Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9044	A. BUILDING: _____ B. WING _____	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD CREEK OF CHEYENNE	6800 FAITH DRIVE 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 12/12/2007 Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001 An initial licensure survey was conducted by Healthcare Licensing and Surveys on 3/1/21 through 3/2/21. In addition, a COVID-19 focused infection control survey was conducted at that time. 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		
S5007	Ch 12 Sec 6 (d)(i) 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: (i) Ensure a safe and sanitary environment for residents and personnel. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, policy and	S5007		

Accepted the POC w/Theresa on 3/27/21
The date of Correction is 4/30/21 : with the exception of S074 : Extended to 10/1/21

3/29/21

Cottonwood Creek Assisted Living
Plan of Correction for Inspection 03/02/21
Ref: LH-2021-0251

1. **S5007:**
   a. All staff will be re-educated to facility infection control policy specific to COVID-19 prevention measures related to resident masking and social distancing.
   b. All residents have the potential to be affected by the deficient practice.
   c. After staff re-education is completed, staff will ensure residents are given masks and will assist residents with proper placement of masks. Staff will social distance residents during meals and activities.
   d. Administrator and Wellness director will monitor activities and meals to ensure compliance. This topic will be reviewed as a part of our infection control review during the quarterly QA meeting for effectiveness
   e. The correction will be complete on or before 04/30/21.

2. **S5010:**
   a. All new staff that has been hired will not be allowed to work in any capacity with direct resident contact until required background check documentation has been received by the facility indicating they are cleared to work.
   b. All residents have the potential to be affected by the deficient practice
   c. The Wellness Director will not schedule any new employee to work in any capacity with direct resident contact until the Administrator gives final approval upon receipt and review of background check documentation.
   d. Review of staffing and personnel requirements will be reviewed quarterly in conjunction with facility QA meeting.
   e. The correction will be complete on or before 04/30/21.

3. **S5018:**
   a. Medication reviews will be completed and documented for residents 1,2,3,4,5,6,7,8,10,11 and 12 as required by regulation.
   b. All residents have the potential to be affected by the deficient practice
   c. Facility will implement a new format of our POS that will trigger and facilitate RN review upon admission, at least every 62 days, and with every medication change or new medication order.
   d. The Wellness Director will monitor all resident charts to ensure compliance. Additionally, compliance will be reviewed in quarterly QA meetings.
   e. The correction will be complete on or before 04/30/21.

4. **S5021:**
   a. Facility has obtained signatures from PCP for resident 2,5,6,7,8 and 11 on the residents admission POS. We have obtained orders for residents to receive TB testing, Influenza and Pneumococcal Vaccines.
   b. All residents have the potential to be affected by the deficient practice.

3/29/21

Cottonwood Creek Ref: LH-2021-0251

S5021 Continued:

c. The facility has implemented a new admission POS format that is standard for all admissions and specifically asks for orders for TB test administration, Influenza and Pneumococcal Vaccines. All admission orders will be signed by the residents following PCP on the day of admission or before. Facility will require orders to be received before proceeding with admission.
d. Wellness Director will ensure compliance by reviewing each admission packet prior to admission. Administrator will approve admission upon receiving affirmation from Wellness Director signed orders have been received. System effectiveness will be reviewed quarterly as part of facility QA program.
e. The correction will be complete on or before 04/30/21.

5. S5022:
   a. Facility will ensure that our RN reviews for accuracy all assessments that were completed by the LPN for residents 2,3,4,5,6,7,8,10 and 11. If any inaccuracies or omissions are identified new assessments will be completed by the RN. If the RN verifies assessment accuracy, they will document as such and sign off of the assessment.
   b. All residents have the potential to be affected by deficient practice.
   c. Facility will ensure that an RN completes the required initial assessments upon admission
   d. Wellness Director will monitor all new residents admission process to ensure ongoing compliance with the regulation. System effectiveness will be reviewed quarterly as a part of the facility QA program
   e. The correction will be complete on or before 04/30/21.

6. S5074:
   a. The Dining Services Manager is actively enrolled and working on completion of an approved CDM training course through the University of North Dakota, which allows up to 1 year to complete. This program was reviewed with the Department upon our initial application filing.
   b. All residents have the potential to be affected.
   c. The Dining Services Manager will complete the CDM coursework and pass the certification test within the time frame as set by the UND program
   d. Administrator will ensure Dining Services Manager is completing the program according to the requirements of the UND Program. Facility Registered Dietician Consultant will provide assistance and education until certification is obtained. Facility will provide the Department bi-monthly updates on coursework progress.
   e. The correction will be complete on or 10/01/2021

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S5007	Continued From page 1 procedure review, review of the Centers for Disease Control and Prevention recommendations, and review of the Wyoming Department of Health Guidance, the facility failed to ensure infection control practices were followed to prevent transmission of COVID-19 in 1 of 2 dining rooms (main dining room). The findings were:with 1. Observation on 3/1/21 at 11 AM showed 2 residents were seated at a dining table within arm's reach of each other and with masks on incorrectly. 2. Observation on 3/1/21 at 11:10 AM showed 2 staff members assisted resident #3 off the sofa and into a dining chair within arm's reach of another resident. Neither resident was wearing a mask. 3. Observation on 3/1/21 at 11:12 AM showed a staff member positioned resident #7 (resident in a wheelchair)'s wheelchair closer to another resident at the dining room table. Neither resident was wearing a mask. 4. Observation on 3/1/21 at 11:16 AM showed resident #12 arrived at the facility and a staff member assisted the resident to sit at a dining table, across from 2 other residents and within arm's reach of 4 residents. None of the residents were wearing a mask. 5. Observation on 3/1/21 at 11:16 AM showed the dining room had 2 tables with 5 residents seated at each table. Each table had a resident at each end, 2 residents seated next each other on one side, and 1 resident seated on the opposite side. All the residents at the table were within arm's reach of another resident and no masks were	S5007		

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S5007	Continued From page 2 utilized. 6. Observation on 3/1/21 at 11:35 AM showed 7 residents were seated in a semi-circle around the television, participating in a trivia activity. Five of the 7 residents had masks; however, all of the masks were positioned incorrectly and did not cover both the residents' noses and mouths. Further observation showed all residents were within arm's reach of another resident. 7. Interview with the wellness director on 3/2/21 at 3:54 PM revealed staff should attempt to have residents wear masks and practice social distancing during meals and activities. 8. Review of the Centers for Disease Control and Prevention "Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities" last updated 5/29/20 showed "...Instead of communal dining, consider delivering meals to rooms, creating a "grab n' go" option for residents, or staggering mealtimes to accommodate social distancing while dining (e.g., a single person per table)...Remind residents to remain at least 6 feet apart from others when they are outside their room..." 9. Review of the Wyoming Department of Health (WDH) "Skilled Nursing and Assisted Living Guidance" dated 3/2/21 showed "...Communal dining and activities may occur if physical distancing of at least 6 feet between each person, with the exception of spouses or roommates, can be maintained...."	S5007		
S5010	Ch 12 Sec 6(e)(ii)(A-L) Personnel And Staffing Requirements	S5010		

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S5010	Continued From page 3 (e) Personnel Policies and Records. (ii) A record for the manager and each employee shall be maintained and contain at a minimum the following information: (A) Name, current address and telephone number; (B) Social Security Number; (C) Education; (D) Work experience, documentation of reference checks; (E) Date of employment (F) Position in the assisted living facility (job description); (G) Documentation of tuberculin testing; (H) Orientation checklist; (I) I-9, (Employment Eligibility Verification); (J) W-4 (Employee's Withholding Allowance Certificate); (K) Licensure, Certification, or Credentials; (e.g., RN, LPN, CNA; and (L) Documentation of all completed background and Central Registry background check with no offenses.	S5010		

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S5010	Continued From page 4 This State Rule and Regulation is not met as evidenced by: Based on personnel file review and staff interview, the facility failed to ensure a completed background and central registry check for 1 of 7 staff (CNA #1) was obtained prior to resident contact. The findings were: 1. Review of the employee file for CNA #1 showed the CNA's first date of resident contact was 3/1/21. Further review showed the central registry and background check were initiated on 3/1/21 and had returned no results at the time of review on 3/2/21. 2. Interview with the wellness director on 3/2/21 at 2:20 PM revealed she thought employees could work prior to the completion of the background and central registry checks being completed as long as the facility could show the checks had been submitted.	S5010		
S5018	Ch 12 Sec 7 (a)(ix)(A) Assisted Living Facility (ALF) Core Services (a) The assisted living facility core services include the following: (ix) Assessments completed by a Registered Nurse. (A) Registered Nurse medication review every two (2) months or sixty-two (62) days or whenever new medication is prescribed or the resident's medication is changed; This State Rule and Regulation is not met as evidenced by: Based on medical record review, staff interview,	S5018		

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S5018	Continued From page 5 and policy and procedure review, the facility failed to ensure a registered nurse performed medication reviews for 11 of 12 sample residents (#1, #2, #3, #4, #5, #6, #7, #8, #10, #11, #12). The findings were: 1. Review of the medical record for resident #1 showed the resident admitted to the facility on 2/28/21, received medications from the facility, and there was no RN review of the medications at the time of admission, every two months, or with medication changes. 2. Review of the medical record for resident #2 showed the resident admitted to the facility on 12/1/20, received medications from the facility, and there was no RN review of the medications at the time of admission, every two months, or with medication changes. 3. Review of the medical record for resident #3 showed the resident admitted to the facility on 11/9/20, received medications from the facility, and there was no RN review of the medications at the time of admission, every two months, or with medication changes. 4. Review of the medical record for resident #4 showed the resident admitted to the facility on 11/26/20, received medications from the facility, and there was no RN review of the medications at the time of admission, every two months, or with medication changes. 5. Review of the medical record for resident #5 showed the resident admitted to the facility on 12/22/20, received medications from the facility, and there was no RN review of the medications at the time of admission, every two months, or with	S5018		

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S5018	Continued From page 6 medication changes. 6. Review of the medical record for resident #6 showed the resident was admitted to the facility on 11/14/20, received medications from the facility, and there was no RN review of the medications at the time of admission, every two months, or with medication changes. 7. Review of the medical record for resident #7 showed the resident admitted to the facility on 12/17/20, received medications from the facility, and there was no RN review of the medications at the time of admission, every two months, or with medication changes. 8. Review of the medical record for resident #8 showed the resident was admitted to the facility on 12/8/20, received medications from the facility, and there was no RN review of the medications at the time of admission, every two months, or with medication changes. 9. Review of the medical record for resident #10 showed the resident admitted to the facility on 12/12/20, received medications from the facility, and there was no RN review of the medications at the time of admission, every two months, or with medication changes. 10. Review of the medical record for resident #11 showed the resident admitted to the facility on 11/15/20, received medications from the facility, and there was no RN review of the medications at the time of admission, every two months, or with medication changes. 11. Review of the medical record for resident #12 showed the resident admitted to the facility on 3/1/21, received medications from the facility, and	S5018		

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S5018	Continued From page 7 there was no RN review of the medications at the time of admission. 13. Interview with the administrator 3/2/21 at 9:13 AM revealed RN medication reviews were not done on any of the resident's at the facility because she forgot to tell the wellness director it was required. 14. Review of the policy titled "Resident Pre-Admission Assessment" dated 2020 showed "...8. A medication review will include the following: a Review of all medications on hand or reported. i. NOTE: A physician order is to be obtained prior to admission day, verifying medications and dosing schedule..."	S5018		
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	S5021		

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S5021	Continued From page 8 contraindicated. The facility must develop and implement policies and procedures to ensure the following: (I) Residents, or their legal representative are educated regarding the risks and benefits of these immunizations. (II) The immunizations are offered unless medically contraindicated or the resident is currently immunized. (III) If the resident is not vaccinated, the medical record must reflect the reason, such as medical contraindication or refusal. This State Rule and Regulation is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure residents had admission orders, including orders for TB screening, influenza vaccinations, and pneumococcal vaccinations for 6 of 12 sample residents (#2, #5, #6, #7, #8, #11). The findings were: 1. Review of the medical record for resident #2 showed the resident admitted to the facility on 12/1/20 and received a tuberculin skin test on 12/11/20. Further review showed there were no admission orders signed by a physician or an order for administration of a tuberculin skin test. 2. Review of the medical record for resident #5 showed the resident admitted to the facility on 12/22/20 and received a tuberculin skin test on 12/24/20. Further review showed there were no admission orders signed by a physician or an order for administration of a tuberculin skin test.	S5021		

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S5021	Continued From page 9 3. Review of the medical record for resident #6 showed the resident admitted to the facility on 11/14/20 and received a tuberculin skin test on 12/11/20. Further review showed there was no order for administration of a tuberculin skin test. 4. Review of the medical record for resident #7 showed the resident admitted to the facility on 12/17/20 and received a tuberculin skin test on 12/18/20. Further review showed there was no order for administration of a tuberculin skin test. 5. Review of the medical record for resident #8 showed the resident admitted to the facility on 12/8/20 and received a tuberculin skin test on 12/11/20. Further review showed there was no order for the administration of a tuberculin skin. 6. Review of the medical record for resident #11 showed the resident admitted to the facility on 11/15/20 and received a tuberculin skin test on 12/12/20. Further review showed there was no order for administration of a tuberculin skin test. 7. Interview with the wellness director on 3/2/21 at 3:54 PM revealed the facility has had a hard time receiving physician orders and telephone confirmation of orders from doctors and some residents do not have signed admission orders or telephone confirmation of orders. Further interview revealed the facility did not obtain orders for administration of tuberculin skin test, influenza vaccinations, or pneumococcal vaccinations. 8. Review of the policy titled "Resident Pre-Admission Assessment" dated 2020 showed "...8. A medication review will include the following: a Review of all medications on hand or reported. i. NOTE: A physician order is to be	S5021		

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S5021	Continued From page 10 obtained prior to admission day, verifying medications and dosing schedule..."	S5021		
S5022	Ch 12 Sec 7 (b)(iii)(A-B) Assisted Living Facility (ALF) Core Services (b) Resident Assessment and Services. The staff/contract Registered Nurse (RN) shall conduct initial and, at a minimum annually, an accurate, standardized, reproducible assessment of each resident's functional capacity, physical assessment and medication review. (iii) The Registered Nurse shall make an initial assessment of the resident's needs, which describes the resident's capability to perform ADLs and notes all significant impairments in functional capability. (A) Initial assessment. A current assessment shall be maintained in each resident's file. (B) The assessment shall include at least the following information: (I) Medically defined conditions and prior medical history; (II) Physical status; (III) Sensory and physical impairments; (IV) Nutritional status and requirements; (V) Special treatments and/or procedures;	S5022		

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S5022	Continued From page 11 (VI) Mental and psychosocial status; (VII) Discharge potential; (VIII) Dental condition; (IX) Activities potential; (X) Rehabilitation potential; and (XI) Medication regimen. (1.) Documentation of resident's ability to self-medicate. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the RN conducted initial assessments for 9 of 12 sample residents (#2, #3, #4, #5, #6, #7, #8, #10, #11). The findings were: 1. Review of the medical record for resident #2 showed the resident admitted to the facility on 12/1/20. Further review showed there was no initial RN assessment. 2. Review of the medical record for resident #3 showed the resident admitted to the facility on 11/9/20. Further review showed there was no initial RN assessment. 3. Review of the medical record for resident #4 showed the resident admitted to the facility on 11/26/20. Further review showed there was no initial RN assessment. 4. Review of the medical record for resident #5 showed the resident admitted to the facility on	S5022		

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S5022	Continued From page 12 12/22/20. Further review showed there was no initial RN assessment. 5. Review of the medical record for resident #6 showed the resident admitted to the facility on 11/14/20. Further review showed there was no initial RN assessment. 6. Review of the medical record for resident #7 showed the resident admitted to the facility on 12/17/20. Further review showed there was no initial RN assessment. 7. Review of the medical record for resident #8 showed the resident admitted to the facility on 12/8/20. Further review showed there was no initial RN assessment. 8. Review of the medical record for resident #10 showed the resident admitted to the facility on 12/12/20. Further review showed there was no initial RN assessment. 9. Review of the medical record for resident #11 showed the resident admitted to the facility on 11/15/20. Further review showed there was no initial RN assessment. 10. Interview with the administrator on 3/2/21 at 9:13 AM revealed residents did not have an initial assessment completed by a RN because she did not see the requirement.	S5022		
S5074	Ch 12 Sec 7 (j)(iii)(A) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (iii) Food service supervision:	S5074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9044	A. BUILDING: _____ B. WING _____	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S5074	Continued From page 13 (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 record review and staff interview, the facility failed to ensure the dietary manager was certified or had experience equivalent to that of a certified dietary manager (CDM). The census was 12. The findings were: 1. Interview with dietary staff member #1 on 3/1/20 at 2:20 PM revealed she and one other individual were responsible for developing the menu and producing the meals identified on the menus and both had completed the ServSafe program. Further interview revealed the dietary staff member had not completed CDM training. 2. Review of the employee record for dietary staff member #1 showed the staff member completed ServSafe training on 10/2/20. There was no evidence the staff member had completed CDM training. 3. Review of the employee record for dietary staff member # 2 showed the staff member completed ServSafe training on 8/27/19. There was no evidence the staff member had completed CDM training. 4. Review of the employee file for the administrator showed the administrator enrolled in a CDM certification program through the	S5074		

Healthcare Licensing and Surveys

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S5074	Continued From page 14 University of North Dakota on 2/3/20; however, there was no evidence the training had been completed. 5. Interview with the administrator on 3/2/21 at 3:40 PM revealed the facility did not have a staff member who had completed the CDM training. Dietary staff member #2 was enrolled in a program to become a CDM; however, the staff member would require one year to complete the program.	S5074		