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 _____	C 08/17/2021

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 08/28/2001. A complaint survey was conducted by Healthcare Licensing and Surveys on 8/17/21. The survey was prompted by complaint intake LIC-21-016. Based on the findings of the survey team, it was determined no deficiencies were identified pertaining to the complaint investigation. In addition, a COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted by Healthcare Licensing and Surveys from 8/17/21 to 8/17/21.	S 000		10/15/21 GH
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	S5003		

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

Kenyne Humphrey — Admin — 9/3/21

Revised 9/30/21 Kenyne Humphrey
10/1/21 10:30 a.m. The POC is accepted, notified the administrator - Colleen Hagen RN

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 _____	C 08/17/2021

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
S5003	Continued From page 1 employed until a work release is obtained. (A) The facility shall prohibit employees with a communicable disease or infected skin 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 and policy and procedure review, the facility failed to ensure infection control measures were maintained in 1 of 3 observations of resident care (resident #1). The findings were: 1. Observation on 8/17/21 at 1:10 PM showed medication aide (MA) #1 and certified nursing assistant (CNA) #1 assisted resident #1 in the bathroom. MA #1 donned gloves, removed the resident's briefs, performed perineal-care and then dressed the resident in clean briefs and pants. MA #1 and CNA #1 then removed their gloves and left the room without performing hand hygiene. CNA #1 used a key to open the janitor's closet door, and MA #1 opened the door and placed garbage in the bin. MA #1 and CNA #1 walked to the kitchen area. MA #1 swiped her badge to unlock the kitchen door, then touched the handle to open the door. Further observation showed both employees then washed their hands at the sink in the kitchen. Interview with both employees at the time stated the only place to wash their hands was in the kitchen, and they did not carry alcohol hand sanitizer in their pocket because the facility did not give them any. They further stated they should have washed their	S5003		

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 _____	C 08/17/2021

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
S5003	Continued From page 2 hands in the resident's room. Interview with the DON on 7/17/21 at 4:22 PM revealed she had just handed out pocket-sized alcohol sanitizer to the staff. She further stated they did not mount alcohol rub dispensers on the walls because some of the residents put it in their mouth. 2. Review of the facility policy titled COVID Policy, with a revision date 3/24/21, showed "...pg. 28...Hands must be washed when visibly dirty; before direct contact with patients; after contact with blood, bloody fluids or excretions, mucous membranes, non-intact skin, or wound dressings; after contact with a patient's intact skin; if hands are moving from a contaminated body site to a clean-body site during patient care, after contact with inanimate objects in the immediate vicinity of a patient; after removing gloves..."	S5003		

PLAN OF CORRECTION – August 17, 2021

Mountain Plaza Assisted Living
4154 Talon Drive
Casper, WY 82604

S5003 Chapter 12, Section 6

Deficiency 1: Failed to ensure infection control measures were maintained in one of three observations of resident care.

Identification of Others: All employees that provide resident care have the potential of not following proper hand hygiene.

Responsibility: Administrator, Director of Nursing

Corrective Action: All current and future employees will be provided education on proper hand hygiene. Each employee will carry hand sanitizer as part of their uniform. Unannounced audits of handwashing practices will be completed. Any deficiency noted during an audit will be immediately corrected with immediate retraining.

Systemic Changes/Education: A wellness department meeting was held 9/1/2021 to review handwashing practices. Hand sanitizer was given to each wellness department employee on 8/17/21 and additional supplies available were received on 8/31/21. Hand sanitizer stations were placed in the utility closet in the memory care unit as well as additional dispensers throughout the building to improve access to hand sanitizer throughout the building.

Monitoring: The Director of Nursing will conduct four hand hygiene audits per day for two weeks, then three audits per day for two weeks, and then randomly each week. Results of the audits will be reported at monthly staff meetings and QA meetings.

Completion Date: Completion at 10/15/2021.

MOUNTAIN PLAZA
ASSISTED LIVING & MEMORY CARE COMMUNITY

Hand Hygiene Audit

Date	Employee	Observation Location	Satisfactory completion?	Retraining required?	Manager Initials
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	