Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE 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 from 4/4/24 to 4/5/24. The survey was prompted by complaint intakes LIC-24-013, LIC-24-025, LIC-24-026, LIC-24-028, LIC-24-032, LIC-24-033, LIC-24-034, and LIC-24-038. The following common abbreviations are used throughout this document. CDC: Centers for Disease Control and Prevention CNA: Certified Nursing Assistant ED: Executive Director LPN: Licensed Practical Nurse RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	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	S5003		

This plan of correction was accepted on 5/17/24. Anne Refior was notified by email and a message was left with the Facility.
Jean Gunnis MT(ASCP) 5/17/24

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S5003	Continued From page 1 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. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, and CDC guidelines, the facility failed to ensure appropriate infection control practices were implemented during 1 random observation. The census was 73. The findings were: 1. Observation on 4/4/24 at 10:30 AM showed RN #1 was carrying an unbagged soiled cloth absorbent pad which was soiled with stool down the hallway. Interview with the RN, at that time, revealed she was unaware of the proper way to handle potentially infectious laundry. 2. Observation on 4/4/24 at 10:36 AM with CNA #3 and RN #1 of the laundry room showed a utility sink, and residential-grade washing machines and dryers. The CNA and RN were unsure how to manage the soiled linens; however, the CNA produced a box of Affresh (a washing machine cleaner) stating they had been	S5003		

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S5003	Continued From page 2 instructed to use the tablets to clean the machines. During the observation a resident entered the laundry room and preceded to start his own laundry using the same washing machines the facility used for soiled linens. 3. Interview on 4/5/24 at 11:20 AM with the ED revealed the "Company" was reviewing the laundry process and confirmed a policy and procedure had not been developed. 4. According to the CDC guidelines titled "Appendix D - Linen and Laundry Management" retrieved from https://www.cdc.gov/hai/prevent/resource-limited/laundry.html on 4/16/24 showed "...never carry soiled linen against the body. Always place it in the designated container...If there is any solid excrement on the linen, such as feces or vomit, scrape it off carefully with a flat, firm object and put it in the commode or designated toilet/latrine before putting linen in the designated container. Place soiled linen into a clearly labeled, leak-proof container in the patient care area. Do not transport soiled linen by hand outside the specific patient care area from where it was removed...Always launder soiled linens from patient care areas in a designated area, which should: be a dedicated space for performing laundering of soiled linen...have handwashing facilities, standard operating procedures, and other job aides to assist laundry staff with procedures...Follow instructions from the washer/dryer manufacturer. Use hot water 158 to 176 degrees Fahrenheit for 10 minutes and an approved laundry detergent. Dry linens completely in a commercial dryer."	S5003		

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S5048	Continued From page 3	S5048		
S5048	Ch 12 Sec 9 (a)(i) Contractual Svcs Provided Outside ALF Auth (a) Residents in an assisted living facility may receive services from an outside entity for care beyond that provided for or specified in the Assisted Living Program Administration Rules. These services must be arranged by the appropriate professional and be incorporated into the resident's assistance plan. The resident's choice of providers must be honored. (i) Components of the outside service(s) contract: (A) Who will provide service(s); (B) What service(s) will be provided; (C) When the service(s) will be provided; (D) Where the service(s) will be provided; (E) How the service(s) will be provided; and This State Rule and Regulation is not met as evidenced by: Based on observation, resident and staff interview, and review of resident records, policy and procedure, and outside agency contracts, the facility failed to ensure services provided by an outside entity for care beyond that provided by the facility were incorporated into the resident's assistance plan and included all required components for 6 of 6 hospice residents (#1, #2, #3, #4, #5, #6) reviewed. The facility currently had 11 residents using hospice services. The facility census was 73. The findings were:	S5048		

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S5048	Continued From page 4 1. Review of the 1/17/24 "Outside Healthcare Agency Service Acknowledgement " form showed resident #5 was to receive skilled nursing services from the hospice agency on a weekly basis and assistance from the hospice aide 2 times a week for 13 weeks. The resident expired on 3/31/24. The following concerns were identified: a. Review of nursing notes from 1/3/24 through 2/27/24 showed the resident had several wounds to his/her lower body and CCP (Compassionate Concierge Physicians) and hospice were providing wound care. The facility was unable to locate a service contract with the agency who provided wound care to the resident. b. Review of the March 2024 "Medication Administration Summary" showed morphine sulfate 20 mg/1ml; .25 ml to 1 ml every 1 hour, as needed, for pain or shortness of breath was prescribed. The resident received the morphine 2 to 9 times a day during the month. In addition, the resident was prescribed 2 mg/ml 0.25 to 1.0 ml of lorazepam every 4 hours, as needed, for agitation or anxiety. The lorazapam was administered once on 3/29/24 and 3 times on 3/30/24. Neither medication was administered between the hours of 10 PM and 6 AM. c. Interview with CNA #2 on 4/5/24 at 8:45 AM revealed the resident had the "worst wounds she had ever seen with large gaping holes". Further, the wounds would weep constantly and the resident's briefs and sheets would be wet with discharge. The CNA stated sometimes the hospice nurses would be in the facility and sometimes not; leaving care to the facility staff. In addition, the CNA stated she had called hospice on a weekend and the nurse was upset because he had to come in to care for the resident. The hospice nurse left the resident with his/her brief	S5048		

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S5048	Continued From page 5 pulled down around his/her ankles, and the resident in tears. The CNA stated she reported the nurse and he has not been back in the facility. 2. Review of a 3/24/24 nurse's note for resident #6 showed the resident had fallen in his/her room at approximately 8:30 PM. The resident's left shoulder could not be moved without causing shoulder pain and his/her hip was hurting. The resident's representative was notified and the nurse was instructed to do whatever hospice advised. The hospice nurse advised the facility to make the resident comfortable. The resident expired on 3/30/24 at approximately 8 AM. The following concerns were identified: a. Review of a 3/29/24 nurse's note showed "Resident calling out into hallway this am and resident noted to be soaked in [his/her] bed and yelling to call 911 and yelling [s/he] wants to go to the hospital. Medication provided for pain relief and increased agitation. CNA staff to room to change bedding and reposition resident. Resident calling out throughout the respositioning process and bed change. No effective response to medications, repeated pain medication dose 1 hour later, resident resting more comfortably at this time." b. Review of a 3/30/24 nurse's note showed "This nurse medicated resident at approximately 2 AM. Upon entering apartment, resident was resting in bed but noted to have labored breathing. Medicated with 0.5 ml of Ativan (antianxiety) and 0.5 ml of Roxanol (pain medication). [Resident] was left resting comfortably in [his/her] bed with no signs of pain or shortness of breath." c. Review of the March 2024 "Medication Administration Summary" report showed 0.25 to 1 ml of 20 mg/1 ml of morphine was to be given, as needed, for pain or shortness of breath. The	S5048		

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S5048	Continued From page 6 medication was administered 17 times between 3/24 and 3/30. Only 2 of the 17 times was the morphine administered after 10 PM; 3/24 at 10:32 PM and 3/30 at 2:06 AM. This medication was administered by the facility's nursing staff. d. Review of the March 2024 "Medication Administration Summary" report showed 0.25 to 1 ml of lorazepam was to be administered every 4 hours, as needed, for anxiety or agitation. The medication was administered 9 times between 3/24 and 3/30. Only 2 of the 9 times was the lorazepam administered after 10 PM; 3/24 at 10:33 PM and 3/30 at 2:11 AM. This medication was administered by the facility's nursing staff. e. Review of the March 2024 "Medication Administration Summary" report showed 0.5 ml of ABHR (antianxiety, antipsychotic, antihistamine) cream was to be applied inside the wrist every 4 hours starting 3/28 at 4:15 PM. Further review showed facility nursing staff administered the medication at 12 AM and 4 AM. f. Interview with CNA #1 on 4/5/24 at 7:45 AM revealed the resident had fallen and became bed-bound. When the CNAs repositioned or provided incontinence care, the resident would scream in pain. g. Interview with CNA #2 on 4/5/24 at 8:45 AM revealed the resident had fallen and "likely broken his/her shoulder and hip." The resident was bed-bound, was in "excruciating pain", and screamed for hours which frightened the other residents. The CNA stated this was "the worse thing she had ever experienced." The CNA stated it was difficult to get hospice to respond on the weekends; stating there was an 80% chance hospice would even answer a phone call and a 50% chance a hospice nurse would come to the facility. g. Interview with LPN #1 revealed the resident was in excruciating pain and she thought	S5048		

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S5048	Continued From page 7 pain medication should have been given around the clock. 3. Review of the 2/20/24 "Simple Plan of Care" showed resident #1 was to receive skilled nursing care 1 to 2 times per week for 14 weeks and the hospice aide was to provide assistance with bathing, dressing, personal care, and light housekeeping 2 times per week for 13 weeks. Review of the resident's 3/15/24 "Master Care Plan" showed the resident had a new vulnerability of choosing clothing or laying out of clothes; required some help with meal setup; and required assistance with oxygen equipment. The following concerns were identified: a. Interview with RN #1 on 4/4/24 at 4:23 PM revealed the resident required assistance with repositioning and required 3 staff members, with the use of a gait belt, to transfer the resident and perform incontinence care. b. Observation on 4/5/24 at 10 AM showed CNA #1, CNA #2, and RN #1 were in the resident's room trying to calm the resident and keep him/her from attempting to get out of bed. The CNAs assisted the resident with bed mobility by having the resident place his/her hands across his/her chest while using bedding to pull the resident to the top of the bed. The RN then placed a pillow underneath the resident's legs. c. Interview with CNA #1 on 4/5/24 at 7:45 AM revealed the resident was a full assist with transfers, was incontinent of both bladder and bowel; and was unable to feed him/herself. Further, it required 3 staff members to perform incontinence care; 2 staff to hold the resident and 1 to perform pericare. d. Interview with CNA #2 on 4/5/24 at 8:45 AM revealed the resident was one of her biggest concerns as she was afraid s/he would fall and break a bone. The CNA stated the resident	S5048		

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S5048	Continued From page 8 required assistance with drinking as s/he could not hold the cup. e. Interview with LPN #1 on 4/5/24 at 9:26 AM revealed the resident was often confused; physically aggressive at times; required incontinence care for both bowel and bladder; and was weak kneed and had recently fallen which required a non-emergent call to the fire department for lift assistance. Further, it required 3 staff members to provide incontinence care with 2 people lifting and 1 person to perform pericare. The LPN stated hospice came in occasionally and spent 30 to 60 minutes with the resident; however, the facility staff provided care for the resident the remainder of the time. f. Review of a 3/22/24 nurse's note showed the night CNAs reported the resident fell during the night sometime before 1:30 AM and non-emergent lift assist from the fire department was called to assist the resident off of the floor. g. Review of the 3/23/24 nurse's note showed the resident was on supplemental oxygen and was repositioned for comfort. The resident was educated on safe transfers with assistance from staff with a gait belt. h. Review of a 3/29/24 nurse's note showed the resident had attempted to climb out of bed, pulled off his/her oxygen; and was complaining of pain. i. Review of a 3/31/24 fall review note showed the resident had fallen on 3/29/24 at 5:35 AM. The fall review showed the resident had an "Increased Susceptibility to Falls: Confusion causes [the resident] to forget [s/he] is unable to ambulate on [his/her] own." Further, the resident did not know why s/he was up or what s/he was doing. It was noted the resident had a small red area on the crown of his/her head. j. Review of a 3/31/24 nurse's note showed that around 7 PM a CNA found the resident	S5048		

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S5048	Continued From page 9 halfway out of bed. The CNA and the nurse were able to assist the resident back in bed and was boosted for comfort. k. Interview with the hospice nurse on 4/4/24 at 9:42 AM revealed she came to the facility 3 times a week from 8 to 10 AM. The hospice nurse stated the resident was independent with bed mobility and transfers and was able to participate in his/her incontinence care. Further, the hospice nurse was unsure if the resident would be able to evacuate the facility during an emergency. l. Further review of the 3/15/24 "Master Care Plan" showed the resident was independent with bed mobility; walked independently with the use of a cane or wheeled walker; was capable of independently managing incontinence; and could respond in an emergency and evacuate independently. m. The facility was unable to locate a service contract with the agency which provided oxygen services. 4. Review of the 3/15/24 hospice plan of care showed resident #2 was to receive skilled nursing care 1 to 2 times per week for 14 weeks and assistance from a hospice aide 2 times per week for 12 weeks and then once per week for 1 week. The hospice aide was to provide assistance with bathing, dressing, personal care, and light housekeeping. Review of the 3/26/24 "Master Care Plan" showed the resident had a new vulnerability which required assistance with dressing, transfers, pericare, and catheter care. In addition, the resident required physical assistance during an emergency to evacuate safely. The following concerns were identified: a. Interview with the resident on 4/4/24 at 10:56 AM revealed s/he was bed-bound and required the assistance of staff with transfers and personal cares. The resident was observed to be	S5048		

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S5048	Continued From page 10 on 2 liters per minute of oxygen via a nasal cannula. b. Interview with RN #1 on 4/4/24 at 4:23 PM revealed the resident was in the hospital in March and came back to the facility on hospice. The RN stated the resident was getting weaker and was now bed-bound. c. Interview with CNA #1 on 4/5/24 at 7:45 PM revealed the resident was completely bed-bound, required extensive pericare, and was developing pressure sores. d. Interview with CNA #2 on 4/5/24 at 8:45 AM revealed the resident was bed-bound; was incontinent of bowel which usually required a full bed change; and had very little bed mobility. In addition, the CNA stated incontinence care required 2 people to hold the resident and one to perform pericare. e. Interview with LPN #1 on 4/5/24 at 9:26 AM revealed the resident was bed-bound and had multiple bowel movements per day which required staff assistance. f. Review of a 3/15/24 nurse's note showed the resident required the physical assist of 2 CNAs, utilizing a gait belt to assist the resident in standing from a seated position. The RN noted she needed to provide additional assistance to the CNAs so one of them could provide pericare. The note stated the hospice nurse was notified of the concern for resident's safety during transfers. g. Review of a 3/16/24 nurse's note showed staff were unable to transfer the resident out of his/her recliner, after an episode of incontinence, and a non-emergent call to the fire department was placed to assist the resident. h. Review of a 3/17/24, 3/18/24, and 3/21/24 nurse's notes showed staff were repositioning the resident every 2 hours in bed. 5. Review of the 2/13/24 hospice "Simple Plan of	S5048		

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S5048	Continued From page 11 Care" document showed resident #3 was to receive skilled nursing care 1 to 2 times per week for 13 weeks and the assistance of a hospice aide for bathing, dressing, personal care, and light housekeeping 2 times per week for 13 weeks. Review of the resident's 3/14/24 "Master Care Plan" had new vulnerabilities which included assistance with dressing, bowel incontinence which required staff assistance, and encouragement and cueing for eating. The following concerns were identified: a. Observation on 4/4/24 at 10 AM showed the resident was sitting in a recliner and was receiving 3 liters of oxygen per minute via nasal cannula and had a catheter. Two discolored absorbent pads were located on the wheelchair. Interview with the resident at that time revealed s/he had an occasional problem with diarrhea. b. Interview with RN #1 on 4/4/24 at 4:23 PM revealed the resident was incontinent of bowel and required the assistance of staff for pericare. Further, the RN stated the resident's catheter was currently leaking and was told by hospice that the catheter was not due to be changed for another two weeks. c. Interview with CNA #1 on 4/5/24 at 7:45 AM revealed the resident had no control over his/her bowel or bladder and had recently had a catheter placed. The CNA stated once the resident started to lose control of his/her bowels it may last 1 to 1.5 hours. d. Interview with CNA #2 on 4/5/24 at 8:45 AM revealed the resident had episodes of explosive diarrhea which required staff assistance. The CNA stated the resident would become very weak from standing and sitting and would require staff to lift him/her to the wheelchair and then into bed. Further, the resident was embarrassed by the catheter bag and would not leave his/her room; a request was made to	S5048		

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S5048	Continued From page 12	S5048		

hospice for a privacy bag which took "2 weeks" before it was received. In addition, the CNA stated the resident struggled with his/her oxygen and at times did not know whether it was on or not.

e. Interview with LPN #1 on 4/5/24 at 9:26 AM revealed the resident had a catheter and was incontinent of bowel. The resident could manage some care independently; however, became overwhelmed and required assistance.

f. Review of a 2/15/24 nurse's note showed the resident had fallen and a non-emergent call was made to the fire department to assist the resident off of the floor.

g. Review of a 3/14/24 nurse's note showed the resident had been incontinent of urine upon waking as well as 3 episodes of bowel incontinence. The resident was incontinent of bowel in his/her brief, the bed, the wheelchair, and the floor near the bed and in the bathroom. The nurse's note stated the CNA assisted the resident with a shower to "clean the resident thoroughly" and lasted approximately 45 minutes. The CNA also reported the second and third episodes of incontinent bowel lasted approximately 15 minutes each. The hospice nurse was notified of the resident's diarrhea.

h. Review of a 3/21/24 nurse's note showed hospice had placed a urinary catheter. Further, "Resident is noted to exhibit inability to manage moving the catheter bag when transferring independently from bed to wheelchair or wheelchair to bed/recliner chair."

i. Review of a 3/31/24 nurse's note showed the resident was incontinent of 2 loose stools and stated the resident was unable to manage the bowel incontinence independently and hospice was notified with instructions to administer Zofran (antinausea medication).

j. The facility was unable to locate a service

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
S5048	Continued From page 13 contract with the agency which provided oxygen services. 6. Review of the "Outside Healthcare Agency Service Acknowledgement" for resident #4 between the hospice agency and the facility showed it was dated 9/26/23 and the duration of services ended after 13 weeks. The 8/14/23 "Simple Plan of Care" showed hospice was to provide skilled nursing care 1 to 2 times per week for 13 weeks. A hospice aide was to provide assistance with bathing, dressing, personal care, and light housekeeping twice a week for 13 weeks. The facility did not provide an updated contract. Review of the 2/23/24 "Master Care Plan" showed the resident had a new vulnerability of requiring assistance with bed mobility and one-person transfers. In addition, the resident required assistance with oxygen equipment and was on hospice care. The following concerns were identified: a. Interview with the resident on 4/4/24 at 10:06 AM revealed s/he used oxygen during the night, required assistance with dressing and incontinence care. b. Interview on 4/4/24 at 10:10 AM with CNA #3 revealed it depended on the day as to how much assistance the resident required. c. Interview with RN #1 on 4/4/24 at 4:23 PM revealed the resident required assistance putting his/her pants and briefs on; however, once on could pull them up and down. d. Interview with CNA #1 on 4/5/24 at 7:45 AM revealed the resident was declining and needed assistance with transfers, pericare, dressing, and did not have any bed mobility. e. Interview with CNA #2 on 4/5/24 at 8:45 AM revealed the resident required assistance with dressing and struggled with transferring out of the bed.	S5048		

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S5048	Continued From page 14 f. The facility was unable to locate a service contract with the agency which provided oxygen services. 7. Interview with the hospice nurse on 4/4/24 at 9:42 AM revealed the facility did not have a licensed nurse on staff from 10 PM to 6 AM so if a resident required consistent medication during that timeframe the hospice nurse on call would come in to administer the medication. 8. Interview with the ED on 4/5/24 at 11:20 AM revealed she was aware of the problem of facility staff providing care outside their scope and was working on a resolution. In addition, the ED confirmed the facility had failed to ensure the contracts with outside healthcare agencies were completed as required. 9. Review of the 8/23/23 "Hospice Agreement" between the facility and the hospice agency showed "...3. The agency retains the responsibility for planning and coordinating services and care on behalf of the patient and family. The agency will work collaboratively with the caregivers, administration and facility nurse to coordinate all services provided." 10. Review of the "Outside Health Care Agency" policy and procedure, dated March 2024 showed "To meet resident needs, Clinical Services should coordinate with health care agencies outside the Community including those related to home health (physical therapy, occupational therapy, mental health, speech therapy, etc.), hospice care and private duty attendants. The Community can support use of providers only if they meet the policy requirements stated below. Clinical Services must follow the steps below to coordinate: 1. Review state regulations to assure	S5048		

Healthcare Licensing and Surveys

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S5048	Continued From page 15 that the resident condition to be treated is within the scope of services the Community can provide (with assistance, if needed)...Note: Outside providers CAN NOT delegate tasks to Edgewood Clinical Services staff."	S5048		

Edgewood

Sierra Hills Assisted Living Community Survey Date: 04/05/2024 Identification Number: ALF008

S5003

1. ED and CSD will provide proper and appropriate training to all staff members on how to handle soiled linens and potential infectious laundry. To be completed no later than June 1, 2024. Once complete, a signed form will be kept in all staff member personnel files. ED will work with AED to file and audit training for all current and new staff members on the training.

2. Provide proper and appropriate training to all staff members on the use of laundry machines and proper cleaning of machines per CDC guidelines. To be completed on or before June 1, 2024

3. ED will work with ESD to establish a consistent and correct laundry process policy to be in compliance with the CDC Guidelines Appendix D. This will be completed on or before June 1, 2024.

The ED will work with ESD and CSD to establish a consistent and correct laundry process policy to be in compliance with the CDC Guidelines Appendix D. A log sheet will be made that will include the cleaning of soiled linens and sanitation of washing machines. ESD will audit the log sheets weekly. Random monitoring of the laundry rooms and observations of staff performing the cleaning tasks will be conducted by ESD or designee on a weekly basis for 4 weeks and then monthly until the deficient practice is resolved. All audits will be submitted to and reviewed by the QAPI committee..

S5048

1. Resident #5 expired.
2. Resident #6 expired.
3. Resident #1 expired.
4. Resident #2 was assessed for nursing needs and was deemed for higher level of care due to being out of the scope of Assisted Living guidelines. Resident was transferred to SNF 04/09/2024.
5. Resident #3 expired.
6. Resident #4 resident chart will be updated to include the Outside Healthcare Agency Services Acknowledgement form by June 1, 2024.

   All future contracts in the resident charts will specifically outline the care that is expected to be given to residents by an outside agency. The charts will be audited for specificity of cares and duration that they will be providing on the acknowledgement form. The facility will coordinate with outside service agencies to ensure that appropriate licensed staff are available to always meet the needs of residents. The facility and outside agency will correlate to evaluate the needs at the time of signing of the original contract along with any changes to care needs during any further evaluations and assessments of residents to determining the needs of the appropriate licensed staff.

   The ED, CSD and Hospice (or other outside service provider as needed) will collaborate on the services to be provided to the residents. This will be included in the signed Outside Healthcare Agency Services Acknowledgement Form to be kept in the residents' file. An audit of 3 residents will be conducted by CSD on the care they receive by the outside agency on a weekly basis for 4 weeks and then on a monthly basis until the deficient practice is resolved. All audits will be submitted to and reviewed by the QAPI committee.

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This plan of correction was accepted on 5/17/24.

Jean Jennie MT(ASCP)
5/17/24.

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 000	General Comments A Life Safety Code complaint investigation survey was conducted by Healthcare Licensing and Surveys on 04/04/2024 and 04/05/2024. The survey was prompted by complaint intake LIC-24-038. The facility was a two story, fully sprinklered building of Type V (111) construction built in 1997. The building was equipped with a supervised wet sprinkler system, and an addressable fire alarm system. The facility had a capacity of 81 licensed beds with a census of 70 residents. Wyoming Department of Health, Rules and Regulations for Licensure of Assisted Living Facilities Chapter 4, Section 10 Life Safety and Electrical Safety. The requirements in the Department of Health Chapter III, Construction Rules for Health Facilities apply. (II) Assisted Living Facilities operating prior to the effective date of these rules, shall meet the Life Safety Code of the National Fire Protection Association that was in effect at the time the facility was licensed as an Assisted Living Facility. All references are based on the requirements of the 1994 NFPA 101, Life Safety Code, New Residential Board and Care unless otherwise noted.	S 000		
S8002	NFPA Life Safety - Nfpa Minimum Construction Req NFPA 101 Minimum Construction Requirements This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the	S8002		

POC accepted on 5/3/24 via phone call w/ED at 1:30 PM

Healthcare Licensing and Surveys

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S8002	Continued From page 1 facility failed to maintain minimum construction requirements in accordance with 1994 NFPA 101, Life Safety Code. Failure to maintain minimum construction requirements could result in smoke and fire spread resulting in injury or death during an emergency. The deficiency affected numerous areas in the facility. The findings were: Observation on 04/04/2024 at 10:46 AM in one of the dining room alcoves, revealed multiple holes in the ceiling membrane exposing structural members. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 1994 NFPA 101, Ch. 22 Sec. 3.1.3.1	S8002		
S8014	NFPA Life Safety - Nfpa Prot of Vertical Openings NFPA 101 Protection of Vertical Openings This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain vertical openings in accordance with the 1994 NFPA 101, Life Safety Code. Failure to maintain vertical openings as required could result in the spread of fire and smoke throughout the facility, which may result in injury or death during an emergency. The deficiency affected multiple vertical openings and could potentially affect all residents, staff, and visitors. The findings were: Observation on 04/04/2024 at 9:19 AM in the north stairwell revealed an attic access hatch in the open position exposing the attic space to the	S8014		

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S8014	Continued From page 2 potential passage of smoke and fire. Further observation in the south stairwell revealed the same deficiency. All interior stairs serving as an exit or exit component shall be enclosed. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 1994 NFPA 101, Ch. 22 Sec. 3.3.1, Ch. 6 Sec. 2.4.4, Ch. 5 Sec. 1.3.1(e) and 2.2.6.1	S8014		
S8015	NFPA Life Safety - Nfpa Prot from Hazards NFPA 101 Protection from Hazards This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with the 1994 NFPA 101, Life Safety Code. Failure to hazardous areas as required could result in the spread of smoke and fire, resulting in injury or death in the event of a fire. The deficiency affected two (2) hazardous areas and could potentially affect all residents, staff, and visitors. The findings were: Observation on 04/4/24 at 9:35 AM at the resident laundry room adjacent to the maintenance office revealed that the self-closing door failed to operate as designed. When drop tested with no initial motion, the door failed to close and latch. Further observation revealed the maintenance office door was held open by a door chalk. Any hazardous area shall be protected by an automatic sprinkler system, and separation that will resist the passage of smoke between the hazardous area and the sleeping area or primary	S8015		

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S8015	Continued From page 3 escape route. Any doors in such separation shall be self-closing or automatic-closing. Interview with the maintenance supervisor at the time of observation acknowledged the deficiency, and indicated he was aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 1994 NFPA 101, Ch.22 Sec. 2.3.2	S8015		
S8027	NFPA Life Safety - Nfpa Emergency Egress & Rel Dr NFPA 101 Emergency Egress and Relocation Drills This State Rule and Regulation is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire exit drills in accordance with NFPA 101, Life Safety Code and Wyoming Department of Health (WDH) Chapter 12 Rules, Program Administration for Assisted Living Facilities. Failure to conduct fire exit drills as required could result in delayed egress during an emergency leading to injury or death. The deficiency could potentially affect all residents, staff, and visitors. The findings were: 1. Document review on 04/04/2024 starting at 1:00 PM and 04/05/2024 starting at 8:00 AM revealed the facility had only been exercising one wing of the facility per drill, instructing other residents to remain in their rooms and close the doors. This is according to the facilities written fire drill instructions to staff. NFPA 101 states that drills shall involve the actual evacuation of all	S8027		

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S8027	Continued From page 4 residents to an assembly point. Residents that cannot meaningfully assist in their own evacuation, or who have special health problems, shall not be required to actively participate in the drill. Section 18.7 shall apply in such instances for those residents. Residents that require assistance shall be indicated in the facility's Evacuation and Relocation plan. Document review did not demonstrate that the facility's plan contained such language. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 1994 NFPA 101, Ch. 22 Sec. 3.5, Ch. 31 Sec. 1.5 2. Document review on 04/04/2024 starting at 1:00 PM and 04/05/2024 starting at 8:00 AM revealed the facility did not demonstrate they provided a contract for outside hospice services identifying the clear delineation of services pertaining to Life Safety Code responsibilities. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: WDH Chapter 12, Sec. 9 (a)(ii)	S8027		
S8030	NFPA Life Safety - Nfpa Miscellaneous NFPA 101 Miscellaneous This State Rule and Regulation is not met as evidenced by: 1. Based on observation and staff interview, the facility failed to handle in-use oxygen containers	S8030		

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S8030	Continued From page 5 within resident rooms in accordance with NFPA 99, Standard for Health Care Facilities. The failure to appropriately handle in-use oxygen containers as required could result in injury or death. The deficiency affected multiple the resident rooms in the facility and could potentially affect the residents, staff, and visitors of those rooms. The findings were: Observation on 04/04/2024 at 9:23 AM in room 130 revealed oxygen cylinders that were not secured from falling. This deficiency was discovered in additional resident rooms throughout the facility. Oxygen storage containers must be secured against damage at all times. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 1993 NFPA 99, Section 8-3.1.11 2. Based on observation and staff interview, the facility failed to maintain a clear egress in resident rooms in accordance with the NFPA 101, Life Safety Code. Failure to maintain a clear means of egress as required could delay egress resulting in injury or death in the event of an emergency. The deficiency affected one (1) resident room in the facility and could potentially affect the residents, staff, and visitors of that room. The findings were: Observation on 04/04/2024 at 11:47 AM in room 231 revealed an excessive amount of items in the room impeding ingress and egress to and from the room. Further observation revealed a curtain hanging in the room further obstructing view of the egress door. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. Hangings or draperies shall	S8030		

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S8030	Continued From page 6 not be placed over exit doors or located so that they conceal or abscure any exit. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 1994 NFPA 101, Ch. 22 Sec. 3.2, Ch. 5 5.2.2 and 5.4.2	S8030		

Edgewood

Sierra Hills Assisted Living Community Survey Date: 04/05/2024 Identification Number: ALF008

S8002

Maintenance Director called a local drywall company on April 26th 2024 to set up service to repair multiple openings in the dining room alcove caused by pipe bursts. The local drywall company will patch the holes May 7-10.

S8014

Hatch closed on April 5th 2024. Maintenance Director called Life Safety Office on April 10th 2024 to verify that taping and sealing is appropriate to do. Maintenance Director will review the expectations with staff at the next mandatory staff meeting to be held on May 16th 2024.

S8015

Maintenace Director removed door handle on April 29th 2024 of south laundry room door adjacent to maintenance office and lubed the striker. Upon multiple tests, the door closes and latches on its own. Maintenance Office door will be closed during all times that it is not occupied.

S8027

1. Please see attachment 1 for building fire drill procedure. Resident evacuation status is included and is reviewed by Maintenance Director and Clinical Services Director monthly.
Sierra Hills Assisted Living will conduct a full building evacuation on or before May 31st 2024 and at each subsequent drill.

2. Evacuation plans for residents receiving hospice services from any entity will have a plan in their individual care plan and a copy to be kept in the resident folder that will be located on or around the refrigerator in resident room. Resident evacuation plans will be in folder no later than May 31st 2024 and upon admission onto hospice services going forward.

S8030

1. On April 5th 2024, Executive Director contacted oxygen companies that service residents of Sierra Hills to ensure that all oxygen tanks have a rack or box depending on the size of the bottle in each resident apartment. On April 26th 2024, Executive Director and Maintenance Director performed and audit on all residents room on oxygen placement and storage. One room was found to be uncompliant. This was taken care of after the audit was completed by placing a rack in the apartment and putting the tanks in the rack. Maintenance Director will go over the safety aspects of proper storage of oxygen with residents at the next scheduled Resident Council to be held on May 2nd 2024. He will also communicate that tanks are not to be used as door stops. At the next mandatory all staff meeting to be held on May 16th 2024, staff will be told to be aware of oxygen storage and to notify management if they find tanks not in compliance.

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Sierra Hills Assisted Living Community Survey Date: 04/05/2024 Identification Number ALF008

S8030

2. Executive Director reached out to family prior to survey to help resident with cleaning and decluttering apartment number 231. Family has set up a private housekeeper who began work on April 23rd 2024 and will hereafter return each Tuesday to provide weekly cleaning and clutter removal. The curtain that obstructed the view of the egress door was removed by Sierra Hills staff on April 26th 2024.

S5003

1. Please see attachment 2 for the soiled linen policy of EDGEWOOD Senior Living Communities. Education will be provided to staff at the next scheduled mandatory all staff meeting to be held on May 16th 2024 going over proper handling of soiled articles through the building.

2. During next mandatory all staff meeting to be held on May 16th 2024, education will be provided to staff on how to clean the laundry machines per OSHA recommendations. This education consists of: after soiled linen is cleaned in washing machine, the multi-purpose peroxide cleanser provided by Sierra Hills is to be sprayed in the machine wetting all surfaces to sanitize for the next user.

3. EDGEWOOD is currently reviewing the soiled linen policy and will update the company Clinical Services Manual at that time. See attachment 2 for the current policy in place.

S5048

1. a. Please see attachment 3 for the documentation of WHO, WHAT, WHEN, WHERE and HOW outside services will be provided by Caring Edge Hospice.

b. EDGEWOOD is in the process of creating a training program for CNA 2 and CMA. CNA 2 training will begin May 14th-16th 2024. Once there are CNA 2s on staff, a CMA class will be offered. A Certified Medical Assistant will be able to administer medications overnight. Until this plan is completed, Sierra Hills and hospice entities practicing at Sierra Hills will have a nurse on call on rotation to ensure proper medications are dispensed throughout the nighttime hours.

c. Caring Edge Hospice has an on-call service for Sierra Hills to use when a staff member is not in the building. The service then calls the nurse on call to come to the community. After the incident listed in this notation, the nurse on call was let go from Caring Edge Hospice the next day.

2. Please see the above information in point number 1. on plan for medication administration for residents on hospice.

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