Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF002	A. BUILDING: _____ B. WING _____	03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN SQUARE OF CASPER	1950 SOUTH BEVERLY STREET CASPER, WY 82601

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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 06/28/2001. A licensure survey was conducted by Healthcare Licensing and Surveys from 3/23/22 to 3/24/22.	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 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.	S5003	The facility will ensure infection control policies are followed. The corrective action that will be taken for employee #2 who was found to be affected by the deficient practice will be for employee #2 to be screened for TB by 06/13/2022. The Clinical Director/Administrator will ensure documentation is completed and placed in the employee's personnel file. To identify any other staff or resident found to be affected by the deficient practice, BOD/ED will conduct an audit of personnel records for TB Screening on new hires within the last 12 months. Any missing screenings will be completed by May 20th, 2022. To ensure the deficient practice does not recur, TB screening forms will be included in the new hire packet. BOD/ED will monitor for completion and negative results before the employee starts working with residents. This will be completed May 1st, 2022. To monitor the corrective action, the BOD/ED will sign off on the New Hire Checklist once TB test and other items listed are completed. This checklist will be utilized and implemented by May 20th, 2022.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mercedes Ortega

TITLE: Executive Director

(X6) DATE: 4.14.22

This POC was accepted 4/25/22, and the DON was notified at 3:59 PM. Their DOC is 5/20/22.

Jason Cooney, RN 42180

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S5003	Continued From page 1 This State Rule and Regulation is not met as evidenced by: Based on employee record review and staff interview, the facility failed to ensure tuberculin (TB) testing or screening was performed and documented for 1 of 4 employees (#2) reviewed. The findings were: 1. Review of the employee record for staff member #2 showed no documentation TB testing or screening had been performed prior to resident contact. 2. Interview with the administrator on 3/24/22 at 1:44 PM confirmed there was no documentation the employee had been screened or tested prior to working with residents.	S5003		
S5006	Ch 12 Sec 7 (b)(i) Assisted Living Facility (ALF) Core Services (b) Resident Assessment and Services, The staff/contract Registered Nurse (RN) shall conduct initial and, at the minimum annually, and accurate, standardized, reproducible assessment of each resident's functional capacity, physical assessment and medication review. (i) The completion of the ALF 102. (A) The current version of the ALF 102 is the designated screening tool. The form may be updated and /or revised periodically by the Program Division. Providers will be notified of changes in the form. The following guidelines apply to the ALF 102: (I) The ALF 102 is only valid if completed within forty-five (45) days prior to admission and there is no change in the	S5006	The facility will ensure accurate assessments for all residents. The corrective action that will be taken for residents #3 and #4 found to be affected by the deficient practice will be to complete a new ALF 102 by 05/01/2022. To identify any other residents found to be affected by the deficient practice will be for the ED/Clinical Director/designee to review records and identify residents that require updated ALF 102 assessment and complete those forms by 5/1/2022. To ensure the deficient practice does not recur, the ALF 102 form will be incorporated into the admission packet by 05/01/2022, with documentation on the admission checklist for new move ins. This will be completed by ED/Clinical Director. For ongoing ALF 102 assessments-ED/Clinical director will complete a spreadsheet/checklist with resident name, date ALF 102 form was last completed and date next due. The ALF 102 forms will be completed on or before the next due date. This will be done by 5/20/2022. To monitor the corrective action, the ED/Clinical director will conduct periodic chart reviews with focus on ALF 102 form completion.	

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S5006	Continued From page 2 resident's condition. (II) The ALF 102 must be completed and signed by an RN. (III) The ALF 102 may be completed telephonically; however, it must be verified in person by an RN. (IV) A new ALF 102 shall be completed at least annually, and when there is a change in the resident's condition. This State Rule and Regulation is not met as evidenced by: Based on resident record review and staff interview, the facility failed to ensure the ALF 102 assessments were completed as required for 2 of 6 sample residents (#3, #4). The findings were: 1. Review of the resident record showed resident #3 was admitted to the facility on 2/26/11 with diagnoses that included Type II diabetes mellitus. The following concerns were identified: a. Review of the resident record failed to show ALF 102 assessments were performed prior to admission in 2011, with no documented annual assessments performed until 2017. Further review showed no assessment was documented in 2018 or 2020. 2. Review of the resident record showed resident #4 was admitted to the facility on 8/18/21 with diagnoses that included Alzheimer's disease. The following concerns were identified: a. Review of the resident record failed to show an ALF 102 assessment was documented prior to admission.	S5006		

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S5006	Continued From page 3 3. Interview with the administrator on 3/24/22 at 1:44 PM confirmed the records were missing the ALF 102 assessments for both residents.	S5006		
S5021	Ch 12 Sec 7 (f) Assisted Living Facility (ALF) Core Services (f) Resident Activities. An activities program shall be available to the resident and shall be designed to enhance each resident's sense of physical, psychosocial, and spiritual well-being. (i) A member of the facility's staff shall be designated as responsible for the resident activities program; (ii) Space, equipment, and supplies for the activities program shall be adequate for individual and/or group activities; and (iii) There shall be regularly scheduled activities during weekdays, evenings and weekends. This State Rule and Regulation is not met as evidenced by: Based on staff interview and activity calendar review, the facility failed to provide regularly scheduled activities for residents during the weekends. The findings were: 1. Review of the facility activity calendar for March 2022 and April 2022 showed multiple daily activities available to the residents on Monday through Friday. However, the calendar failed to show any activities available on Saturdays or Sundays.	S5021	The facility will ensure regularly scheduled activities during weekends. The corrective action that will be taken for residents found to be affected by the deficient practice will be to revise the april activities calendar to include weekend activities for the remainder of the month. This will be completed by 04/15/2022 by the Activity Director To ensure the deficient practice does not recur, The Activity Director will include weekend activities on all subsequent calendars before posting in the community. ED will provide documented training to the Activity Director re: weekend activities. This will be completed by 5/1/2022. To monitor the deficient practice from occurring again, ED will conduct weekly review of Activity calendars before posting to ensure weekend activities are included.	

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S5021	Continued From page 4 2. Interview with the administrator on 3/24/22 at 1:44 PM revealed the activity director was new, and trying to get the program going again. She further stated the facility did not have activities scheduled over the weekend.	S5021	The facility will ensure safe and sanitary food standards. The corrective action that will be taken for anyone found to be affected by the deficient practice will be that the ED will provide sanitation and safe food handling training to staff assisting with food preparation by 05/01/2022. To ensure the deficient practice does not recur the Dietary Manager/ED will monitor to ensure staff are using safe techniques during food handling. Additionally, Staff training on sanitation and safe food handling will be conducted at least annually for staff assisting with food preparation and handling. The corrective action that will be taken for any residents found to be affected by the deficient practice will be to dispose of any opened items with no dates (open or expiration) on the container by 05/01/2022. This will be completed by the Dietary Manager/ED.	
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 and staff interview, the facility failed to ensure food was prepared and stored in a clean and sanitary manner during 2 random observations. The findings were: 1. Observation of the facility kitchen during meal preparation on 3/24/22 at 8:20 AM showed 4 employees preparing breakfast, including the facility administrator and van driver. The following concerns were identified: a. Observation on 3/24/22 at 8:36 AM showed the facility van driver wearing gloves, a hair net, and apron while preparing and handling food and items on the kitchen steam table. She removed a lid to one of the steam table bins, removed the remaining breakfast rolls, and carried them to the trash can, dropping one roll onto the floor in the process. After disposing of the rolls she was carrying, she picked up the roll from the floor with her gloved hand, and disposed of it. Without	S5030		

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S5030	Continued From page 5 changing her gloves or washing her hands, she returned to the steam table and began again handling food and items on the table. b. Interview with the van driver at that time revealed she " ... didn't realize I needed to change [the gloves] since it's all probably dirty." 2. Observation of the resident common area showed a refrigerator and freezer free to be used by the residents and activity program. The following concerns were identified: a. Observation of the "Refrigerator & Freezer Temperature Log" posted on the side of the refrigerator was dated "March 2021" and only contained 2 documented temperatures. b. Observation of the contents of the refrigerator and freezer showed 32 separate items that did not display open or expiration dates of any kind. c. Interview with the administrator on 3/24/22 at 9:35 AM confirmed the temperature log had not been completed or monitored. She also confirmed the posted log was from one year ago, and was not aware who was supposed to be monitoring the temperatures. She further confirmed the numerous items in the refrigerator and freezer needed to be dated and documented on because staff and residents all had access to the common area and appliances.	S5030	The corrective action that will be taken for any residents found to be affected by the deficient practice will be for the ED to provide an updated temperature log for the refrigerator with current temps documented. This will be completed by 05/01/2022. To prevent the deficient practice from occuring again, the Dietary Manager/ED will assign staff to check and record temps at the frequency indicated on the temperature log. The Dietary Manager/ED will monitor temp log weekly for completion. Additionally, the Dietary Manager/ED will monitor refrigerator weekly for open/expired dates on the labels of opened containers and disposing of those containers beyond the expiration date.	
S5046	Ch 12 Sec 7 (o)(iii) Assisted Living Facility (ALF) Core Services (o) (iii) Fire Safety. (A) Portable fire extinguishers shall be installed, inspected, and maintained according with NFPA 10, Standard for Portable Fire Extinguishers.	S5046		

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S5046	Continued From page 6 (I) State of Wyoming certified individuals shall inspect and service the extinguishers. All extinguishers shall have a tag or label securely attached that indicate the month and year the maintenance was performed and that identifies the person performing the service. (B) Readily available and clearly readable telephone numbers for emergency contacts shall be located near all telephones. (C) Clearly readable floor diagrams reflecting the actual floor arrangement showing the exit locations and evacuation routes shall be posted in conspicuous places. Each resident shall be instructed with its use on the first day of admission. (D) Residents training for the fire emergency plan shall be in accordance with the Life Safety Code Operating Features sections. (I) On the first day of admission, each resident shall be instructed in the proper action of the fire emergency plan, including the location of all the exits. A record of this instruction shall be in each resident file. (E) Fire exit drills shall be conducted in accordance to the Life Safety Code Operating Features sections. The minimum number of drills, as amended, shall be held at least twelve (12) times per year on a monthly basis with a minimum of one drill conducted each quarter on each shift. Fire exit drill records over a two-year period shall be available upon request at the facility.	S5046	The facility will ensure fire safety protocols for all residents and staff. The corrective action that will take place for Residents 3, 4, 5, 6 found to be affected by the deficient practice will be for residents to receive fire emergency training and a fire plan acknowledgement placed in their charts by 05/20/2022. This will be completed by Maintenance Director/ED. To identify any other residents from being affected by the deficient practice will be for the ED/Designee to review resident charts for completed Fire emergency training and the Fire emergency plan. The acknowledgment will be completed and filed in the chart for those records/residents without them. This will be completed by 5/20/2022. To prevent the deficient practice from recurring, the Maintenance Director/ED will provide documented training of fire emergency and the fire emergency plan for new residents upon admission. Once completed, the documents will be filed in the resident chart. ED will conduct chart reviews of new residents within 30 days of move in to ensure documentation of the fire emergency training and plan have been completed, documented and filed in the chart via the Move in Checklist.	

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S5046	Continued From page 7 (l) The facility shall be responsible for recording fire exit drills on an evaluation form that include at least the following: (1.) Date of drill; (2.) Time of day; (3.) Type of drill (Practice, Announced, Surprise); (4.) Residents who participated including staff and family members; (5.) The required (minutes and seconds) to evacuate all residents (including staff) from the occupied areas to a point of assembly as defined in the Life Safety Code; (6.) List of anyone, including staff and family members, who did not evacuate in the required time allowed by the evacuation capability rating of the facility. Evacuation capability rating for each facility shall be listed on the form; (7.) Comments on the factors that contributed to each individual's inability to evacuate successfully and any corrective actions recommended; and (8.) Signature and date of the person completing the form. This State Rule and Regulation is not met as evidenced by: Based on resident record review and staff interview, the facility failed to ensure 4 of 6 sample residents (#3, #4, #5, #6) were instructed on the facility's fire emergency plan upon admission. The findings were:	S5046		

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S5046	Continued From page 8 1. Review of the resident record showed resident #3 was admitted to the facility on 2/26/11 with diagnoses that included Type II diabetes mellitus. The following concerns were identified: a. Review of the resident record showed no documentation of the facility's fire emergency plan, or evidence education had been provided to the resident. 2. Review of the resident record showed resident #4 was admitted to the facility on 8/18/21 with diagnoses that included Alzheimer's disease. The following concerns were identified: a. Review of the resident record showed no documentation of the facility's fire emergency plan, or evidence education had been provided to the resident. 3. Review of the resident record showed resident #5 was admitted to the facility on 12/2/21 with diagnoses that included hypertension. The following concerns were identified: a. Review of the resident record showed no documentation of the facility's fire emergency plan, or evidence education had been provided to the resident. 4. Review of the resident record showed resident #6 was admitted to the facility on 8/4/20 with diagnoses that included coronary artery disease. The following concerns were identified: a. Review of the resident record showed no documentation of the facility's fire emergency plan, or evidence education had been provided to the resident. 5. Interview with the administrator on 3/24/22 at 1:44 PM revealed the resident record should contain a copy of the emergency plan education, and confirmed the documents were missing for all	S5046		

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S5046	Continued From page 9 four of the resident records.	S5046		