Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF030	A. BUILDING: _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE CHEYENNE, WY 82009

(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 complaint survey was conducted by Healthcare Licensing and Surveys on 5/4/22. The survey was prompted by complaint intakes LIC-22-020 and LIC-22-021.	S 000		
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,	S5005	Executive Director Primrose Retirement Community of Cheyenne May 27, 2022	

Notified Chris Allen the Executive Director.
The date of Compliance is 5/26/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF030	A. BUILDING: _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1630 DOROTHY LANE CHEYENNE, WY 82009

(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
S5005	Continued From page 1 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; (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;	S5005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF030	A. BUILDING: _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE CHEYENNE, WY 82009

(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
S5005	Continued From page 2 (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. This State Rule and Regulation is not met as evidenced by: Based on observation, resident, staff and family interview, and resident record review, the facility failed to ensure 2 of 5 sample residents (#1, #2) did not require care beyond the core services for assisted living facilities. The findings were: 1. Review of the 3/4/22 resident evaluation showed resident #2 had diagnoses that included atrial fibrillation, memory loss, chronic pain and depression. The resident required physical assist of 2 for showers and managing bowel and bladder care. The evaluation showed home health services were providing catheter care other than emptying of the catheter bag, which the facility staff were providing. The following concerns were identified: a. Review of the 12/18/21, 1/9/22, 2/17/22, 3/10/22, and the 4/16/22 monthly summaries showed the resident was bed bound and required assist of 2 to move in bed and required maximum assistance for dressing and grooming. The 2/17/22 monthly summary showed the resident was being discontinued from hospice care on 3/1/22. b. Observation of the resident on 5/4/22 at 11:24 AM showed s/he was lying in a hospital bed. The resident appeared well-groomed and there were no odors. Interview with the resident at	S5005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF030	A. BUILDING: _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE CHEYENNE, WY 82009

(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
S5005	Continued From page 3	S5005		

that time confirmed s/he was bed bound. The resident stated s/he could not walk and could not get out of bed without 2 people to help. The resident further stated s/he was happy with the care and ate meals in bed because s/he could not get out of bed to go to the dining room. When asked about toilet use the resident confirmed s/he did not use the toilet, the care was provided for him/her in bed.

c. Review of the third party service agreement dated 3/8/22 showed home health services were provided for catheter care as needed and monthly. The agreement dated 3/30/22 showed home health physical therapy services were provided 1 to 3 times per week. There were no additional service agreements for care to be provided outside of the assisted living facility staff.

2. Review of the 12/21/21 resident evaluation showed resident #1 had diagnoses that included dementia and cognitive confusion deficit. The evaluation showed the resident had intermittent episodes of incontinence and staff were to assist with incontinence care as needed. Review of the outside service care plan with a start date of 3/1/22 showed a personal care provider provided services daily from 6:30 AM to 9:30 AM. The services included incontinence care, bathing/dressing, cleaning and ensuring the resident made it to the morning meal in the dining room. The following concerns were identified:

a. Review of the 3/11/22 monthly summary showed the resident required extensive assistance for bathing, toileting, housekeeping and laundry. The notes showed care giver services provided the assistance in the mornings for these areas; however, there was increased incontinence during the day and the night.

b. Review of the 4/16/22 monthly summary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF030	A. BUILDING: _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE CHEYENNE, WY 82009

(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
S5005	Continued From page 4 showed the resident required "...continuous reminders and toileting every 2-3 hours...frequently incontinent of urine and stool, increased at night...increased need for observation due to falls..." c. Interview with the resident and the visiting family member on 5/4/22 at 11:03 AM confirmed the resident was pleasant but confused. Observation at that time showed the resident was dressed and seated in a recliner with an incontinence pad underneath him/her, and the room had an odor of urine. The family member stated s/he visited daily and confirmed the caregiver service was there only in the mornings. S/he stated s/he did not provide any care, and further confirmed the resident was requiring routine care for frequent bowel and bladder accidents. 3. Interview with the DON on 5/4/22 at 3:28 PM verified the extensive care required for these residents was beyond infrequent and although there were outside service agreements in place, the facility staff was providing the needed care when the outside service providers were not there.	S5005		

RR 6/10/22

PROVIDER'S PLAN OF CORRECTION

Date: **June 6, 2022**

Provider: **Primrose Retirement Community of Cheyenne**
1530 Dorothy Lane
Cheyenne, WY 82009

Provider/ CLIA Number: **ALF030**

Survey Completed: **May 4, 2022**

S5005 Assisted Living Facility Core Services

Resident #1 was discharged to another facility on May 19, 2022, for higher care. Resident #2 obtained additional third-party services beginning the week of May 9, 2022, and significant improvement has already been seen. Going forward, the nursing director will meet weekly with nursing staff to discuss any resident care issues or changes of condition. The nursing director has also instructed all care staff on the need for continuous observation of residents who would benefit from additional third-party services. Residents needing additional third-party services will also be discussed as part of the facility's Quality Assurance Team monthly meetings going forward.

Substantial compliance was achieved on May 26, 2022.

Please contact me at (307) 634-1530 or christopher.allen@primroseretirement.com if you have any questions or concerns. Thank you.

Sincerely,

Christopher W. Allen
Executive Director
Primrose Retirement of Cheyenne