Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF011	A. BUILDING: _____ B. WING _____	C 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE JOURNEY	624 TWIN RIDGE AVENUE EVANSTON, WY 82930

(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 06/26/2001. A complaint survey was conducted by Healthcare Licensing and Surveys on 11/15/21 to 11/16/21. The survey was prompted by complaint intake LIC-22-001. In addition, a COVID-19 focused infection control survey was conducted by Healthcare Licensing and Surveys on 11/15/21 to 11/16/21. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant LPN: Licensed Practical Nurse 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;	S5003		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joy Bell | TITLE: Owner | (X6) DATE: 12/9/2021

1/10/22 2:45 pm: the POC is accepted with a DOC 12/31/21. Notified the owner, Joy Bell - Colleen Hopkins

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S5003	Continued From page 1 (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 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 review of the Wyoming Department of Health guidelines and "14-day Transmission Indicators by County" report the facility failed to ensure appropriate infection control practices were implemented to prevent the spread of COVID-19. The census was 12. The findings were: Related to source control: 1. Observation on 11/15/21 at 5:15 PM showed LPN #1, CNA #1, and 6 residents were in the dining room. 2 residents sat across from each other at table #1 and 4 residents (including resident #1) were seated at table #2, within an arm's length of each other, preparing for the evening meal and visiting. The residents, LPN #1 and CNA #1 were not wearing facemasks. 2. Observation on 11/15/21 at 5:35 PM showed the owner arrived at the facility and did not don a facemask upon entrance.	S5003		

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S5003	Continued From page 2 3. Observation on 11/16/21 at 8:16 AM of the facility showed the owner, staff #1, cook #1, CNA #2, and LPN #1 were not wearing facemasks. 4. Interview with LPN #1 on 11/16/21 at 8:20 AM revealed staff did not wear a facemask in the facility unless someone was sick or coughing, however if a staff member was sick they were asked not report to work. In addition, LPN #1 stated the facility attempted to social distance the residents. 5. Interview with the owner on 11/15/21 at 5:50 PM revealed the facility had chosen to not have staff wear facemasks unless someone showed signs or symptoms of an infection. The owner stated 70% of the facility's staff and 11 out of the facility's 12 residents had been vaccinated against SARS-CoV-2. In addition, she stated staff members were "careful" when they were out in the community and the residents and staff social distanced themselves. In an additional interview on 11/16/21 at 8:30 AM the owner confirmed the facility was using the infection control guidance issued by the Wyoming Department of Health. 6. Review of the Wyoming Department of Health "Updated Nursing and Assisted Living Facility Guidance", dated 5/7/21, showed "...The following precautions should be taken during communal dining: Fully vaccinated residents can participate in communal dining without use of source control or physical distancing. If unvaccinated residents are dining in a communal area, all residents should wear masks when not eating and unvaccinated residents should continue to remain at least six (6) feet from others...In general, fully vaccinated staff should continue to wear masks while at work. However, fully vaccinated staff	S5003		

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S5003	Continued From page 3 could dine and socialize together in break rooms and conduct in-person meetings without masks or physical distancing. If unvaccinated staff are present, everyone should wear masks and unvaccinated staff should physically distance from others..." Related to routine COVID-19 testing of unvaccinated or not fully vaccinated staff: 1. Review of the facility's documentation showed no evidence routine COVID-19 testing of unvaccinated staff was conducted. 2. Interview with the owner on 11/16/21 at 8:35 AM confirmed the facility was not conducting routine testing of unvaccinated staff members. 3. Review of the Wyoming Department of Health "14-Day Transmission Indicators by County November 4, 2021 through November 17, 2021" showed Uinta County had a test positivity rate of 9.1%. 4. Review of the Wyoming Department of Health "Updated Nursing and Assisted Living Facility Guidance", dated 5/7/21, showed "...Facilities should conduct routine screening testing of unvaccinated or not fully vaccinated staff according to the schedule below. Fully vaccinated staff may be exempt from screening testing. Facilities located in counties with > 10% positivity of viral tests in the past week should test unvaccinated staff twice a week. Facilities located in counties with 5-10 % positivity of viral tests in the past week should test unvaccinated staff once a week. Facilities located in counties with <5% positivity of viral tests in the past week should test unvaccinated staff once a month."	S5003		

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S5014	Continued From page 4	S5014		
S5014	Ch 12 Sec 7 (c) 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: (i) Be treated with respect and dignity; (ii) Privacy; (iii) Free from physical or chemical restraints not required to threat the resident's medical symptoms. No chemical or physical restraints will be used except by order of a physician; (iv) Not to be isolated or kept apart from other resident's (v) Not to be physically, psychologically, sexually, or verbally abused, humiliated, intimidated, or punished. (vi) Live free from involuntary confinement or financial exploitation; (vii) Full use of the facility's common areas; (viii) Voice grievances and recommend changes in policies and services; (ix) Communicate privately, including, but not	S5014		

Healthcare Licensing and Surveys

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S5014	Continued From page 5 limited to, communicating by mail or telephone with anyone; (x) Reasonable use of the telephone, which includes access to operator assistance for placing collect telephone calls; (xi) Have visitors, including the right to privacy during such visits; (xii) Make visits outside the facility. The facility manager and the resident shall share responsibility for communicating with respect to scheduling such visits; (xiii) Make decisions and choices in the management of personal affairs, assistance plans, funds, or property; (A) Including choice of home health agencies, pharmacies, personal care providers and any other private pay provider. (xiv) Except the cooperation of the provider in achieving the maximum degree of benefit from those services which are made available by the facility; (xv) Exercise choice in attending and participating in religious activities; (xvi) Reimbursed at an appropriate rate for work performed on the premises for the benefit of the operator, staff, or other residents, in accordance with the resident's assistance plan; (xvii) Informed by the facility thirty (30) days in advance of changes in services or charges;	S5014		

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S5014	Continued From page 6 (xviii) Have advocates visit, including members of community organizations whose purpose include rendering assistance to the residents; (xix) Wear clothing of choice unless otherwise indicated in the resident's plan, and in accordance with reasonable dress code; (xx) Participate in social activities, in accordance with the assistance plan; and (xxi) Examine survey results. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview the facility failed to ensure residents were treated with respect and dignity during 1 random observation which affected resident #4. The findings were: 1. Observation on 11/16/21 at 8:16 AM showed resident #4 was seated on the sofa in the common room. The resident was dressed with his/her undergarments on the outside of his/her pants. CNA #2 was quietly encouraging the resident to come with her to attend to the situation. Staff #1 came out of the office and began laughing, and called to LPN #1 to come and get your "laugh for the day." At that time the surveyor intervened. During an interview with staff #1 and LPN #1 following the incident, both staff members confirmed laughing at a resident with dementia was inappropriate. 2. Interview with the owner on 11/16/21 at 12:20 PM confirmed the resident had not been treated with respect and dignity.	S5014		

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S5020	Continued From page 7	S5020		
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; (V) Name, address, and telephone number of resident's personal physician, dentist, ophthalmologist or optometrist; (VI) Medicare number or other	S5020		

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S5020	Continued From page 8 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 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	S5020		

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S5020	Continued From page 9 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 of 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 al 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. (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.	S5020		

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S5020	Continued From page 10 (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 review of facility incident reports, resident record review, staff interview, and review of the Licensing Division incident reporting log, the facility failed to report 3 out of 4 incidents reviewed to the Licensing Division that required such reporting. These incidents involved residents #4, #5, #6 and #7. The findings were: 1. Review of a facility incident report showed the facility received a phone call on 8/27/21 from the police department informing them resident #6 had fallen in the subdivision next door to the facility and was taken via ambulance to the emergency department. Review of a progress note dated 8/27/21 showed "[Resident] had walked down the street and had fallen, ambulance had been called. [Resident] was taken to ER for assessment and discharged. Some scrapes and bruises. Extremely confused when [s/he] got back	S5020		

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S5020	Continued From page 11 to facility; more so than usual." Interview with the owner and LPN #1 on 11/16/21 at 12 PM revealed they were unaware the resident had left the facility grounds until they received the phone call from the police department. The facility put precautions in place following the incident to prevent a reoccurrence. Review of the Licensing Division incident reporting log showed no evidence the incident was reported. 2. Review of a facility incident report showed a resident-to-resident altercation occurred on 3/11/21 between resident #4 and resident #7. Review of the Licensing Division incident reporting log showed no evidence the incident was reported. 3. Review of a facility incident report showed resident #5 had fallen in the bathroom on 2/21/21. The resident was unable to move his/her left leg or hand, had slurred speech, and was lethargic. The ambulance was called and the resident was transferred to the emergency department. Review of the Licensing Division incident reporting log showed no evidence the incident was reported. 4. Interview with LPN #1 and the owner on 11/16/21 at 12 PM confirmed the incidents had not been reported to the Licensing Division as required.	S5020		

Name of Provider: Compassionate Journey

Date of Survey: 11/16/2021

Prefix tag numbers: S5503, S5014, S5020

Tag S5003 – Personnel and Staffing Requirements

(d) Infection Control

In order to address the changes needed in the Infection Control arena, specifically with regard to COVID 19 compliance, Compassionate Journey, its staff and its residents, will do the following:

1. The owner will access either the CDC website or the Uinta County Public Health office to obtain the current Uinta County positivity rate each Monday at the beginning of the standard work week. Based on that number, the CDC and Wyoming Department of Health adopted guidelines will be followed by both staff and residents.
2. Based on the County positivity rate, the unvaccinated staff and residents will be tested for SARS COVID 19 will be tested for the virus based on the current protocols. The vaccinated staff and residents will follow the CDC procedure as well, based on the weekly positivity rate.
3. The owner of Compassionate Journey will review the guidelines and updates weekly and make any necessary changes to the way in which the guidelines need to be applied. The owner of the facility will keep up-to-date on the latest procedures set forth by the State of Wyoming and the CDC. The owner will review the guidelines by 12/6/2021.
4. The owner of Compassionate Journey will encourage all unvaccinated staff and residents to become fully vaccinated for COVID 19.
5. All staff will be required to don masks during their shifts, and will also be required to socially distance within the facility.
6. Unvaccinated residents will need to don masks in the facility when they are unable to be socially distant from other in the facility.
7. All staff and visitors will be screened for signs and symptoms of COVID 19 daily, using the CDC protocol in place. The staff and resident records will be kept in the facility records. The visitor information will be recorded with a sign-in sheet available at the entrance of the building and recorded in a separate file from the staff and resident records. The owner will review the information regarding staff and visitors at the beginning of each month.
8. All visitors will be required to don masks during their visit in the facility.
9. The owner of the facility is responsible for communicating and implementing the changes in protocol in place for COVID 19. The changes in current procedure will be fully implemented by 12/13/2021.
10. All data gathered regarding the COVID 19 infection control regulations will be reviewed quarterly through analysis of the information presented to the owner. The data will include

Name of Provider: Compassionate Journey

Date of Survey: 11/16/2021

Prefix tag numbers: S5503, S5014, S5020

Tag S5003 - continued

temperature and symptom logs, weekly information on status of Uinta County at CDC website, the visitor log, and the surveillance testing log.

Tag S5014 – Ch 12 Sec 7 (c) Assisted Living Facility (ALF) core services

(c) Resident Rights

In order to correct the issues with regard to Resident Rights, Compassionate Journey will implement the following:

1. The owner will review the current policy regarding Resident Rights to ensure that it is complete and contains all resident rights stipulated in the statute. This task will be completed by 12/13/2021.
2. The two employees involved in the violation of the Resident Rights were each counseled by the owner on the violation, the resident right that was violated, and how to change their behavior and address the residents in a more compassionate and dignified manner. Additionally, safeguards were put in place to ensure that residents are appropriately covered if not appropriately dressed. Counseling and changes in process will be completed by 12/6/2021.
3. The current staff at Compassionate Journey was educated on resident rights, and the document was presented to each one. Each member of the staff has a more complete understanding of the rights and how to implement changes, when needed, to ensure the rights are held in high regard. All staff will be made knowledgeable by 12/24/2021.
4. Upon hire of new employees, the owner will review the resident rights with each new staff member hired. This will be completed within 5 days of hiring. It will become part of the orientation of the new employee. Each staff member will sign a document indicating that Resident Rights have been reviewed.
5. Upon admission of a new resident to the facility, the owner will review the Resident Rights document with the new resident and necessary family members.
6. The owner will post Resident Rights documentation in the common areas of the building, in all offices, and in each resident room. The posting will be completed within the facility areas by December 17, 2021.
7. All resident and personnel files will be reviewed for signature on the Residents Rights document by the owner by 12/31/2021 to ensure that there is a clear understanding of the document and how it is implemented in the facility.

Name of Provider: Compassionate Journey

Date of Survey: 11/16/2021

Prefix tag numbers: S5503, S5014, S5020

Tag S5014 - continued

8. Resident rights reviews for existing and new staff and residents will be added to the quality improvement process and reviewed on a quarterly basis. Information regarding the number of new staff, new residents, and dates of review will be available for review.

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

(e) Resident Records and Reports

In order to correct the issues with regard to Incident Reporting, Compassionate Journey will implement the following:

1. Each incident will be reviewed within 1 business day of its occurrence. The owner or manager of the facility will review the documentation and make decisions necessary to solve any issues within the facility.
2. The owner and manager will place the flowchart in the Incident Report binder so that it can be easily accessed to review incidents. This will be done by 12/13/2021.
3. The owner and manager will log all incidents and tag all incidents that were reported to the State of Wyoming. The flowchart will be available in the binder by December 13, 2021.
4. The person reviewing the incident reported will access the flow chart provided by the State of Wyoming Department of Health for guidance to decide if the incident is at a level in which it needs to be reported at the State level.
5. If the incident is determined to meet the State reporting requirements, the owner or manager will report the incident through the reporting system established by the Department of Health. This reporting will occur within 1 business day of the in-house incident review.
6. With regard to the incidents not reported in a timely manner to the State of Wyoming, Resident #5 passed away; Resident #6 has been moved to a facility because of a requirement for a higher level of care, and Resident #4 remains at the facility. Resident #4 is watched consistently for interaction with other residents as he becomes agitated when others are close to him or touch his belongings (walker, chair, etc). When he enters the common areas of the building, staff is on alert to be more vigilant about interaction between him and other residents. Any interaction that is inappropriate with other residents will be reported within one business day.

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7. The incident reports and log will be kept in the administrative office at the facility. The reports and log will be reviewed quarterly by the owner to ensure that all incidents that qualified for reporting to the Department of Health have been sent through the reporting system. The review of the incident reports will be added to the quality improvement program for Compassionate Journey by 12/31/2021.