PRINTED: 08/25/2021
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
	ALF010	A. BUILDING: _____ B. WING _____	C 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF EVANSTON	1949 WEST UINTA STREET EVANSTON, WY 82930

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S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020. Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 08/28/2001. A complaint survey was conducted by Healthcare Licensing and Surveys on 8/4/21 to 8/13/21. The survey was prompted by complaint intake LIC-21-017. In addition, a COVID-19 focused infection control survey was conducted by Healthcare Licensing and Surveys on 8/4/21/21 to 8/13/21.	S 000		
S5003	Ch 12 Sec 6 (d) Personnel and Staffing Requirements (d) Infection Control. Written policies must 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 written polices must, at a minimum: (i) Ensure a safe and sanitary environment for residents and personnel; (ii) Require tuberculin testing, or screening as appropriate; and (iii) Prohibit any person with an airborne, contagious, or infectious disease from being employed until a work release is obtained. (A) The facility shall prohibit employees with a communicable disease or infected skin	S5003		

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Eric McMillan TITLE: President (X6) DATE: 9/4/21

STATE FORM 49V011 If continuation sheet 1 of 1

POC accepted. DOC 10/1/21, Spoke to Eric McMillan, President on 9/27/21 @ 4:30pm.

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S5003	Continued From page 1 lesions from direct contact with residents and their food, if direct contact will transmit a disease. (B) 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 observation, staff interview, review of facility policies, and review of Wyoming Department of Health guidance, the facility failed to implement measures to prevent the spread of COVID-19. Specifically, the facility failed to: ensure screening for residents, staff, and visitors for COVID-19 signs and symptoms and failed to ensure staff wore masks when interacting with residents. The resident census was 5. The findings were: 1. Observation on 8/4/21 from 4:47 PM to 4:56 PM showed certified nurse aide (CNA) #1 did not wear a mask while delivering food and beverages to residents #1, #4, #5 and #3 in the dining room. Observation on 8/4/21 at 4:57 PM showed CNA #1 did not wear a mask while assisting resident #4 with medication administration. 2. During an interview on 8/5/21 at 9:49 AM CNA #1 stated employees no longer did any temperature checks or other symptom screening when arriving at work. She stated the facility used to have a screening log for that, but they no longer used it. 3. On 8/5/21 at 10:35 AM the assistant manager stated staff no longer did screening for COVID-19 symptoms or temperature checks when arriving at work. She further stated the facility didn't do any screening for residents either. She stated	S5003		

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S5009	Continued From page 2 vital signs were taken "weekly" for residents. 4. Observation on 8/5/21 at 11 AM revealed a visitor came to the facility to visit resident #4. The visitor was not wearing a mask, but asked the assistant manager if he should wear one. The assistant manager handed the visitor a mask, but did not do any screening for COVID-19. 5. Review of the facility policy "Willow Creek Communities COVID-19 Policies", (undated, but faxed on 8/12/21 to the surveyor), showed "...Employees will wear face masks, face shields or other appropriate face covering approved by CDC and state agencies throughout their entire shift...All visitors are screened for temperature before entry. Temps above 100 degrees shall not be permitted in our facilities. Questions regarding recent travel will be asked of all visitors." 6. Review of the "Updated Nursing and Assisted Living Facility Guidance" by the Wyoming Department of Health, dated 5/7/21 showed "...Visitors should be screened and restricted from visiting, regardless of their vaccination status, if they have: current COVID-19 infection, symptoms of COVID-19; or prolonged contact (within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period) with someone with COVID-19 infection in the prior 14 days or have otherwise met criteria for quarantine...Continue to screen all residents daily and staff at the start of each shift for symptoms of respiratory illness...In general, fully vaccinated staff should continue to wear masks while at work. However, fully vaccinated staff could dine and socialize together in break rooms and conduct in-person meetings without masks or social distancing. If unvaccinated staff are present, everyone should wear masks and	S5009		

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S5003	Continued From page 3 unvaccinated staff should physically distance from others.*	S5003		
S5005	Ch 12 Sec 7 (a) Assisted Living Facility (ALF) Core Services (a) The assisted living facility core services include the following: (i) Meals, housekeeping, personal and other laundry services; (A) Provision of mechanically altered diets and dietary supplements, if required. (ii) A safe and clean environment; (iii) Assistance with local transportation; (iv) Assistance with obtaining medical, dental, and optometric care, in addition to social services; (v) Assistance in adjusting to group living activities; (vi) Maintenance of a personal fund account, if requested by the resident or resident's responsible party, showing any and all deposits, withdrawals, and transactions of the account; (vii) Provision of appropriate recreational activities in/out of the assisted living facility; (viii) Care of individuals who require any or all of the following services: (A) Partial assistance with personal care, e.g. bathing, shampoos;	S5005		

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S5005	Continued From page 4 (B) Limited assistance with dressing; (C) Minor non-sterile dressing changes; (D) Stage I skin care - skin integrity intact; (E) Infrequent assistance with mobility. The resident may use an assistive device; e.g., wheel chair, walker, cane; (F) Cuing guidance with ADLs for the visually impaired resident, or the intermittently confused and/or agitated resident requiring occasional reminders to time, place and person; (G) Care of the resident who can independently manage his own catheter or ostomy, e.g., resident who can change his own catheter bags, able to clean and care for his ostomy; (H) Care of the resident incontinent of bowel or bladder if the condition can be managed independently; (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 residents' medication is changed; (X) Twenty-four (24) hour monitoring of each resident.	S5005		

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S5005	Continued From page 5 This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a clean environment The resident census was 5. The findings were: 1. Observation on 8/4/21 at 6 PM revealed the door to the bedroom for resident #3 was shut. The carpet outside of the room (in the hallway) was sticky, and there were brown-colored stains. There were also numerous brown colored splashes and streaks on the door. The resident opened the door and allowed the surveyor to look into his/her room. There were cigarette smoke and urine odors in the room. There were cigarette butts littered on the carpeted floor all throughout the room. In addition, there was trash scattered on the floor and numerous stains on the carpet. Upon leaving the resident's room, observation showed brown-colored stains, which were sticky, on the carpet in the hallway leading to the front entry (past rooms 4 and 5). 2. Interview on 8/4/21 at 5:04 PM with CNA #1 revealed the brown stains in the carpet in the hallway were human feces. She stated resident #3 gets naked and poops on the carpet and tracks it throughout the facility. She also stated the resident "sneaks cigarettes" and smokes in his/her bedroom.	S5005		
S5009	Ch 12 Sec 7 (b)(iv) Assisted Living Facility (ALF) Core Services (b) (iv) Frequency of assessment. An assessment must be conducted: (A) No earlier than one (1) week prior to admission;	S5009		

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S5009	Continued From page 6 (B) Immediately upon any significant change in the resident's mental or physical condition; or (C) No less than once every twelve (12) months. This State Rule and Regulation is not met as evidenced by: Based on resident record review and staff interview, the facility failed to ensure registered nurse (RN) assessments were conducted no less than every 12 months for 5 of 6 sample residents (#2, #4, #6, #7, #8). The findings were: 1. Review of the resident record for resident #2 showed s/he was admitted on 7/15/16. Review of the most recent RN assessment showed it was completed on 6/5/20. 2. Review of the resident record for resident #4 showed s/he was admitted on 12/7/16. Review of the most recent RN assessment showed it was completed on 6/5/20. 3. During an interview on 8/13/21 at 2:24 PM the manager confirmed there were no other RN assessments completed since 6/5/20 for residents #2 and #4. He stated he's had a "hard time" getting the nurse to come in to do assessments. 4. On 8/5/21 on 11:21 AM the RN assessments for three closed records (#6, #7, #8) were requested via a telephone call with the owner. On 8/9/21 at 10:29 AM and again on 8/11/21 at 8:22 AM the closed records were again requested via telephone call with the manager. On 8/13/21 at 2:24 PM the surveyor spoke to the manager and	S5009		

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S5009	Continued From page 7 stated the facility would be out of compliance with the assessments unless the records could be produced. The manager replied the records were "out in the shed" and he wasn't able to produce the documentation at that time.	S5009		
S5020	Ch 12 Sec 7 (e) 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 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. This 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;	S5020		

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S5020	Continued From page 8	S5020		

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

(VI) Medicare number or 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 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 of 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

Jan 9/4/21

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S5020	Continued From page 9 personal funds in the 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 personal funds 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 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.	S5020		

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S5020	Continued From page 10 (ii) The resident shall be assured of confidential treatment of all information in the record, and the resident's written consent (or the consent of the guardian) shall be required for the release of information to persons not otherwise authorized for receive it. (iii) All residents' records shall be retained in a physically secure area for a minimum of six (6) years after the resident has left the facility and may be disposed of, by shredding or burning, after that time. (iv) In the event of dissolution of the facility, the manager shall notify the Licensing Division as to the location of all residents' records. (v) All records shall be protected from damage by fire, water and other hazards. (vi) All entries in each resident's record shall be made in ink, signed and dated. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interviews, the facility failed to ensure resident records were maintained in folders which were made available to the Licensing Division upon request for 3 of 3 open sample residents (#2, #3, #4) and 3 of 3 closed sample residents (#6, #7, #8). The findings were: 1. Observation on 8/5/21 at 9:30 AM revealed a cabinet in the staff room which contained binders with room numbers. None of the current resident binders were in the cabinet, including for residents #2, #3, and #4. Interview with certified	S5020		

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S5020	Continued From page 11 nurse aide (CNA) #1 at that time revealed "they were in there yesterday." When asked if she could locate the records for the current residents, or for the closed records (#6, #7, #8), she stated she did not know where they were. On 8/6/21 at 10:57 AM the assistant manager stated she did not know where any of the resident records were. She stated the manager (who was out) would probably know where they were. The surveyor was unable to review any resident records during the onsite visit on 8/4/21 and 8/5/21 because they were not available. 2. On 8/5/21 on 11:21 AM resident record documentation was requested for three current residents (#2, #3, #4) and three closed records (#6, #7, #8) via a telephone call with the owner. On 8/9/21 at 10:29 AM and again on 8/11/21 at 8:22 AM the resident record information was again requested via telephone call with the manager. On 8/11/21 the resident record information for the current residents (#2, #3, #4) was received via fax. However, there was no information from the closed records (#6, #7, #8). On 8/13/21 at 2:24 PM the surveyor spoke to the manager and he stated the records were "out in the shed" and he wasn't able to produce the documentation at that time.	S5020		
S5047	Ch 12 Sec 8 (a) Services Which Cannot Be Provided By Level 1 (a) The following services cannot be provided: (i) Continuous assistance with transfer and mobility; (ii) Care of the resident who is unable to feed himself independently and/or; monitoring of	S5047		

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S5047	Continued From page 12 diet is required; (iii) Total assistance with bathing and dressing; (iv) Invasive catheter or ostomy care, such as changing of catheter or irrigation of ostomy; (v) Care of resident who is on continuous oxygen, if; (A) Continuous monitoring is required; or (B) Oxygen is ordered by the physician of physician extender to be titrated based on oxygen saturation levels; (vi) Care of resident whose wandering jeopardizes the health and safety of the resident; (vii) Incontinence care by facility staff; (viii) Wound care requiring sterile dressing changes; (ix) Stage II skin care and beyond; (x) Care of the resident with inappropriate social behavior; e.g. frequent aggressive, abusive, or disruptive behavior; and (xi) Care of resident demonstrating chemical abuse that puts him and/or other at risk; (xii) Monitoring of acute medical conditions. 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	S5047		

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S5047	Continued From page 13 to ensure residents were appropriate for a level I Assisted Living Facility for 1 of 5 (#3) current residents. Resident #3 exhibited unsafe and inappropriate social behaviors. The findings were: 1. Review of the 5/21/21 significant change registered nurse (RN) assessment showed resident #3 "...has been urinating everywhere (bed, floor, porch, lawn, closet, etc)...Pr stated (s/he) is doing it because [s/he's] not 'getting the (things) I want. I just want my Klonopin.' The assessment also documented the resident was smoking in his/her bedroom. 2. Review of the 5/21/21 Plan of Care showed the resident was urinating everywhere (bed, floor, closet, etc) and was smoking in his/her bedroom. 3. Review of progress notes showed on 8/1/21 the resident had lit a cigarette in another resident's room. On 8/3/21 it was documented the resident "left BM [bowel movement/human feces] in the hall...tracked it everywhere." 4. On 8/4/21 at 4:40 PM certified nurse aide (CNA) #1 stated resident #3 was "destroying (his/her) room and has BM everywhere." She stated she had been told the resident's family was trying to find another place for him/her to go. 5. Observation on 8/4/21 at 5 PM revealed the resident's bedroom door was shut. The carpet outside of the room (in the hallway) was sticky, and there were brown-colored stains. There were also numerous brown-colored splashes and streaks on the door. The resident opened the door and allowed the surveyor to look into his/her room. There were cigarette smoke and urine odors in the room. There were cigarette butts littered on the carpeted floor all throughout the	S5047		

Sen 9/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF010	A. BUILDING: _____ B. WING _____	C 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF EVANSTON	1949 WEST UINTA STREET EVANSTON, WY 82930

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S5047	Continued From page 14 room. In addition, there was trash scattered on the floor and numerous stains on the carpet. Upon leaving the resident's room, observation showed brown-colored stains, which were sticky, on the carpet in the hallway leading to the front entry (past rooms 4 and 5). 6. Interview on 8/4/21 at 5:04 PM with CNA #1 revealed the brown stains in the carpet in the hallway were human feces. She stated the resident "gets naked and poops on the carpet" and tracks it throughout the facility. She also stated the resident "sneaks cigarettes" and smokes in his/her bedroom. When asked how long the resident was exhibiting those behaviors, she stated about a month. Resident #2 walked up then and said "it's been going on longer than that. [The resident] shouldn't be here." 7. Observation on 8/5/21 at 10:03 AM revealed CNA#1 gathered the sheets and blankets from the resident's bed that the resident had put outside of the bedroom door. The CNA pointed out the numerous burn marks from cigarettes on the sheets and blankets and stated the resident was a "fire hazard." 8. Observation on 8/5/21 at 10:30 AM revealed CNA #1 and the assistant manager went to the resident's room because they wondered if the resident was smoking in there. The two staff members came out of his/her room and stated the resident was smoking. The staff stated they removed his/her cigarettes. 9. During an interview on 8/5/21 at 10:33 AM the assistant manager stated she thought the facility had been working on trying to get the resident out of the facility for about 3 weeks. She stated the resident's room was a mess and s/he was	S5047		

Sm 9/4/21

PRINTED: 08/25/2021
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
	ALF010	A. BUILDING: _____ B. WING _____	C 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S5047	Continued From page 15 smoking in there. 10. During a phone conversation on 8/13/21 at 2:24 PM the manager confirmed the resident was still in the facility. He stated they had been working on trying to get the resident to another facility for about 3 weeks, however he was not sure a written discharge notice has been issued to the resident or the resident's family.	S5047		

Em 9/4/21

Willow Creek
ElderCare Communities

Evanston

September 3rd, 2021

Corporate office Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by Willow Creek Community, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by Willow Creek Community of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

ID Prefix Tag

S5003 Ch 12 Sec 6 (d) Personnel & Staffing Requirements

- Corporate officer and manager will conduct a COVID-19 training for documentation of temperatures and 3rd party temp checks policies with staff.
- Staff will continue to screen all visitors and employees that enter our facility as we currently do. Staff will take temperatures & verbally screen for Respiratory Infections, or other signs & symptoms of COVID-19 for visitors and staff.
- Manager will review with staff, masking requirements for direct care and non-social distanced interactions with residents and other staff.
- Manager will review with residents, enhanced temperature, and infectious screening processes recommendations. Residents are currently referred to healthcare providers for additional screening if any signs or symptoms of contagious illness are present. Staff will monitor for signs and symptoms with verbal cues and temp checks daily and documented in residents' files.
- Corporate officer and Manager will continue screening residents with their weekly vitals as documented in the survey. We additionally we add daily temperature check and verbal screening for signs and symptoms and document. Following our policies,

any positive signs or symptoms will be referred to medical professional for further testing.

- Corporate officer and Manager will review training and documentation in 1 week from training. A review will be conducted every week thereafter for 1 month to ensure completion of documentation & duties.
- Corporate officer and Manager will verify the success of training and policies in the upcoming Quality Assurance review.
- Date of compliance 10/1/2021

S5005 Ch 12 Sec 7 (a) Assisted Living Facility (ALF) Core Services

- Corporate officer and Manager have contacted resident POA to provide outside services to professionally clean resident #3 room and hallway due to resident's noncompliance and behaviors.
- Facility and resident #3 POA have been working on finding alternative housing for resident before survey findings, due to company policy violations and appropriateness.
- Corporate officer and Manager have cleaned the areas in question with the facilities carper cleaner to immediately resolve issue.
- Family for resident #3 will need to engage in a negotiated risk agreement to provide further assistance for resident #3 that is beyond our normal scope of care.
- Corporate officer & Manager will visit every other day until resident rehomes.
- Meeting for upcoming QA with Manager & Corporate officer will discuss resolution of this matter.
- Date of compliance 10/1/2021

S5009 Ch 12 Sec 7 (a) Assisted Living Facility (ALF)

- The DON or RN has completed all previous RN Assessments on all residents.
- All current residents #1 - #5 will have an assessment and ALF-102 which includes but is not limited to; medical and past medical conditions, physical status, sensory and physical impairments, nutritional status, special treatments and/or procedures, mental and

psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, and medication regimen completed by the DON prior to 9/15/2021.

- The facility's RN will fulfill the needs of the residents #1 - #5 through annual assessments and after an incident, change in condition, or discharge from hospital or rehabilitation facility.
- All residents change in condition, care needs, medication needs, or any other care needs will be discussed in monthly QA meeting.
- Current resident charts #1 - #5 will be audited by October 1,2021 and then every 6 months thereafter.
- Date of compliance 10/01/2021.

S5020 Ch 12 Sec 7 (e) Assisted Living Facility (ALF) Core Services

- Corporate Officer and Manager will review policies and practices with record keeping and file storage.
- All current resident's charts will be audited and updated by October 1, 2021.
- Corporate Officer and Manager will provide a training of appropriate resident file management, ease of access for qualified employees, record retention and storage.
- Manager and Corporate Officer will review current resident files to validate that all necessary paperwork is in each file, they are located in a safe and secure place and accessible to appropriate personnel. Current files as well as Discharged files will be retained for a minimum of 6 years, contain all the necessary state required documentation and made available by advanced request in a reasonable timeframe as they are stored offsite.
- Corporate Officer and Manager will audit resident files once a month for 3 months, then every quarter following our regular quarterly reviews.
- Upcoming QA meeting will encompass resident file storage, resident file contents, accessibility and file retention longevity.
- Date of compliance 10/01/2021

S5047 Ch 12 Sec 8 (a) Services Which Cannot Be Provided By Level 1

- The DON or RN will complete a residents assistance plan, annually, with new admission or change of condition.
- The company had issued the resident and POA a 30 day notice prior to survey to find alternative placement due to company policy violations, behaviors and inappropriateness. Case manager and corporate have been working with POA in assisting with a safe and smooth transition for Resident 3.
- Corporate and Manager will monitor the situation every other day until Resident 3 is discharged to a safe environment.
- Corporate officer and Manager will conduct a training for staff regarding discharge policies, transfer of care and grievance.
- Corporate officer and Manager will consult with RN regarding all other residents, assessments and care plans, inappropriateness for future monitoring and upcoming QA meeting.
- Corporate officer and Manager have been notified and are working with ombudsman, case manager, POA regarding discharge and transfer of resident 3.
- Our upcoming QA meeting will include discussions addressing any care need changes with residents, Care Plans, Annual Assessments and other.
- The DON or RN will review assistance plans (by 09/10/2021) for each current residents 1- 5.
- RN will validate that current ALF 102's, resident Assessments and Care Plans that were started 6/1/21 are completed and in resident's files.
- Date of compliance 10/01/2021

Eric McMillan, President: Eric McMillan Date: 9/4/21