Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9055	A. BUILDING: _____ B. WING _____	05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN PLAZA ASSISTED LIVING	536 EAST 20TH AVENUE TORRINGTON, WY 82240

(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. An initial licensure survey was conducted by Healthcare Licensing and Surveys from 5/9/23 to 5/10/23.	S 000		
S5004	Ch 12 Sec 6 (e) Personnel and Staffing Requirements (e) Personnel Policies and Records. (i) Management shall provide new employee orientation and education regarding resident rights, evacuation, and emergency procedures, as well as training and supervision designed to improve resident care. (ii) A record for the manager and each employee shall be maintained and contain at a minimum, the following information: (A) Name, current address and telephone number; (B) Social Security Number; (C) Education; (D) Work experience, documentation of reference checks; (E) Date of employment;	S5004		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dwight Shael, RN | TITLE: Executive Director | (X6) DATE: 6/2/2023

6/7/2023 POC Accepted 6/7/23 @ 1:48 PM spoked with Brian Small ED. He was notified of the acceptance of POC. Latest DOC is 6/20/2023 — Julia Arana RN

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S5004	Continued From page 1 (F) Position in the assisted living facility (job description); (G) Documentation of tuberculin testing; (H) Orientation checklist; (I) I-9, (Employment Eligibility Verification); (J) W-4, (Employee's Withholding Allowance Certificate); (K) Licensure, Certification, or Credentials; (e.g., RN, LPN, CNA, etc.); (L) Documentation of all completed background and Central Registry background check with no offenses. This State Rule and Regulation is not met as evidenced by: Based on review of personnel files, staff interview and review of the facility policy, the facility failed to provide new employee orientation and education, as required, for 6 of 7 sample employees (#1,#2, #3, #4, #5, #6). The findings were: 1. Review of the personnel file for employee #1 showed a hire date of 11/24/21. Further review showed a blank, unsigned form titled "Onboarding/personnel file" that included education on evacuation, emergency procedures, training and supervision to improve resident care. 2. Review of the personnel file for employee #2 showed a hire date of 2/9/22. Further review showed a blank, unsigned form titled "Onboarding" that included education on	S5004		

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S5004	Continued From page 2 evacuation, emergency procedures, training and supervision to improve resident care. 3. Review of the personnel file for employee #3 showed a hire date of 10/10/22. Further review showed a blank, unsigned form titled "Onboarding" that included education on evacuation, emergency procedures, training and supervision to improve resident care. 4. Review of the personnel file for employee #4 showed a hire date of 9/26/14. Further review showed a blank, unsigned form titled "Onboarding" that included education on evacuation, emergency procedures, training and supervision to improve resident care. 5. Review of the personnel file for employee #5 showed a hire date of 7/6/21. Further review showed a blank, unsigned form titled "Onboarding" that included education on evacuation, emergency procedures, training and supervision to improve resident care. 6. Review of the personnel file for employee #6 showed a hire date of 2/14/00. Further review showed a blank, unsigned form titled "Onboarding" that included education on evacuation, emergency procedures, training and supervision to improve resident care. 7. Interview with the executive director on 5/10/2023 at 10:30 AM the Executive Director verified "if the onboarding list is not in the employee file the training was not done." 8. Review of the facility's policy titled "Staff Training," no date, showed "Direct care staff will receive initial orientation and ongoing inservice training based on state regulations and the needs	S5004		

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S5004	Continued From page 3 of the residents being served in the community." The implementation includes: " ..... d. Fire, safety and emergency procedures, including identification of unsafe environmental factors. ... ... f. Emergencies, evacuations, disasters, incident reporting."	S5004		
S5008	Ch 12 Sec 7 (b)(iii) Assisted Living Facility (ALF) Core Services (b) (iii) The Registered Nurse shall make an initial assessment of the resident's needs, which describes the resident's capability to perform ADLs and notes all significant impairments in functional capability. (A) Initial assessment. A current assessment shall be maintained in each resident's file. (B) The assessment shall include at least the following information: (I) Medically defined conditions and prior medical history; (II) Physical Status; (III) Sensory and physical impairments; (IV) Nutritional status and requirements; (V) Special treatments and/or procedures; (VI) Mental and psychosocial status;	S5008		

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S5008	Continued From page 4 (VII) Discharge potential; (VIII) Dental condition; (IX) Activities potential; (X) Rehabilitation potential; and (XI) Medication regimen. (1.) Documentation of resident's ability to self-medicate This State Rule and Regulation is not met as evidenced by: Based on medical record review, resident interview, staff interview and review of the facility policies, the agency failed to assess the residents' ability to self-medicate for 2 of 3 sample residents that were allowed to do so (#3, #5). The findings were: 1. Medical record review for resident #3 showed a move-in date of 7/6/22 and orders that showed the resident was able to manage his/her own medications. Interview with the resident on 5/10/23 at 9:25 AM revealed s/he could not recall a nurse assessing his/her ability to correctly and safely self-medicate. 2. Medical record review for resident #5 showed a move-in date of 9/20/22 and orders that showed the resident was able to manage his/her own medications. Interview with the resident on 5/10/23 at 9:30 AM revealed s/he could not recall a nurse assessing his/her ability to correctly and safely self-medicate. 3. Interview with the ED/DON on 5/10/23 at 11 AM confirmed the assessments were overdue.	S5008		

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S5008	Continued From page 5 4. Review of facility policy policy titled, "Medication Administration", dated 8/1/21, showed..."6. Self Medication: Residents able to self medicate may keep prescription medications in their room if deemed safe and appropriate by the RN." 5. Review of the of facility policy titled, "Medication Storage", no date, c..."Quarterly evaluation of the resident's ability to safely store and self-administer his/her medications."	S5008		

Evergreen Plaza

Health Survey Plan of Correction

Survey ending 5/10/2023

This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied.

S5004

1. Employees #1, #2, #3, #4, #5, #6 received orientation at time of hire but were not requested to sign the documentation reflecting their training. Employees will meet with the Executive Director to review all items on the orientation checklist. Once the employee and the Executive Director agree that items have been satisfactorily addressed, the employee will sign and date the updated forms. The signed forms will be placed in the employees' personnel files.
2. Personnel files were reviewed for evidence of signed orientation documents. Employees without a signed orientation checklist will receive training and their signed documents will be placed in their personnel files.
3. The facility has had, and continues to have, a comprehensive orientation program for each employee upon hire. Evidence of completion of this training is placed in the personnel file. The Executive Director will audit each personnel file upon completion of the orientation process to include the signed orientation checklist. The Executive Director will provide his/her signature in the personnel file indicating the file is complete.
4. The Executive Director is responsible for ensuring that each employee receives the proper training for their hired position. Two audits of each personnel file will occur: the initial audit at time of hire by the Executive Director, and an annual audit completed by HR Director or designee. Any concerns about this process will be brought to the QA committee for review and resolution. Evidence of the annual audit will be kept in the Executive Director's office.
5. Completion date: June 20, 2023

S5008

1. Residents #3 and #5 have been assessed for the ability to self-administer their medications.
2. Medical records for current residents were reviewed for additional residents that have not been evaluated for self-administration of medications. No other residents were identified to have this same concern.
3. The Executive Director consulted with the facility pharmacist and discussed the best plan of action regarding residents that self-administer medications. Each resident will be evaluated for the ability to self-administer medications at the time of admission. The assessment is completed by an RN. A new assessment will be completed any time there is a concern about the resident's ability to self-administer medications, with any condition change, and annually. Assessments are part of the medical record. The facility policy has been changed to reflect the correct frequency of the assessments.
4. The Executive Director is responsible for ensuring timely and accurate assessments. The Executive Director or designee will conduct monthly audits x 3 months, and quarterly audits thereafter to ensure assessments are completed as required. Results of these audits will be brought to the QA committee for review and resolution of any problems with this process.
5. Completion date: June 20, 2023

Brian Schaal, RN