 at 11:47 AM revealed the resident was originally on a pureed diet when s/he came into the facility and some instructions had been provided from the speech therapist at the hospital related to the resident's diet. The managers were aware the resident was on nectar-thickened liquids and the diet had been changed from puree to mechanical soft and this was the current texture being provided. The managers stated the resident's liquids were thickened with a powdered thickener and they had a reference from a diet manual to know what foods they could serve to the resident. However, they had not received any guidance or education from an RD for this resident's diet plan and modified texture diets. b. Interview with the executive director on 3/31/21 at 9 AM verified the facility did not have a RD on contract or employed. She was also	S5072		

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S5072	Continued From page 10 attempting to locate the physician diet order and information from the speech therapist to show the current diet texture. As of 4/7/21 this information had not been provided.	S5072		
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 employee file review and staff interview, the facility failed to ensure the food service management qualifications were met. The census was 49. The findings were: Interview with the executive director on 3/31/21 at 9 AM revealed the role of dietary manager was shared. She stated neither of the managers had a certification or were enrolled in a certification program. Review of hiring information showed manager #1 was hired on 2/8/2018. Review of his resume showed experience working with food and catering; however, there was lack of nutrition education or food safety education. Review of hiring information showed manager #2 was hired on 11/29/2015. Review of her application showed grocery store management and restaurant	S5074		

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S5074	Continued From page 11 experience; however, education related to nutrition and food safety were lacking.	S5074		

PLAN OF CORRECTION – MARCH 31, 2021

Mountain Plaza Assisted Living
4154 Talon Drive
Casper, WY 82604

S5008 Chapter 12, Section 6

Deficiency 1: Failed to ensure employee TB testing was completed upon hire.

Responsibility: Administrator, Director of Nursing, Office Manager

Corrective Action: MPAL will ensure newly hired employees will receive their TB test (Mantoux) when the initial hire paperwork is turned in unless the employee has proof of a negative TB test within the last 12 months. Upon hire, the office manager will coordinate the completion of new hire paperwork and have the nurse complete a TB test at that time. New employees with documentation of a prior TB test in the last 12 months will not have to complete the TB test.

Education: The policy was distributed to all nurses and management for review.

Monitoring: The hiring manager and Office Manager will confirm that a TB test has been administered at the time the new hire paperwork is completed and document it in the employee file.

Completion Date: 04/23/2021

PLAN OF CORRECTION – MARCH 31, 2021

S5020 Chapter 12, Section 7

Deficiency 1: Failed to ensure the ALF 102 was fully completed and signed.

Responsibility: Administrator, Director of Nursing, and RNs

Corrective Action: MPAL will ensure all ALF 102 assessments are fully completed signed before being filed in the resident file. Resident #5 and #6's ALF 102 forms have been completed and a copy attached to the correction plan.

Education: A nurses meeting was held 4/22/2021 to discuss incomplete ALF 102 assessments.

Monitoring: The Director of Nursing or nurse on duty completing the ALF 102 will give it to the Administrator to be reviewed for completion. Quarterly chart audits as part of the QA process will be completed to ensure the forms are complete.

Completion Date: 04/23/21

PLAN OF CORRECTION – MARCH 31, 2021

S5021 Chapter 12, Section 7

Deficiency 1: Failed to ensure TB screening was completed in one out of two residents.

Responsibility: Administrator, Director of Nursing, and RNs

Corrective Action: MPAL will ensure all new residents have received a TB test or have proof of a TB test within the last 12 months. #5's TB test was completed 04/26/2021.

Education: A nurses meeting was held 4/22/2021 to discuss TB tests and the TB policy was distributed for nurse review.

Monitoring: The Director of Nursing or nurse completing the TB test will have the Administrator review for completion prior to being placed in the resident file. Quarterly chart audits as part of the QA process will be completed to ensure all TB tests are complete.

Completion Date: 04/26/2021

PLAN OF CORRECTION – MARCH 31, 2021

S5041 Chapter 12, Section 7

Deficiency 1: Failed to ensure one out of five residents had a fully completed advanced directive document.

Responsibility: Administrator, Director of Nursing, and RNs

Corrective Action: MPAL will ensure all new residents have a fully completed advance directive form in their resident file. Resident #5 was missing a box checked when the resident, physician, and family completed the form. The family was asked to meet with the physician and resident to properly complete the POLST/advanced directive form.

Education: A nurses meeting was held 4/22/2021 to discuss reviewing advanced directives/POLST forms for full completion.

Monitoring: The Director of Nursing or nurse reviewing the POLST/advanced directives upon move-in will ensure all forms are completed correctly. The Administrator will complete a final review to double check completion. Quarterly chart audits as part of the QA process will be completed to ensure all forms are completed correctly.

Completion Date: Son is coming in 04/26/2021 to complete the form.

PLAN OF CORRECTION – MARCH 31, 2021

S5053 Chapter 12, Section 7

Deficiency 1: Failed to ensure appropriate medication supervision occurred in one out of three observations.

Responsibility: Administrator, Director of Nursing, RNs, and certified medication assistants

Corrective Action: MPAL will ensure all residents with any level of cognitive impairment are observed taking all medication at every medication pass.

Education: A nurses meeting was held 4/22/2021 to discuss proper medication administration and a copy of the Nurse Practice Act was distributed.

Monitoring: The Director of Nursing and Administrator will observe medication administration of each RN, LPN, and certified Medication Aide at least once a week to ensure supervision occurs when residents with a cognitive impairment are taking their medication.

Completion Date: 4/22/2021 and ongoing

PLAN OF CORRECTION – MARCH 31, 2021

S5072 Chapter 12, Section 7

Deficiency 1: Failed to ensure a Registered Dietitian was employed or contracted for guidance on special diets.

Responsibility: Administrator and Food Services Director

Corrective Action: MPAL will ensure a Registered Dietitian is available for consultation when a resident is prescribed a special diet. Crandall Corporate Dietitians were contacted 4/23/2021 to obtain a contract for services. Once a contract is in place, the Food Services Manager will begin consultations for any resident on a specialized diet, including resident #1. Resident #1 is scheduled for a swallow evaluation and diet recommendations with Rocky Mountain Therapy.

Education: Food Service and Nutrition regulations from Chapter 12 were distributed to all dietary employees. Employees in the food services department are presently enrolled and have or are completing multiple courses in food related topics. Please see printout attached.

Monitoring: The Director of Nursing and Administrator will ensure any special diets are coordinated with the Dietitian at the time of move-in.

Completion Date: pending signed contract with Crandall Corporate Dietitians and Resident 1 assessment. Anticipate completion by 04/30/2021.

PLAN OF CORRECTION – MARCH 31, 2021

S50 Chapter 12, Section 7

Deficiency 1: Failed to ensure food service management qualifications were met.

Responsibility: Administrator, Food Services Director, Relias Training Coordinator

Corrective Action: MPAL will ensure proper education pertaining to nutrition and food safety occurs for all dietary employees. Relias Training will be utilized along with more formalized nutrition courses from an accredited college or university.

Education: All food service employees are enrolled in a variety of food related topics in Relias Training. The Food Services Director or Administrator will enroll in educational courses that are considered the equivalent to that of a Certified Dietary Manager or enroll in a Certified Dietary Manager course. One potential option for the Administrator is:

FCSC-1141 Principles of Nutrition (3 Credits)

FCSC 1141 Principles of Nutrition (3L,3CR) [E] This course is designed to give students a general understanding of nutrition concepts. The course content emphasizes key nutrients and the human body's need for and utilization of those nutrients. Students will be informed of the importance of individualized nutrition plans and will be exposed to some of the latest research in nutrition. Also addressed are nutritionally relevant topics such as eating disorders, nutritional supplements, dieting and food safety. Recommended for nutrition majors, physical education, and early childhood education majors and other interested nonmajors.

Monitoring: The Relias Training Coordinator will ensure monthly food related training topics are assigned to the food services department. The Coordinator and Administrator will verify training completion monthly through Relias Training reports.

Completion Date: pending guidance