Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF014	A. BUILDING: _____ B. WING _____	09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING WIND ASSISTED LIVING COMMUNITY	1072 NORTH 22ND STREET LARAMIE, WY 82072

(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 9/8/21. In addition, a COVID-19 focused infection control survey was conducted by Healthcare Licensing and Surveys on 9/8/21. The following common abbreviations are used throughout this document: CNA: Certified Nurse Assistant DON: Director of Nursing Less commonly used abbreviations will be annotated in each deficiency.	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	S5003	**S5003** **Ch 12 Sec 6 (d) Personnel and Staffing Requirements** A: Executive Director and Business Director completed a full Audit of all personnel files identifying all TB records missing or out of compliance. Business Director will work with nurses to complete all TB testing and screenings, bringing all files back to compliance.	

Accepted. I spoke with Ron Shriver, ED on 10/29/21
The date of Correction is 11/5/21 Lora Lee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF014	A. BUILDING: _____ B. WING _____	09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING WIND ASSISTED LIVING COMMUNITY	1072 NORTH 22ND STREET LARAMIE, WY 82072

(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 (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 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 review of personnel records, staff interview, and policy and procedure review, the facility failed to ensure tuberculin (TB) testing or screening was completed for 3 of 4 records reviewed (staff #1, staff #2, staff #4). The findings were: 1. Review of the personnel record for staff #1 showed she was employed as a cook on 8/30/21. The record failed to include information related to TB testing or screening. 2. Review of the personnel record for staff #2 showed she was employed as a CNA on 6/25/21. The record failed to include information related to TB testing or screening. 3. Review of the personnel record for staff #4 showed she was employed as a personal care assistant on 6/25/21. The record failed to include information related to TB testing or screening. 4. Interview with the executive director on 9/8/21 at 5:25 PM confirmed the information related to	S5003	C. To ensure we remain compliant, Executive Director or Business Director will randomly audit no less than 3 employee files monthly as part of our monthly QA process. This is in addition to adding TB testing to our initial hiring packet and creation of document to track each employees TB test expiration dates.	11/05/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF014	A. BUILDING: _____ B. WING _____	09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING WIND ASSISTED LIVING COMMUNITY	1072 NORTH 22ND STREET LARAMIE, WY 82072

(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 TB testing and screening was not available for those staff members. 5. Review of the August 2020 policy and procedure for "TB Screening Wyoming-Employee" showed: "Each new employee will receive Tuberculin testing prior to employment and annually thereafter or provide documentation of a negative test administered within the last 12 months."	S5003	**S5030 (1)** **Ch 12 Sec 7 (j)(vi) Assisted Living (ALF) Core Services** A: Executive Director and Environmental Service Director have scheduled the repairs of both the damaged floor and damaged wall. B: Damaged floor will be scraped and cleaned. New commercial vinyl floor will be installed over damaged area. Damaged wall will be scraped and cleaned. Wall will be painted with appropriate commercial paint. Both projects will be completed after hours to eliminate the risk of cross contamination. C: Damages such as this will be added to our monthly kitchen inspection. All identified physical damages will be addressed and/or repaired immediately upon discovery. Kitchen inspections will be completed by Executive Director, as part of our Monthly QA process.	11/05/2
S5030	Ch 12 Sec 7 (j)(vi) Assisted Living Facility (ALF) Core Services (j) (vi) The kitchen and dining area shall be kept clean and sanitary in accordance with standards established in the current edition of FDA Food Code. The dining area shall provide suitable furniture and adequate space to comfortably seat all residents. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, and review of the FDA Food Code, the facility failed to ensure sanitation standards were met in 2 of 2 food service areas (the kitchen and the memory care dining area). The findings were: 1. Observation on 9/8/21 at 4:24 PM showed there was damage to the floor in the back food storage area of the kitchen. The area measured 12 feet by 4 feet where the tile was missing under and around 2 refrigerator units. The area created a surface that was not easily cleanable and debris was building up around the edges. 2. Observation on 9/8/21 at 4:25 PM showed the	S5030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF014	A. BUILDING: _____ B. WING _____	09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING WIND ASSISTED LIVING COMMUNITY	1072 NORTH 22ND STREET LARAMIE, WY 82072

(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
S5030	Continued From page 3 wall behind the food preparation table was damaged. There was scraped paint and the wall was not clean with food/splash debris visible. 3. Observation of the noon meal in the memory care dining area on 9/8/21 at 12:03 PM showed 2 CNAs were responsible to dish up the food for the residents from a small heated unit and then serve the meals. CNA#1 was observed to dish up the food on to plates and she did not wear any hair restraint. CNA #2 took the plates to the residents. CNA #2 donned gloves at 12:07 PM without any hand washing prior, she then delivered resident meals without any hand hygiene between residents. When delivering meals she handled the plates and utensils and was observed to touch at least one resident on the arm. Interview with CNA #2 on 9/8/21 at 12:13 PM stated she usually used hand sanitizer between deliveries of resident meals; however, today chose to wear gloves. 4. Interview with the DON and the Executive director on 9/8/21 at 5:30 PM confirmed hand hygiene was expected to take place in between resident cares. Additionally, the executive director confirmed he was aware the floor and wall in the kitchen were in need of work and the work needed to be scheduled. 5. According to Food Code 2017, U.S. Public Health Service: 2-301.14 "FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLE and: " ...(H) Before donning gloves to initiate a task	S5030	**S5030 (2)** **CH 12 Sec 7 (j)(vi) Assisted Living (ALF) Core services** A: Executive Director and Dining Director have identified appropriate education and training to provide all employees assisting in the dining experience. Education includes food service hygiene and proper glove use. B: All appropriate personnel will be provided education and training. All appropriate future employees will be provided food service hygiene and proper glove use training during the onboarding process. C: Documentation of all provided training and education topics will be completed on our online education program (relias online education) This will be overseen by our Business Director.	11/05/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF014	A. BUILDING: _____ B. WING _____	09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING WIND ASSISTED LIVING COMMUNITY	1072 NORTH 22ND STREET LARAMIE, WY 82072

(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
S5030	Continued From page 4 that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands." 6. According to Food Code 2017, U.S. Public Health Service: 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. 7. According to Food Code 2017, U.S. Public Health Service: 2-402.11 "(A) ...FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES."	S5030		