Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF27	A. BUILDING: _____ B. WING _____	C 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONDELL HEIGHTS RETIREMENT COMMUNIT	106 E MAIN STREET NEWCASTLE, WY 82701

(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 Survey from 5/31/22 to 6/2/22. Also reviewed in the course of the survey was complaint intake LIC-22-025. The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide LPN: Licensed Practical Nurse RN: Registered Nurse Less Commonly used abbreviations will be annotated in each deficiency	S 000		
[redacted]	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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christi Taylor — TITLE: Owner/Administrator — (X6) DATE: 6/26/2022

7/25/22 - POC accepted. Julie VanDyke
DOC = 7/30/22.

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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 observation, staff interview, and review of Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to ensure appropriate infection control practices were implemented to prevent the spread of COVID-19. The census was 20. The findings were: 1. Observation on 5/31/22 at 12:05 PM showed CNA #2 was at the entry door, interacting with visitors, and no face mask was utilized. 2. Observation on 5/31/22 at 12:05 PM showed LPN #1 was in the dining room and provided medications to residents. At that time, neither the residents nor staff utilized a face mask. 3. Observation on 5/31/22 at 12:10 PM showed LPN #1 allowed RN #1 to enter the facility. Neither staff member wore face masks or practiced social distancing. 4. Interview with RN #1 and LPN #1 on 6/1/22 confirmed it had not been protocol to wear masks while in patient care areas; however, all staff wore masks shortly after the survey began, and for the	S5003		

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S5003	Continued From page 2 remainder of the survey. 5. Interview with owner #2 at 6/2/22 at 8:20 AM confirmed that since wearing masks was recommended and not mandatory, there was not an expectation, from administration, for staff to wear masks in the patient care areas. 6. Review of CDC Guidance titled "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic last updated 2/2/22, "...This guidance is applicable to all U.S. settings where healthcare is delivered...Implement Source Control measures... Source Control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source Control options for HCP [Healthcare Personnel] include: A NIOSH-approved N95 or equivalent OR a respirator approved under standards in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators... OR a well-fitting facemask...Source Control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a healthcare setting...Cloth mask...They are not personal protective equipment (PPE) appropriate for use by healthcare personnel..."	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	S5006		

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S5006	Continued From page 3 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 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, staff and resident interview, facility incident report review, and policy review, the facility failed to ensure ALF 102 assessments were completed as required for 5 of 6 sample residents (#1, #2, #3, #4, #5). The findings were:	S5006		

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S5006	Continued From page 4 1. Review of the resident record showed resident #1 was admitted to the facility on 3/1/22 with diagnoses that included Type II diabetes and hypertension. The resident was discharged home on 5/14/22. The following concern was identified: a. Review of the resident record failed to show an ALF 102 assessment was done prior to admission or during the resident's stay from 3/1/22 to 5/14/22. 2. Review of the resident record showed resident #2 was admitted to the facility on 6/2/17 with a diagnosis of arthritis. The resident was discharged to a higher level of care on 5/31/22. The following concerns were identified: a. Review of the resident record showed no evidence an ALF 102 was completed annually in the years of 2018, 2019, or 2021. b. Review of the facility incident reports showed that the resident had 7 falls between the dates of 2/18/22 to 5/12/22 and there was no evidence an ALF 102 was completed due to a change in the resident's condition. 3. Review of the resident record showed resident #3 was admitted to the facility on 4/26/19 with a diagnosis of Type II diabetes. The following concerns were identified: a. Review of the resident record showed the resident developed a decline in mobility following an illness and received physical therapy (PT) in order to improve strength and mobility. Further review showed no evidence an ALF 102 was completed at the time of the resident's illness or due to the resident's functional decline. b. Interview with the resident on 5/31/22 at 3:15 PM confirmed the resident contracted COVID-19 in January, 2022 and was isolated in the room for 2 weeks. Further interview revealed s/he became weak, requested PT services, and	S5006		

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S5006	Continued From page 5 had difficulty with transfers. 4. Review of the resident record showed resident #4 was admitted to the facility on 3/20/20 with a diagnosis of dementia. The following concerns were identified: a. Review of the resident record showed the facility failed to perform an annual ALF 102 assessment for the year of 2021. 5. Review of the resident record showed resident #5 was admitted to the facility on 1/6/22 with a diagnosis of anxiety. The following concern was identified: a. Review of the resident record showed the facility failed to perform an ALF 102 on admission or following admission. 6. Interview with the executive director and RN #1 on 6/1/22 at 1:30 PM confirmed the ALF 102 assessments were not performed as required. 7. Review of facility policy titled, "Admission, Transfer, and Discharge of Resident", no date, showed, "All residents shall have an ALF 102 screening form completed...annually and when there is a change in the resident's condition. The signed document shall be maintained in the residents file."	S5006		
S5007	Ch 12 Sec 7 (b)(ii) Assisted Living Facility (ALF) Core Services (b) (ii) Admission orders. A resident shall be admitted only if accompanied by a history and physical completed by a physician or physician extender within ninety (90) days prior to admission. The facility shall confirm the resident's medication regimen and special treatment orders	S5007		

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S5007	Continued From page 6 at the time of admission. (A) Admission orders shall include an order for TB screening, influenza and pneumococcal immunization status and orders for immunization if required, unless contraindicated. The facility must develop and implement policies and procedures to ensure the following: (I) Residents, or their legal representative are educated regarding the risks and benefits of these immunizations. (II) The immunizations are offered unless medically contraindicated or the resident is currently immunized. (III) If the resident is not vaccinated, the medical record must reflect the reason, such as medical contraindication or refusal. This State Rule and Regulation is not met as evidenced by: Based on record review, admission order form review, and policy review, the facility failed to ensure that admission orders included tuberculosis (TB) screening for 4 of 4 sample residents (#3, #4, #5, #6). The findings were: 1. Review of the resident record for resident #3 showed the resident was admitted on 4/26/19 and there was no evidence the resident had an order for TB screening or TB screening had been performed since admission. 2. Review of the resident record for resident #4 showed the resident was admitted on 3/20/20 and there was no evidence the resident had an order	S5007		

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S5007	Continued From page 7 for TB screening, or TB screening had been performed since admission. 3. Review of the resident record for resident #5 showed the resident was admitted on 1/6/22 and there was no evidence the resident had an order for TB screening, or TB screening had been performed since admission. 4. Review of the resident record showed resident #6 showed no order for a TB screen and the ordering physician answered "no" to the question, "Is this individual free of communicable disease?" In addition, the last TB screen was done in the "1960's." 5. Review of the admission order form used by the facility showed it did not contain an order to screen residents on admission to the facility. 6. Review of facility policy titled, "Admission, Transfer, and Discharge of Resident", no date, showed, "prior to admission...all residents will have...an order for a TB screening, or evidence of current test."	S5007		
S5009	Ch 12 Sec 7 (b)(iv) Assisted Living Facility (ALF) Core Services (b) (iv) Frequency of assessment. An assessment must be conducted: (A) No earlier than one (1) week prior to admission; (B) Immediately upon any significant change in the resident's mental or physical condition; or	S5009		

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S5009	Continued From page 8 (C) No less than once every twelve (12) months. This State Rule and Regulation is not met as evidenced by: Based on resident record review, resident and staff interview, and facility incident report review, the facility failed to ensure an assessment was completed immediately upon a change of condition for 3 of 6 sample residents (#2, #3, #4). The findings were: 1. Review of the resident record showed resident #2 was admitted to the facility on 6/2/17 with a diagnosis of arthritis. The resident was discharged to a higher level of care on 5/31/22. The following concern was identified: a. Review of the facility incident reports showed that the resident had 7 falls between the dates of 2/18/22 to 5/12/22. There was no evidence an assessment related to the change in the resident's condition was performed. 2. Review of the resident record showed resident #3 was admitted to the facility on 4/26/19 with a diagnosis of Type II diabetes. The following concern was identified: a. Review of the resident record showed the resident developed a decline in mobility following an illness and was receiving physical therapy (PT) the past 30 days in order to improve strength and mobility. There was no evidence an assessment related to the change in the resident's condition was performed due to the resident's illness or upon initiation of physical therapy. b. Interview with the resident on 5/31/22 at 3:15 PM confirmed the resident contracted COVID-19 in January 2022. Further interview revealed s/he became weak, had difficulty with	S5009		

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S5009	Continued From page 9 transfers, and requested PT services. 3. Review of resident record showed resident #4 was admitted to the facility on 3/20/20 with a diagnosis of dementia. The following concern was identified: a. Review of the facility's incident reports showed the resident was a "wander risk" and was found outside of the locked building on 3/30/22. The resident reported that he was "looking for the people he arrested." There was no evidence an assessment related to the change in the resident's condition was performed. 4. Interview with the executive director and RN #1 on 6/1/22 at 1:30 PM confirmed the assessments were not performed as required.	S5009		
S5010	Ch 12 Sec 7 (b)(v) Assisted Living Facility (ALF) Core Services (b) (v) Use of the assessment. (A) The results of the assessment are used to develop, review, and revise the resident's individualized assistance plan. This State Rule and Regulation is not met as evidenced by: Based on resident record review and staff interview, the facility failed to use the results of the assessment to develop the resident's assistance plan for 2 of 6 sample residents (#1, #5). The findings were: 1. Review of the resident record showed resident #1 was admitted to the facility on 3/1/22 with diagnoses which included Type II diabetes and hypertension. The record showed a nurse	S5010		

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S5010	Continued From page 10 assessed the resident on 2/15/22; however, the resident did not have an individualized assistance plan developed based on the assessment. 2. Review of resident record showed resident #5 was admitted to the facility on 1/6/22 with a diagnosis of anxiety. The record showed a nurse assessed the resident on 1/6/22; however, the resident did not have an individualized assistance plan developed based on the assessment. 3. Interview with CNA #2 on 6/1/22 at 12:30 PM confirmed the CNAs would look in the resident's record for the assistance plan to direct their care for each resident. 4. Interview with RN #1 on 6/1/22 at 1:30 PM confirmed neither resident #1 nor #5 had an assistance plan in their record.	S5010		
S5042	Ch 12 Sec 7 (m) Assisted Living Facility (ALF) Core Services (m) Facility Policies and Procedures. (i) Management shall develop policies and procedures that are available to residents and staff, including but not limited to: (A) Resident rights; (B) Disciplinary procedures surrounding substantiated cases of resident abuse; (C) Admission, transfer, bed hold days, and discharge of residents; (D) Medication management;	S5042		

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S5042	Continued From page 11 (E) Emergency care of residents (including missing resident, blizzard, water outage, etc.); (F) Fire/disaster plan; (G) Departure and return; (H) Smoking; (I) Visiting hours; (J) Activities; (K) Management of resident trust accounts; (L) Personnel policies; (M) Grievance procedure; (N) Per Diem rate/charges/fees, to include a listing of what is included in the established charges; (O) Incident reports; (P) Notification of change in established per diem rate/charges/fees; (Q) Outside contractual responsibilities; and (R) Identification and notification of change in resident's condition. This State Rule and Regulation is not met as evidenced by: Based on resident record review, staff and resident interview, and policy review, the facility	S5042		

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S5042	Continued From page 12 failed to perform simulated evacuation drills as required for 4 of 4 sample residents (#3, #4, #5, #6). The findings were: 1. Review of the resident record showed resident #3 was admitted to the facility on 4/26/19 and there was no evidence the resident was oriented to fire or evacuation procedures at the time of admission. 2. Review of resident record showed resident #4 was admitted to the facility on 3/20/20 and there was no evidence the resident was oriented to fire or evacuation procedures at the time of admission. 3. Review of resident record showed resident #5 was admitted to the facility on 1/6/22 and there was no evidence the resident was oriented to fire or evacuation procedures at the time of admission. Interview with resident #5 on 5/31/22 at 3:50 PM revealed the resident had lived in the facility since 1/6/22 and did not recall being trained on fire safety at the time of admission or participating in any drills since admission. 4. Review of resident record showed resident #6 was admitted to the facility on 6/1/22 and there was no evidence the resident was oriented to fire or evacuation procedures at the time of admission. 5. Interview with the executive director on 6/1/22 at 9:30 AM revealed as the new owners, they did not have access to documentation related to drills prior to their ownership and a form was developed; however, fire drills had not been performed so far this calendar year. 6. Review of the facility's policy titled, "Evacuation	S5042		

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S5042	Continued From page 13 Capability, Emergency Procedures and Fire Safety", no date, shows "These plans and procedures are designed to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents...All employees...shall be trained in emergency procedures when they begin work...C. The evacuation plan shall be discussed with each resident at the time of his/her admission...E. A simulated evacuation drill shall be performed every month at irregular hours,...and all residents shall participate. A written record of each drill shall be kept on file."	S5042		

Mondell Heights Retirement Community (MHRC)
Ruth Taylor, Administrator
106 E. Main Street
Newcastle, Wy. 82701

Ref: LH-2022-0707 June 16, 2022

Statement of deficiencies

S5003

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

A. Upon review of CDC Guidance titled "Interim Infection Prevention and Control "Recommendations" for Healthcare Personnel During the Coronavirus Disease 2019 (Covid-19) Pandemic last updated 2/2/22 it clearly states that a face mask is "recommended" NOT "required by law" or "mandated" by the Wyoming Governor, MHRC will not require our employees to wear a face mask at this time. We are not taking this "recommendation" lightly however due to the high rate of "fully" vaccinated residents and staff and the low rate of active cases in our county we have decided not to run our facility as a prison and demand our staff to wear a face covering that they do not feel comfortable with. We have not found that any residents have been affected by our current practice.

MHRC has implemented a Covid-19 Infection Control Addendum update effective 07/12/22 that we will use as a guideline.
Please see attached.

New

How you will identify other residents having the potential to be affected by the same deficient practice(s) and what corrective action(s) will be taken;

MHRC will continue to monitor the Weston County community risk level and monitor our resident's symptoms to see if anyone is affected and if so we will evaluate the need for face masking at that time.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice(s) does not recur;

Since MHRC does not consider this to be a deficient practice no measures of changes will be made at this time.

How will you monitor the corrective action(s) performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action(s) evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.

Since MHRC does not consider this to be a deficient practice no measures of changes will be made at this time.
MHRC has implemented a Covid-19 Infection Control Addendum update effective 07/12/22 that we will use as a guideline.
Please see attached. New

Must include dates when corrective action(s) will be completed. The corrective action completion dates must be within acceptable time frames.

MHRC considers this to be an un-tagable deficiency and has no dates for correction of such un-tagable deficiency at this time.
Apparently a Covid-19 Focused Infections Control Addendum-Update 8/19/20 was found at the state however this addendum was written by the previous owners and the current owners were unaware that this addendum even existed and is NOT currently in effect for us as the new owners. It shows 08/19/20 until discontinued so please consider it discontinued as of 01/04/2022 when we took over the business.
MHRC has implemented a Covid-19 Infection Control Addendum update effective 07/12/22 that we will use as a guideline.
Please see attached. New

S5006

Resident #1
a. Review of the resident record failed to show an ALF 102 assessment was done prior to admission or during the resident's stay from 03/1/22 to 5/14/22.

Please see attachment as we have an ALF 102 on file dated 03/1/22. Therefore no deficiency is detected.

Resident #2
a. Review of the resident record showed no evidence an ALF 102 was completed annually in the years of 2018,2019, or 2021.

Please see attachment as we have an ALF 102 on file dated 09/2/2019.
We did not own the facility in 2018 however we purchased the facility in 2021 and our DON failed to complete the ALF 102 in 2021.
Resident #2 was discharged from our facility on 05/31/2022 for a higher level of care so an ALF 102 was not and will not be completed. New

b. No evidence an ALF 102 was completed due to a change in the resident's condition dates 02/18/22 to 05/12/22.

Our DON failed to complete the ALF 102 due to a change in the resident's condition for those dates.

Resident #3
a. Due to COVID-19 in January, 2022 causing a functional decline review showed no evidence an ALF 102 was completed at the time of the resident's illness or for the resident's functional decline.

Our DON failed to complete the ALF 102 due to a change in the resident's condition for that date.
Resident #3 left our facility on 06/11/22 due to a broken ankle and is currently in Casper Wy at the Sacred Heart Rehabilitation Center.
She is planning on returning to MHRC sometime soon and when she returns our current DON will be completing a ALF 102 at that time.

Resident #4
a. Review showed the facility failed to perform an annual ALF 102 assessment for the year of 2021.

Our DON failed to complete an annual ALF 102 assessment for the year of 2021.
An ALF 102 was completed by our current DON on 06/14/2022
See attached.

Resident #5
a. Resident was admitted to the facility on 1/6/22 and review of the resident record showed the facility failed to perform and ALF 102 on admission or following admission.

Please see attachment as we have an ALF 102 on file dated 1/6/22. Therefore no deficiency is detected.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

On 05/31/2022 MHRC owner's (Don and Ruth Taylor) made a decision to replace the Director of Nursing for our facility due to the findings of state regulations not being completed such as ALF 102's, care plans etc. We have a new DON for MHRC that will be completing the ALF 102's on admission for all new residents, annually for all current resident's and whenever there is a change of condition for any current resident's. These will be completed and signed by the DON and will be maintained in the residents file. We have also implemented Point Click Care to keep digital charting and can run reports that will tell us when annual ALF 102's are due.

How you will identify other residents having the potential to be affected by the same deficient practice(s) and what corrective action(s) will be taken;

Our new DON will go through each and every current resident file to make sure we have current annual ALF 102's in every resident profile. Going forward the DON will be aware of any change in conditions of resident"s and complete a new ALF 102 accordingly. We have also implemented Point Click Care to chart any change of conditions for residents at which time the DON will upload a new ALF 102 into the resident's profile.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice(s) does not recur;

The measures are already in the Policies and Procedures manual and MHRC will assign the quality assurance manager (Debbie) to implement the monitoring of reviewing resident profiles to ensure the ALF 102's are being completed. Debbie will do this quarterly. Also we have implemented Point Click Care to digitally chart and will be able to run reports which will tell us when an annual ALF 102 is coming due.

How will you monitor the corrective action(s) performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action(s) evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.

We will print reports frequently that will help us determine if annual ALF 102's are coming due. We will monitor incident reports to determine if a change of condition occurs and will upload a new ALF 102 accordingly. We will assign our quality assurance manager (Debbie) to implement and monitor and review resident profiles to ensure the ALF 102's are being completed for admission, annually for every current resident, and for any change of condition for current resident's and she will do this quarterly. At this quarterly meeting both the DON and the quality assurance manager will evaluate the effectiveness of this plan.

Must include dates when corrective action(s) will be completed. The corrective action completion dates must be within acceptable time frames.

The current residents will all have ALF 102 in their files by July 30, 2022 for either an annual or a change in condition. Going forward from today 06/22/22 all new admits will have an ALF 102 done prior to or upon admission.

S5007

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

We have downloaded a TB Symptom Screening Questionaire from the CDC website that the DON will utilize as a tool to see if a PPD test is needed. The DON will have this screening form filled out and put into each current residents file and will also utilize this form for all resident admissions and annually going forward.
MHRC has obtained a standing order from a local PA-C for the TB (PPD) solution to be kept at the facility in order for our DON to do a TB 1 step test if the DON deems necessary either from a screening or just if she feels necessary. Please see the attached order.
So to recap either an actual PPD test or a screening will be done going forward and uploaded into the residents file.

This also applies to new staff hires and current employees.
Please see attached the TB Screening form that we will utlilize.
Please see attached the standing order form we will use to order the PPD solution.
Please see attached the PPD testing results cards we will utilize.
Resident#3
Resident #3 left our facility on 06/11/22 due to a broken ankle and is currently in Casper Wy at the Sacred Heart Rehabilitation Center.
She is planning on returning to MHRC sometime soon and when she returns our current DON will be completing a TB screening questionnaire at that time.
Resident#4
Resident #4 was given a TB screening questionnaire by our DON on 07/13/2022.
See attached.
Resident#5
Resident #5 was given a TB screening questionnaire by our DON on 07/13/2022.
See attached.
Resident#6
Resident #6 was given a TB screening questionnaire by our DON on 07/13/2022.
See attached.

How you will identify other residents having the potential to be affected by the same deficient practice(s) and what corrective action(s) will be taken;

Our new DON will go through each and every current resident file to make sure we have a either a TB screening done and uploaded into their profile in Point Click Care OR an actual PPD test.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice(s) does not recur;

The measure is already included in our Policies and Procedures Manual and we have implemented Point Click Care digital charting to upload either the TB screening form or the test result cards that will be signed by our DON when the test is done and what the testing results are.

How will you monitor the corrective action(s) performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action(s) evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.

The measures are already in our Policies and Procedures manual and will assign the quality assurance manager (Debbie to implement the monitoring of reviewing resident profiles to ensure that either the TB Screening Form or the PPD testing results are uploaded into all current resident files and will be included in the resident admission process going forward. This will be monitored quarterly.

Must include dates when corrective action(s) will be completed. The corrective action completion dates must be within acceptable time frames.

These corrective actions will be completed by 07/30/2022

S5009

Based on the resident record review, resident and staff interview, and facility incident report review, the facility failed to ensure a care assessment was completed immediately upon a change of condition for residents #2, #3, and #4.

Everything that applies to S5006 also applies to S5009 in my plan of correction.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

On 05/31/2022 MHRC owner's (Don and Ruth Taylor) made a decision to replace the Director of Nursing for our facility due to the findings of state regulations not being completed such as ALF 102's, care plans assessments etc. We have a new DON for MHRC that will be completing the ALF 102's on admission for all new residents, annually for all current resident's and whenever there is a change of condition for any current resident's. These will be completed and signed by the DON and will be maintained in the residents file. We have also implemented Point Click Care to keep digital charting and can run reports that will tell us when annual ALF 102's and assessments are due.

Resident #2

A care assessment was completed for resident #2 on 05/17/22. See attached.

Resident#3

A care assessment was completed for resident #3 on 05/19/2022. See attached.

Resident #3 left our facility on 06/11/22 due to a broken ankle and is currently in Casper Wy at the Sacred Heart Rehabilitation Center.

She is planning on returning to MHRC sometime soon and when she returns our current DON will be completing a care assessment at that time.

Resident#4

A care assessment was completed for resident #4 on 06/15/2022. See attached.

New

How you will identify other residents having the potential to be affected by the same deficient practice(s) and what corrective action(s) will be taken;

Our new DON will go through each and every current resident file to make sure we have current annual ALF 102's and assessments in every resident profile. Going forward the DON will be aware of any change in conditions of resident"s and complete a new ALF 102 or care plan assessment accordingly. We have also implemented Point Click Care to chart any change of conditions for residents at which time the DON will upload a new ALF 102 and care plan assessment into the resident's profile.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice(s) does not recur;

The measures are already in the Policies and Procedures manual and MHRC will assign the quality assurance manager (Debbie) to implement the monitoring of reviewing resident profiles to ensure the ALF 102's and care plan assessments are being completed when there is a change in condition. Debbie will do this quarterly. Also we have implemented Point Click Care to digitally chart and will be able to run reports which will tell us when an annual ALF 102 is coming due.

How will you monitor the corrective action(s) performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action(s) evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.

We will print reports frequently that will help us determine if annual ALF 102's are coming due. We will monitor incident reports to determine if a change of condition occurs and will upload a new ALF 102 and care plan assessment accordingly. We will assign our quality assurance manager (Debbie) to implement and monitor and review resident profiles to ensure the ALF 102's and care plan assessments are being completed for admission, annually for every current resident, and for any change of condition for current resident's and she will do this quarterly. At this quarterly meeting both the DON and the quality assurance manager will evaluate the effectiveness of this plan.

Must include dates when corrective action(s) will be completed. The corrective action completion dates must be within acceptable time frames.
Going forward from today 06/22/2022 whenever there is a resident change in condition a care plan assessment will be done and uploaded into the resident file.

S5042

The facility failed to perform simulated evacuation drills as required.
We as the new owners could not find any fire drill training or simulated evacuation drill documentation prior to our taking over the facility 01/04/2022.

We as the new owners have failed to perform training and simulated evacuation drills as required since 01/04/2022.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
An evacuation drill was completed on 06/29/2022 see attached.
MHRC will start performing monthly evacuation drills and shall meet prompt or slow capability for our facility requirements.
MHRC shall train all employees in the emergency procedures and the new staff will be trained within the first week of employment.
MHRC shall review the procedures with staff at least every 12 months and the record will be maintained in each personnel file.

MHRC shall perform monthly evacuation drills with a minimum of one drill conducted each quarter on each shift.
MHRC will maintain records of such evacuation drills over a 2-year period and shall be available up request.
MHRC has created an Evacuation Drill form (see attached) that will be filled out monthly when such drills are performed that meet all requirements of the regulations.

How you will identify other residents having the potential to be affected by the same deficient practice(s) and what corrective action(s) will be taken;

Since MHRC has failed to complete these requirements thus far so all current residents have been affected and we will follow all the corrective actions mentioned above going forward.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice(s) does not recur;

The measures are currently in our policies and procedures and the changes we plan to make is to have our activities director include the monthly evacuation drills in her monthly activities calendar.

How will you monitor the corrective action(s) performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action(s) evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system.

MHRC will assign our quality assurance manager (Debbie) to integrate the monthly fire evacuation drills into her quarterly assurance meetings to ensure that our correction is achieved and sustained.
Must include dates when corrective action(s) will be completed. The corrective action completion dates must be within acceptable time frames.

MHRC will perform a fire evacuation drill in the Month of June for 2022 and monthly thereafter going forward.
MHRC will have all new staff trained within the required regulation time frames.
MHRC will be fully in compliance with this regulation by 07/30/2022.

SCREENING

All visitors should be screened for temperature and symptoms upon entry to the building as follows. If a visitor:

- Registers a temperature in excess of 100.4 they will not be allowed in the building; or
- Demonstrates Covid-19 symptoms such as cough, runny nose, sore throat, diarrhea or other related illness, they will not be allowed into the building.

All staff will be screened at the beginning of their shift. If an employee:

- Registers a temperature in excess of 100.4 they will not be allowed in the building; or
- Demonstrates Covid-19 symptoms such as cough, runny nose, sore throat, diarrhea or other related illness, they will not be allowed into the building.

Residents will be screened for temperature and symptoms daily:

- Any resident with a temperature of 100.4 or above; or
- Covid-19 symptoms including cough, runny nose, sore throat, diarrhea or other related illness will be isolated in their suite and reported to the nurse for assessment.
- If the nurse determines that the person requires isolation
  - The resident should quarantine for 5 days or until there are no further symptoms, or
  - Referred for medical care, and/or
  - Tested for infectious disease and found negative
  - The infectious person's suite will be thoroughly disinfected.

If there is an outbreak in the facility all residents should continue to be monitored for symptoms and signs of infection and if tested and found positive for Covid-19 the above protocol should be followed for each individual resident accordingly.

A supply of appropriate PPE equipment will be maintained, as long as they are available.

HAND HYGIENE

All staff should perform hand hygiene before and after all patient contact by washing hands with soap and water for at least 20 seconds and/or using hand sanitizer. Staff should disinfect between caring for each resident.

TRAINING

All staff and residents should be trained regarding

- Infectious disease including COVID-19
- Infection control practices, including proper hand washing techniques and location of infection control stations
- Resident isolation