

HEALTHCARE LICENSING AND SURVEYS		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
SUMMARY OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF028	A. BUILDING _____ B. WING _____		C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
LEGACY HOMES ASSISTED LIVING	2391 MUDDYSTONE RD 117 THAYNE, WY 83127

DEFICIENCY	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
------------	--	---------------	---	--------------------

5000 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 08/28/2001. A complaint survey was conducted by Healthcare Licensing and Surveys from 11/29/22 to 11/30/22. The survey was prompted by complaint intake LIC-23-004.

S6001: Ch 12 Sec 6 (b) Personnel and Staffing Requirements

(b) Staffing.

(i) The staffing level shall be sufficient to meet the needs of all residents of the facility, and insure the appropriate level of care is provided.

(ii) There shall be personnel on duty to maintain order, safety, and cleanliness of the premises, to prepare and serve meals, to keep and adequate supply of clean linens, to assist the residents in personal needs and recreational activities, and to meet the other operational needs of the facility.

(iii) The assisted living facility shall not employ an individual as a nurse assistant who is not currently certified by the Wyoming State Board of Nursing. Certification must be verified by the manager of the assisted living facility.

(iv) There shall be at least one (1) RN, LPN, or CNA on duty every shift. There shall be at least one (1) person on duty and awake at all times.

S 000

S5001

S6001

Staffing will be sufficient to meet the needs of all residents and insure appropriate level of care is provided at Legacy Homes Assisted Living Facility.

The owner will insure that at all times there shall be at least (1) RN, LPN, or CNA on duty every shift. All CNA's employed will be certified by the Wyoming Board of Nursing and verified by the manager at Legacy Homes.

Staff #1 and #2 will not be on duty without another CNA, LPN or RN on duty in facility RN to perform the CNA duties as required effective immediately.

Staff #1 and #2 will take the next CNA course available in community and be certified as a CNA through the Wyoming Board of Nursing prior to being on duty without a CNA, LPN or RN.

Licensures and Certifications for all staff will be verified by the manager on hire and with each specific discipline renewal.

Will be monitored through the facility's QA Program. 11/6/23

1/29/22

Wyoming Dept. of Health, Aging, Disability & Healthcare Licensing and Surveys
LABORATORY DIRECTOR'S OR PROVIDER'S PRIOR REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Eileen Merditt owner 12-24-22

RO8811

If continuation sheet 1 of 1

Changes made per phone call with Eileen Merditt, owner, on 11/6/23 @ 11:07 am. POC accepted.

Janet Con

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	J1: PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF528	J2: MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	J3: DATE SURVEY COMPLETED C 11/30/2022
---	--	---	---

NAME OF PROVIDER OR SUPPLIER LEGACY HOMES ASSISTED LIVING	STREET ADDRESS CITY STATE ZIP CODE 2391 BRADYSTRING RD 117 THAYNE, WY 83127
--	---

DEFICIENCY 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
---	---------------------	--	--------------------------

§ 200 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 from 11/29/22 to 11/30/22.
The survey was prompted by complaint intake
LIC-23-004.

S5001 Ch 12 Sec 6 (b) Personnel and Staffing
Requirements

(b) Staffing.

(i) The staffing level shall be sufficient to
meet the needs of all residents of the facility, and
insure the appropriate level of care is provided.

(ii) There shall be personnel on duty to
maintain order, safety, and cleanliness of the
premises, to prepare and serve meals, to keep
and adequate supply of clean linens, to assist the
residents in personal needs and recreational
activities, and to meet the other operational
needs of the facility.

(iii) The assisted living facility shall not
employ an individual as a nurse assistant who is
not currently certified by the Wyoming State
Board of Nursing. Certification must be verified by
the manager of the assisted living facility.

(iv) There shall be at least one (1) RN, LPN,
or CNA on duty every shift. There shall be at least
one (1) person on duty and awake at all times.

S 000

S5001

Cont'd

S5001

The owner / Manager of Legacy Home 1/29/22
Assisted Living Facility will keep up
with notification from the state of any
waivers to regulations as well as when
the waivers are lifted in an attempt to
prevent non-compliance in the future
due to lack of knowledge of changes.

This will be done by ensuring that all
emails from the state are read and not
filtered to the facility's email spam.
The facility may request all regulatory
changes be mailed to the facility
address if available to further insure
notification of compliance changes.

Wyoming Dept. of Health, Aging Director, Healthcare Licensing and Surveys
SIGNATURE OF DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

RO8811

If continuation sheet 1 of 3

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/30/2022
NAME OF PROVIDER OR SUPPLIER LEGACY HOMES ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2391 MUDDYSTRING RD 117 THAYNE, WY 83127			
(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
S5001	Continued From page 1 (v) If the assisted living facility does not employ an RN, the facility shall Contract with an RN to provide the initial assessment, periodic reviews, assistance plans, as well as the periodic updates of resident assessment, reviews, assistance plans, and medication management. This State Rule and Regulation is not met as evidenced by: Based on review of staffing schedules, staff interview, and verification of licensure on the Wyoming Board of Nursing (WBON) website, the facility failed to ensure there was at least one registered nurse (RN), licensed practical nurse (LPN), or certified nurse aide (CNA) on duty every shift. The census was 11. The findings were: 1. Review of the staffing schedules for October and November 2022 showed six employees (#1, #2, #3, #4, #5, #6) were on the schedules. The following concerns were identified: a. During an interview on 11/29/22 at 2:22 PM the manager stated not all of the staff working were CNAs. She stated the facility was short-staffed and she couldn't find any CNAs. She stated there was not going to be a CNA class available until January. b. Verification of licensure on the WBON website on 11/29/22 at 3:20 PM showed employees #1 and #2 did not have at least a CNA license. c. Further review of the schedules showed employee #1 worked shifts by herself on 12 of 31 days in October 2022 and 6 days in November 2022. d. Further review of the schedules showed employee #2 worked shifts by herself on 12 of 31 days in October 2022 and 13 days in November 2022.	S5001			

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/30/2022
NAME OF PROVIDER OR SUPPLIER LEGACY HOMES ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2391 MUDDYSTRING RD 117 THAYNE, WY 83127			
(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