Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (X4) ID PREF X 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<br><br>Rules and Regulations utilized for this survey are:<br><br>Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020.<br><br>Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001.<br>A licensure survey was conducted by Healthcare Licensing and Surveys from 2/25/25 to 2/27/25.<br>Also reviewed in the course of the survey was complaint intake LIC-24-007.<br><br>The following common abbreviations are used throughout this document:<br><br>DON: Director of Nursing<br><br>Less commonly used abbreviations will be annotated in each deficiency. | S 000 | | |
| S5002 | Ch 12 Sec 6 (c) Personnel and Staffing Requirements<br><br>(c) Background checks. All staff of the assisted living facility shall successfully complete, at minimum, a State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check and a Department of Family Services Central Registry Screening before direct resident contact.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on review of personnel records and staff interview, the facility failed to ensure the required background checks were completed prior to direct resident contact for 1 of 5 (staff #2) employees reviewed. The findings were: | S5002 | Showboat Retirement Center Management has performed an audit of all employee files to identify files that do not include an up-to-date background screening. Those files found not to contain an up to date background screening will be screened immediately. All necessary DFS checks will be performed by April 4th and all fingerprints will be mailed to the Division of Criminal Investigation office for DCI background checks by April 4th, and all employees who do not meet these deadlines will not be allowed to return to work until their DFS screenings have been received and/or until their fingerprint cards are returned.<br><br>Staff #2 is no longer working at Showboat, he worked on the 21st and has been out sick with no communication since the 22nd, and his employment has been terminated due to job abandonment.<br><br>Showboat will draft a current employment policy which will include a section prohibiting employees to have resident contact until DFS screening results and blue fingerprint cards have been received. The policy will be acknowledged and management and staff will be educated on the policy by no later than the 28th of April. | 4/4/25<br>4/28/25<br>JH |



This plan of correction was accepted on 4/3/25. The facility manager was notified via email on 4/3/25 at 10:06 am.

Jean Jennie 4/3/25

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5002 | Continued From page 1<br><br>1. Review of the personnel file for staff #2 showed he was hired as a housekeeper on 1/23/25. There was no evidence a State of Wyoming Division of Criminal Investigation fingerprint background check and a Department of Family Services Central Registry Screening had been completed.<br><br>2. Interview with the facility manager on 2/26/25 at 3:20 PM confirmed the background checks had not been completed. | S5002 | Continued from page 1<br><br>All employee files will be audited during the quality improvement program self questionnaire every other Monday until all files are in compliance, and then quarterly thereafter, to ensure that all employees have been screened as appropriate. | |
| S5003 | Ch 12 Sec 6 (d) Personnel and Staffing Requirements<br><br>(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:<br><br>(i) Ensure a safe and sanitary environment for residents and personnel;<br><br>(ii) Require tuberculin testing, or screening as appropriate; and<br><br>(iii) Prohibit any person with an airborne, contagious, or infectious disease from being employed until a work release is obtained.<br><br>(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.<br><br>(B) The facility shall require staff to follow | S5003 | Showboat Retirement Center management will perform an audit of all employee files to ensure that all members of staff who have not had tuberculin testing within the last year, will receive it. Management will ensure that all personnel files have record of the results of the tuberculin testing, as well as an updated record of vaccination status by no later than the 28th of April.<br><br>We have already contacted a nurse with Public Health and are working with her to schedule a TB testing clinic, during which, she will come to the facility to perform the test on all of our staff and residents who need the TB test performed. It has been scheduled for the 8th of April with the TST to be read on the 10th.<br><br>Showboat Retirement Center Management will work with Public Health to develop a policy regarding Tuberculin testing for both staff and residents. We will include in | 4/28/25 |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5003 | Continued From page 2<br>universal precautions when performing direct resident care.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on personnel file review, policy and procedure review, staff interview, and review of the Wyoming Department of Health Tuberculosis Program Facility Risk Assessment, the facility failed to ensure 2 out of 3 newly hired employees (staff #1, staff #2) were tested for tuberculosis and 2 out of 2 employees (staff #3, staff #4) were tested or screened as appropriate for tuberculosis. The findings were:<br><br>1. Review of the personnel file for staff #1 showed she was hired on 4/27/23. There was no evidence the staff member had been tested for tuberculosis prior to resident contact.<br><br>2. Review of the personnel file for staff #2 showed he was hired on 1/23/25. There was no evidence the staff member had been tested for tuberculosis prior to resident contact.<br><br>3. Review of the personnel file for staff member #3 and #4 showed no evidence the employees had received an annual test and/or were screened as appropriate.<br><br>4. Review of the facility's "Personnel Policies" policy showed "2. All personnel must have a TB test before employment and annually thereafter."<br><br>5. Interview with the facility manager on 2/26/25 at 11:12 AM confirmed staff #1 and staff #2 had not been tested for tuberculosis prior to having contact with residents. In addition, the manager stated it was her understanding if an annual risk assessment was completed and showed the | S5003 | Continued from page 2<br><br>this policy at minimum: additional TB screening requirements, a section for immunization status requirements, as well as what to do in the event that a resident or staff member declines vaccination, and a section prohibiting any person with an airborne, contagious, or infectious disease from being employed until a work release is obtained. The Policy will be published and acknowledged and all management, staff, and residents will be educated on the policy by no later than the 28th of April.<br><br>All staff files will be audited during the quality improvement self-assessment questionnaire every other Monday until compliance is achieved, and then quarterly thereafter to ensure that all staff members have appropriate testing that meets the minimum requirements of the new policy mentioned above.<br><br>Staff #1, #3 and #4 have been notified that they will be required to either go to Public Health or their primary care physician and receive a TST on their own time by no later than the 28th of April, or attend the clinic that is being held on the 8th of April. Staff #2 received a TST on March 3rd and received a negative read on the 5th, but has not returned to work since the 21st of March. | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5003 | Continued From page 3<br>facility was at low risk for tuberculosis, testing was no longer required.<br><br>6. Review of the Wyoming Department of Health Tuberculosis Program Facility Risk Assessments dated 2/7/24 and 1/30/25 and signed by the facility manager showed the box was marked yes to "Does your facility have an infection control plan for confirmed or suspected TB cases that includes how those clients are triaged and isolated?" In addition, the box was marked yes to "Does your facility have a TB screening program for health care workers?" The risk assessment showed the facility was at "Low Risk" and the Wyoming Department of Health recommendations for screening included a baseline two-step TST (tuberculin skin test) or IGRA (interferon-gamma release assay) upon hire; no annual testing (unless other risks occur); and standard contact investigation for unprotected exposure to M. tuberculosis.<br><br>7. Interview with the DON and facility manager on 2/26/25 at 3:15 PM revealed the facility was currently working on a new policy. | S5003 | | |
| S5007 | Ch 12 Sec 7 (b)(ii) Assisted Living Facility (ALF) Core Services<br><br>(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 at the time of admission.<br><br>(A) Admission orders shall include an order for TB screening, influenza and | S5007 | Showboat Retirement Center management will perform an audit of all resident files to ensure that all resident files contain vaccination records and results of a TB test. All residents who have not received influenza and pneumococcal immunizations will be assisted in getting immunized, or if assistance is declined, their medical records will be updated to reflect the reason for declining immunization. | 4/28/25 |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5007 | Continued From page 4<br>pneumococcal immunization status and orders for immunization if required, unless contraindicated. The facility must develop and implement policies and procedures to ensure the following:<br><br>(I) Residents, or their legal representative are educated regarding the risks and benefits of these immunizations.<br><br>(II) The immunizations are offered unless medically contraindicated or the resident is currently immunized.<br><br>(III) If the resident is not vaccinated, the medical record must reflect the reason, such as medical contraindication or refusal.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on resident record review and staff interview, the facility failed to have admission orders which included orders for tuberculosis screening, influenza and pneumococcal immunization status, and orders for immunization if required, unless contraindicated for 3 of 3 (#1, #2, #3) newly admitted residents reviewed. In addition, the facility failed to develop a policy and procedure to ensure residents or their legal representative were educated on the risks and benefits of the immunizations; were offered, unless medically contraindicated or the resident was currently immunized; and a process for documenting the resident's immunization status or declination in the resident's record. The findings were:<br><br>1. Review of the resident record for resident #1 showed s/he was admitted to the facility on | S5007 | Continued from page 4<br>We have already contacted a nurse with Public Health and are working with her to schedule a TB testing clinic, during which, she will come to the facility to perform a TST screening on all of our staff and residents who need the TB test performed. It has been scheduled for the 8th of April with the TST to be read on the 10th. Results from the TB tests including immunization records will be placed in each resident file. Resident #1, #2, and #3 will be present at the TB clinic or will be assisted to their Primary Physician to receive a TST before the 28th of April.<br><br>A form has been drafted to be included in each resident file during resident intake that will show immunization status, offer immunization if not currently immunized, confirm that they understand the risks and benefits of vaccinations, and will include a section that will reflect the reason they are not vaccinated if they choose to decline. Our Physicians Consent form will be updated to request records of resident immunizations, which will be required along with the signed Physician Consent before a resident is allowed to move in. Both forms will be present in the resident intake packet master copy by the 28th of April, and used for all future intakes.<br><br>A hand-out has been created with information from the CDC website on both | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5007 | Continued From page 5<br>2/1/25. The resident's admission orders did not include an order for tuberculosis screening, influenza, or pneumococcal immunizations. Further review showed no evidence the resident had been screened for tuberculosis prior to admission; however, the resident's vaccination status was included in his/her record.<br><br>2. Review of the resident record for resident #2 showed s/he was admitted to the facility on 10/27/24. The resident's admission orders did not include an order for tuberculosis screening, influenza, or pneumococcal immunizations. Further review showed no evidence the resident had been screened for tuberculosis prior to admission and there was no record of the resident's immunization status.<br><br>3. Review of the resident record for resident #3 showed s/he was admitted to the facility on 9/1/24. The resident's admission orders did not include an order for tuberculosis screening, influenza, or pneumococcal immunizations. Further review showed no evidence the resident had been screened for tuberculosis prior to admission; however, the resident's vaccination status was included in his/her record.<br><br>4. Interview with the facility manager and the DON on 2/26/25 at 3:15 PM confirmed the admission orders were incomplete. Further, the facility manager was unable to locate an immunization policy. | S5007 | Continued from page 5<br>the influenza and pneumococcal immunizations to better educate residents and their family members/legal representatives on the risks and benefits of immunization.<br><br>Our Infection Control policy will be written to reflect the above requirements and will be published, and management, staff, and residents will be educated on this policy by no later than the 28th of April.<br><br>All resident files will be audited during the quality improvement self-assessment questionnaire every other Monday until compliance is achieved, and then quarterly thereafter; to ensure that all residents have appropriate testing that meets the requirements of the Infection Control policy mentioned above. | |
| S5014 | Ch 12 Sec 7 (c) Assisted Living Facility (ALF) Core Services<br><br>(c) Resident Rights. The facility shall adopt and follow a written policy of resident rights. The | S5014 | The Residents Rights were framed and placed in the front lobby on March 13th, where they can be seen by residents, staff, and visitors. Management will ensure that these are present during | 3/19/25 |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5014 | Continued From page 6<br>policy shall be posted in a conspicuous place, and there shall be documentation in the resident's record that the resident read, or management explained, the policy. This policy shall not exclude, take precedence over, or in any way abrogate the legal and constitutional rights enjoyed by all adult citizens and shall include, but is not limited to the following:<br><br>(i) Be treated with respect and dignity;<br><br>(ii) Privacy;<br><br>(iii) Free from physical or chemical restraints not required to treat the resident's medical symptoms. No chemical or physical restraints will be used except by order of a physician;<br><br>(iv) Not to be isolated or kept apart from other resident's<br><br>(v) Not to be physically, psychologically, sexually, or verbally abused, humiliated, intimidated, or punished.<br><br>(vi) Live free from involuntary confinement or financial exploitation;<br><br>(vii) Full use of the facility's common areas;<br><br>(viii) Voice grievances and recommend changes in policies and services;<br><br>(ix) Communicate privately, including, but not limited to, communicating by mail or telephone with anyone;<br><br>(x) Reasonable use of the telephone, which includes access to operator assistance for | S5014 | Continued from page 6<br>each self- assessment survey performed quarterly, to ensure that compliance is maintained. The requirement was discussed during the manager meeting held on March 19th and all members of management have been educated on the location of the Resident Rights as well as the requirement stating that they be posted in a conspicuous place. | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5014 | Continued From page 7<br>placing collect telephone calls;<br><br>(xi) Have visitors, including the right to privacy during such visits;<br><br>(xii) Make visits outside the facility. The facility manager and the resident shall share responsibility for communicating with respect to scheduling such visits;<br><br>(xiii) Make decisions and choices in the management of personal affairs, assistance plans, funds, or property;<br><br>(A) Including choice of home health agencies, pharmacies, personal care providers and any other private pay provider.<br><br>(xiv) Except the cooperation of the provider in achieving the maximum degree of benefit from those services which are made available by the facility;<br><br>(xv) Exercise choice in attending and participating in religious activities;<br><br>(xvi) Reimbursed at an appropriate rate for work performed on the premises for the benefit of the operator, staff, or other residents, in accordance with the resident's assistance plan;<br><br>(xvii) Informed by the facility thirty (30) days in advance of changes in services or charges;<br><br>(xviii) Have advocates visit, including members of community organizations whose purpose include rendering assistance to the residents; | S5014 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5014 | Continued From page 8<br><br>(xix) Wear clothing of choice unless otherwise indicated in the resident's plan, and in accordance with reasonable dress code;<br><br>(xx) Participate in social activities, in accordance with the assistance plan; and<br><br>(xxi) Examine survey results.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to post the resident rights policy in a conspicuous place. The census was 22. The findings were:<br><br>1. Observation of the facility on 2/25/25 at 2 PM showed no evidence the resident rights policy was posted.<br><br>2. Interview with the facility manager and DON on 2/26/25 at 3:22 PM revealed the resident rights policy was previously posted on the bulletin boards; however, they were unsure what had happened to them. | S5014 | | |
| S5026 | Ch 12 Sec 7 (j)(ii) Assisted Living Facility (ALF) Core Services<br><br>(j) (ii) There must be an organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome and sanitary in accordance with the rules. The dietetic service must ensure that food prepared in nutritionally adequate in accordance with the Dietary | S5026 | The Fridge/Freezer Temperature Log was updated on the 28th of March, to include the Kenmore chest freezer, Gibson upright freezer, and Frigidaire upright freezer; thermometers will be placed in each freezer to be checked and charted daily. An audit of the facility showed that no further storage units were affected.<br><br>Kitchen staff will be shown the updated | 4/18/25 |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5026 | Continued From page 9<br>Reference Intakes (DRI) for adults.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on observation, staff interview, and review of the FDA 2022 food code regulations, the facility failed to ensure food was prepared, stored, and distributed under sanitary conditions in 1 of 1 kitchen and 1 of 2 food storage areas (freezer room). The census was 22. The findings were:<br><br>Related to temperature monitoring of food storage units:<br><br>1. Observation on 2/25/25 at 1:45 PM and again on 2/27/25 at 8:50 AM showed one Kenmore chest freezer, one Gibson upright freezer, and one Frigidaire upright freezer were located in a room outside of the kitchen and contained frozen food for resident use. Interview with the facility manager on 2/25/25 at 1:45 PM revealed the facility did not monitor the temperature of the freezers located outside of the kitchen. Interview with cook #1 on 2/27/25 at 8:50 AM revealed the temperature of the freezers located outside of the kitchen were not monitored on a regular basis.<br><br>2. According to the 2022 FDA Food Code "2-103.11 Person in Charge. The PERSON IN CHARGE shall ensure that..(J) FOOD EMPLOYEES are properly maintaining the temperature of TIME/TEMPERATURE CONTROL FOR SAFETY FOODS during thawing through daily oversight of the FOOD EMPLOYEE'S routine monitoring of FOOD temperatures..."<br><br>Related to the sanitary environment of the | S5026 | Continued from page 9<br><br>Fridge/Freezer Temperature log during the scheduled kitchen meeting on April 2nd, will be instructed by facility manager and dietary manager in training, on how to fill out the new form, and will be required to use the new form moving forward.<br><br>Showboat staff will undergo additional food safety training. At minimum the training will include an in-depth demonstration on hand hygiene, and in-depth information on food storage. UV reactive powder has been purchased to do a practical demonstration on handwashing and how bacteria can be transferred even when using gloves, and an in-service will be held to perform the demonstration. The facility manager and kitchen manager will discuss food born pathogens and stress the importance of labeling and dating food properly and when food should be thrown away. The meeting will be held on the 18th of April and all staff will be required to attend.<br><br>A Kitchen Procedures Manual will be published before the 4th of April, and all staff will read, and be required to adhere to the procedures. These procedures will include information from the The 2022 FDA Food Code, and include in-depth sections regarding food labeling, food storage, and handwashing. Management | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5026 | Continued From page 10<br>kitchen:<br><br>1. Observation on 2/25/25 at 1:45 PM showed the Maytag "Fridge A" contained unidentified frozen food in a plastic resealable storage bag dated 11/24/24, and two resealable plastic storage bags labeled "taco meat" dated 1/25/25 and 2/19/25. The food in the resealable storage bags appeared to have a build-up of frost. In addition, there was an unlabeled and undated, of what appeared to be frosting, in an icing piping bag. Observation and interview with cook #1 on 2/27/25 at 8:50 AM revealed she was unaware of how long the frozen food could be stored and immediately discarded the food dated 11/24/24, 1/25/25, and the frosting. In addition, cook #1 revealed it was her responsibility to monitor the refrigerators and freezers for outdated food items.<br><br>2. Observation on 2/25/25 at 4:42 PM showed cook #2 was placing slices of bread on paper plates with her gloved hands. The cook removed her gloves and without performing hand hygiene performed various tasks throughout the kitchen ending with retrieving a loaf of bread from the refrigerator. Without performing hand hygiene cook #1 donned gloves and began making sandwiches with deli meat and cheese touching the bread, meat, and cheese with her gloved hands. The cook removed the gloves and without performing hand hygiene opened the refrigerator door and retrieved a jar of jelly.<br><br>3. Observation on 2/25/25 at 4:22 PM showed residents were gathering in the dining room for the evening meal. Staff #2 was wearing gloves and serving beverages to the residents and performing tasks in the kitchen. At 4:55 PM staff #2 was observed using a can opener and then doffed his gloves. Without performing hand | S5026 | Continued from page 10<br><br>will make themselves more present in the kitchen and will aid in praising staff with good handwashing habits and reminding staff to wash hands frequently in order to get staff in the habit of washing hands as appropriate. Freezers and refrigerators will be inspected twice weekly by the kitchen manager while putting away new groceries, at minimum; and any food not meeting Showboat standards (food not labeled with name of the food and date, expired, or covered in ice crystals) will be thrown away immediately.<br><br>An in-service will be held at least twice a year reminding staff of the importance of handwashing and sanitary food conditions and will contain information from the 2022 FDA Food Code. Meeting minutes will be reviewed during each quality assurance self assessment performed quarterly and evaluated to ensure that they include signatures of staff in attendance and the presence of education on handwashing and sanitation requirements to ensure ongoing compliance. | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5026 | Continued From page 11 | S5026 | | |

hygiene staff #2 donned new gloves and carried a coffee mug with his thumb on the inside of the mug to a resident.

4. Observation on 2/26/25 at 4:43 PM showed cook #2 rinsed her hands in a sink which contained a bucket of sanitizer and dried her hands on a towel which was hanging on the range handle. With the towel the cook retrieved a cutting board and a bowl and then replaced the towel on the range handle. Without performing hand hygiene, the cook donned gloves and began slicing tomatoes. After completing the task cook #2 doffed her gloves and cleaned the counter with a sanitizing solution, stirred the contents of the pot on the stovetop, and retrieved tortillas from the refrigerator. Without performing hand hygiene, the cook donned gloves and placed the tortillas on individual plates to serve to the residents.

5. Interview with cook #1 on 2/27/25 at 8:50 AM revealed the sink delegated for hand-washing was located on the far wall of the kitchen and the sink with the sanitizer solution was not to be used for hand-washing.

6. Interview with the facility manager on 2/26/25 at 3:20 PM revealed kitchen staff were given on-the-job training by the resident care specialist, the facility manager, and the assistant manager. Further interview with the facility manager on 2/27/25 at 9:01 AM revealed she had been working on updating the kitchen policies.

7. According to the 2022 FDA Food Code showed "2-301.11 Clean Condition. FOOD EMPLOYEES shall keep their hands and exposed portions of their arms clean. 2-301.12 Cleaning Procedure. (A) Except as specified in ¶ (D) of this section,

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5026 | Continued From page 12<br>FOOD EMPLOYEES shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound in a HANDWASHING SINK that is equipped as specified under § 5-202.12 and Subpart 6-301. (B) FOOD EMPLOYEES shall use the following cleaning procedure in the order stated to clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands and arms: (1) Rinse under clean, running warm water; (2) Apply an amount of cleaning compound recommended by the cleaning compound manufacturer; (3) Rub together vigorously for at least 10 to 15 seconds while: (a) Paying particular attention to removing soil from underneath the fingernails during the cleaning procedure, and (b) Creating friction on the surfaces of the hands and arms or surrogate prosthetic devices for hands and arms, finger tips, and areas between the fingers; (4) Thoroughly rinse under clean, running warm water; and (5) Immediately follow the cleaning procedure with thorough drying using a method as specified under § 6-301.12. (C) TO avoid recontaminating their hands or surrogate prosthetic devices, FOOD EMPLOYEES may use disposable paper towels or similar clean barriers when touching surfaces such as manually operated faucet handles on a HANDWASHING SINK or the handle of a restroom door. (D) If PROVED and capable of removing the types of soils encountered in the FOOD operations involved, an automatic handwashing facility may be used by FOOD EMPLOYEES to clean their hands or surrogate prosthetic devices."<br><br>8. According to the 2022 FDA Food Code showed "2-301.14 When to Wash FOOD EMPLOYEES shall clean their hands and exposed portions of | S5026 | | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5026 | Continued From page 13<br>their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in ¶ 2-403.11(B); (D) Except as specified in ¶ 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using TOBACCO PRODUCTS, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands."<br><br>9. According to the 2022 FDA Food code showed "2-301.15 Where to Wash FOOD EMPLOYEES shall clean their hands in a HANDWASHING SINK or APPROVED automatic handwashing facility and may not clean their hands in a sink used for FOOD preparation or WAREWASHING, or in a service sink or a curbed cleaning facility used for the disposal of mop water and similar liquid waste." | S5026 | | |
| S5027 | Ch 12 Sec 7 (j)(iii) Assisted Living Facility (ALF) Core Services<br><br>(j) (iii) Food service supervision: | S5027 | Facility manager will take the Certified Food Manager (CFM) course from the International Food Service Executives Association, and will | 4/4/25 |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5027 | Continued From page 14<br><br>(A) Day to day responsibilities for food production and management of the dietary services shall be assigned to a person with nutrition and food service management experience equivalent to that of a Certified Dietary Manager.<br>Based on personnel records and staff interview, the facility failed to employ a food service manager to oversee the day-to-day responsibilities for food production and management of the dietary services with experience equivalent to that of a Certified Dietary Manager. The census was 22. The findings were:<br><br>1. Review of the 2/1/25 "Employee Contact List" provided by the facility upon entrance showed the position of dietary manager was not listed.<br><br>2. Interview with the facility manager on 2/26/25 at 3:25 PM revealed the assistant manager was currently enrolled in a certified dietary manager course and was due to complete the course in April of 2025. | S5027 | Continued from page 14<br><br>oversee kitchen activities until the dietary manager in training has finished his Dietary Management course. The facility manager will complete the course by the 4th of April. The dietary manager in training has a projected graduation date of April 30th. | |
| S5041 | Ch 12 Sec 7 (l) Assisted Living Facility (ALF) Core Services<br><br>(l) Quality Improvement.<br><br>(l) The facility shall have an active quality improvement program to ensure effective utilization and delivery of resident care services.<br><br>(A) A member of the facility's staff shall be designated to coordinate the quality improvement program. | S5041 | New QA Program policies will be drafted before the 28th of April, to include updated meeting requirements to require quarterly QA meetings. All management, staff, and residents will be educated on the new policy by the 28th of April.<br><br>The policy will be drafted to include meeting minute requirements to include a section for problem areas identified, the corrective action, the person in charge of the corrective action, and how the | 4/28/25 |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5041 | Continued From page 15<br>(B) The quality improvement program shall encompass a review of all services and programs provided for all residents. the program shall have:<br>(I) A written description;<br>(II) Problem areas identified;<br>(III) Monitor identification;<br>(IV) Frequency of monitoring;<br>(V) A provision requiring the facility to complete annually a self-assessment survey of compliance with the regulations; and<br>(VI) A satisfaction survey shall be provided to the resident, resident's family, or resident's responsible party at least annually.<br>(C) Problems identified during the annual survey or the quality improvement process shall be addressed with appropriate written corrective actions.<br>(D) The quality improvement program shall be re-evaluated at least annually.<br>This State Rule and Regulation is not met as evidenced by:<br>Based on facility documentation, policy and procedure review, and staff interview, the facility failed to have an active quality improvement program. The census was 22. The findings were:<br>1. Review of the "Quality Assurance Program" policy showed "Organization The manager is | S5041 | Continued from page 15<br>corrective action will be monitored. The next QA meeting will be scheduled before the end of April, and the minutes for the meeting will meet these requirements and the same format will be used for all future QA meetings.<br>A new self-assessment questionnaire was created on the 14th of March, and will be used every other week starting on the 17th of March, and every other Monday thereafter, until compliance is achieved, and then quarterly at a minimum. | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5041 | Continued From page 16 | S5041 | | |

responsible for coordinating the Quality Assurance Program. The manager will be the leader of the Quality Assurance Committee. A representative from each department will be chosen by the manager to participate in the Quality Assurance Committee...Program The Quality Assurance Committee will meet monthly. Minutes of the Quality Assurance Committee meetings will be kept and filed in a Quality Assurance notebook and maintained by the Quality Assurance Committee. Decisions regarding corrective actions will be communicated to the staff by regularly scheduled staff meetings. Each Department will submit reports to the committee regarding identified service delivery problems. These reports will include suggested plans of correction. Each month, along with discussion newly identified problems, the committee will review all areas of study to determine if there are any new service delivery problems and to determine if previous plans of correction have been adequate to solve the previously identified problems. Areas of Study 1. Evaluation of personal services - dressing, bathing, laundry, hygiene. 2. Evaluation to determine if meals meet residents' needs and preferences. 3. Evaluation if internal and external fire and life safety drills. 4. Evaluation of the infection control program. 5. Evaluation of nursing services. 6. Evaluation of medication reminder services. 7. Evaluation of care planning. 8. Evaluation of resident counsel. 9. Evaluation of discharge planning.10. Evaluation of activity program. 11. Evaluation of housekeeping services. 12. Evaluation of maintenance services. 13. Evaluation of transportation services. 14. Evaluation of basic reminder services. 15. Evaluation of resident and staff accidents of injuries (incident reports). The following concerns were identified:

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5041 | Continued From page 17<br>a. Review of the 10/4/24 and 1/31/25 quality assurance meeting minutes showed the committee failed to provide a written description of a problem area identified, what corrective action was taken, and how the corrective action was going to be monitored. The previous quality assurance meeting minutes were dated 5/26/21.<br>b. Review of the facility's self-assessment surveys showed a survey was conducted on 1/30/18, 9/4/24, and 1/4/25. Review of the 9/4/24 self-assessment showed the facility marked "yes" to all questions except for "is tuberculin testing accomplished for each employee prior to employment and annually thereafter?" Review of the 1/4/25 self-assessment showed the facility marked "yes" to all the questions. There was no evidence data had been obtained to support the "yes" responses.<br>c. There was no evidence satisfaction surveys had been provided to residents, resident's family, or a resident's responsible party on an annual basis.<br><br>2. Interview with the facility manager on 2/27/25 at 8:30 AM revealed she was currently working on the quality assurance program and was drafting a satisfaction survey which she hoped to distribute to the residents by the end of March. Further, the facility manager stated the facility was not currently working on any quality improvement projects. | S5041 | | |
| S5042 | Ch 12 Sec 7 (m) Assisted Living Facility (ALF) Core Services<br><br>(m) Facility Policies and Procedures.<br><br>(i) Management shall develop policies and procedures that are available to residents and | S5042 | A policy regarding the management of resident trust accounts, per diem rate/ charges/fees, and outside contractual responsibilities will be drafted and published. The policy will be finalized and managment, staff, and residents will be educated on the new policies by the 28th | 4/28/25 |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5042 | Continued From page 18<br>staff, including but not limited to:<br><br>(A) Resident rights;<br><br>(B) Disciplinary procedures surrounding substantiated cases of resident abuse;<br><br>(C) Admission, transfer, bed hold days, and discharge of residents;<br><br>(D) Medication management;<br><br>(E) Emergency care of residents (including missing resident, blizzard, water outage, etc.);<br><br>(F) Fire/disaster plan;<br><br>(G) Departure and return;<br><br>(H) Smoking;<br><br>(I) Visiting hours;<br><br>(J) Activities;<br><br>(K) Management of resident trust accounts;<br><br>(L) Personnel policies;<br><br>(M) Grievance procedure;<br><br>(N) Per Diem rate/charges/fees, to include a listing of what is included in the established charges;<br><br>(O) Incident reports; | S5042 | Continued from page 18<br><br>of April.<br><br>A book containing all of Showboat Retirement Center policies will be created, and the policies and procedures book will be reviewed every other Monday until compliance is achieved, and then annually thereafter; to ensure that all policies and procedures required by the board of Healthcare Licensing and Surveys are present, and all information in these policies are up to date with current standards. | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5042 | Continued From page 19<br>(P) Notification of change in established per diem rate/charges/fees;<br>(Q) Outside contractual responsibilities; and<br>(R) Identification and notification of change in resident's condition.<br>This State Rule and Regulation is not met as evidenced by:<br>Based on review of policies and procedures and staff interview, the facility failed to develop 3 of 18 of the required policies and procedures. The findings were:<br>1. Review of the facility's policies and procedures failed to include a policy for the management of resident trust accounts; per diem rate/charges/fees, to include a listing of what is included in the established charges; notification of change in established per diem rate/charges/fees; and outside contractual responsibilities.<br>2. Interview with the facility manager on 2/26/25 at 3:11 PM confirmed the policies and procedures were not available. | S5042 | | |
| S5046 | Ch 12 Sec 7 (o)(iii) Assisted Living Facility (ALF) Core Services<br>(o) (iii) Fire Safety.<br>(A) Portable fire extinguishers shall be installed, inspected, and maintained according with NFPA 10, Standard for Portable Fire Extinguishers. | S5046 | All resident files were audited to ensure that each resident file contained the fire emergency plan including the location of all exits on the 10th March. All residents whose files found not containing the fire emergency plan, will be shown the fire emergency plan, will be asked to sign the bottom of the emergency plan, and that emergency plan will be placed into their | 3/31/25 |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5046 | Continued From page 20<br>(I) State of Wyoming certified individuals shall inspect and service the extinguishers. All extinguishers shall have a tag or label securely attached that indicate the month and year the maintenance was performed and that identifies the person performing the service.<br><br>(B) Readily available and clearly readable telephone numbers for emergency contacts shall be located near all telephones.<br><br>(C) Clearly readable floor diagrams reflecting the actual floor arrangement showing the exit locations and evacuation routes shall be posted in conspicuous places. Each resident shall be instructed with its use on the first day of admission.<br><br>(D) Residents training for the fire emergency plan shall be in accordance with the Life Safety Code Operating Features sections.<br><br>(I) On the first day of admission, each resident shall be instructed in the proper action of the fire emergency plan, including the location of all the exits. A record of this instruction shall be in each resident file.<br><br>(E) Fire exit drills shall be conducted in accordance to the Life Safety Code Operating Features sections. The minimum number of drills, as amended, shall be held at least twelve (12) times per year on a monthly basis with a minimum of one drill conducted each quarter on each shift. Fire exit drill records over a two-year period shall be available upon request at the facility.<br><br>(I) The facility shall be responsible | S5046 | Continued from page 20<br>file by the 31st of March. The intake packet master copy has been updated and currently includes a copy of the fire emergency plan so that all future intake orientations will include instruction on the proper action of the fire emergency plan including the location of all exits. All members of management were educated on these requirements on the 19th of March.<br><br>Management will meet with resident #1, #2, and #3 to review the proper action of the fire emergency plan including the location of all exits, and their signed copy of the fire plan will be placed into their files by the 31st of March.<br><br>All resident files will be audited during the quality improvement survey every other Monday until compliance is achieved, and then quarterly thereafter to ensure that the deficiency does not recur. | |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5046 | Continued From page 21 | S5046 | | |

for recording fire exit drills on an evaluation form that include at least the following:

(1.) Date of drill;

(2.) Time of day;

(3.) Type of drill (Practice, Announced, Surprise);

(4.) Residents who participated including staff and family members;

(5.) The required (minutes and seconds) to evacuate all residents (including staff) from the occupied areas to a point of assembly as defined in the Life Safety Code;

(6.) List of anyone, including staff and family members, who did not evacuate in the required time allowed by the evacuation capability rating of the facility. Evacuation capability rating for each facility shall be listed on the form;

(7.) Comments on the factors that contributed to each individual's inability to evacuate successfully and any corrective actions recommended; and

(8.) Signature and date of the person completing the form.

This State Rule and Regulation is not met as evidenced by:
Based on review of resident records and staff interview, the facility failed to instruct new residents on the fire emergency plan for 3 of 3 newly admitted residents (#1, #2, #3) reviewed. The findings were:

1. Review of the resident record for resident #1

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5046 | Continued From page 22<br>showed s/he was admitted on 2/1/25. There was no evidence the resident had been instructed in the proper action of the fire emergency plan, including the location of all the exits.<br><br>2. Review of the resident record for resident #2 showed s/he was admitted on 10/27/24. There was no evidence the resident had been instructed in the proper action of the fire emergency plan, including the location of all the exits.<br><br>3. Review of the resident record for resident #3 showed s/he was admitted on 9/1/24. There was no evidence the resident had been instructed in the proper action of the fire emergency plan, including the location of all the exits.<br><br>4. Interview with the facility manager on 2/26/25 at 3:11 PM confirmed no further documentation was available. | S5046 | | |
| S5048 | Ch 12 Sec 9 (a)(i) Contractual Svcs Provided Outside ALF Auth<br><br>(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.<br><br>(i) Components of the outside service(s) contract:<br><br>(A) Who will provide service(s);<br><br>(B) What service(s) will be provided; | S5048 | A contract has been drafted to be used for companies providing services such as oxygen, wound care, or physical therapy. Management was educated on the new contract and the requirements regarding its use. An audit was performed on the 10th of March and no other problems were identified. A signed contract will be obtained with each company currently entering the facility to provide services for resident #1, #5, #7, #8, #9, and #10. A roster will be created and used to obtain a signed contract with each corresponding company, and all contracts will be signed and received by the 31st of March or before services are provided again. The | 4/28/25 |

Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 23<br><br>(C) When the service(s) will be provided;<br><br>(D) Where the service(s) will be provided;<br><br>(E) How the service(s) will be provided; and<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on review of facility documentation, review of policy and procedures, and staff interview, the facility failed to ensure a service contract was developed which included all required components for 5 of 5 residents (#1, #5, #7, #8, #9, #10) who received services from an outside entity. The findings were:<br><br>1. Review of documentation provided by the facility manager upon entrance showed resident #1 received wound care and physical therapy; resident #5 required physical therapy; resident #7 required oxygen therapy; resident #8 required physical therapy and occupational therapy; resident #9 required wound care; and resident #10 required oxygen therapy. Review of the residents' records showed no evidence a contract had been developed between the outside care entity and the facility.<br><br>2. Review of the facility's policies and procedures showed no evidence a contractual services policy had been developed.<br><br>3. Interview with the facility manager on 2/26/25 at 3:11 PM confirmed no contracts were available. | S5048 | Continued from pate 23<br><br>policy regarding outside services will reflect the requirement of receiving a signed contract with a company before outside services are received. All management, staff, and residents will be educated on this new policy by April 28th.<br><br>The roster containing a list of residents receiving services and the binder of contracts will be reviewed during each self-assessment survey every other Monday until compliance is achieved, and then quarterly thereafter; to ensure that all services are documented and that the corresponding service contract is present and signed. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALF013 | A. BUILDING: _____ B. WING _____ | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHOWBOAT RETIREMENT CENTER | 150 WYOMING STREET LANDER, WY 82520 |

| (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 |
|---|---|---|---|---|
| S5060 | Continued From page 24 | S5060 | | |
| S5060 | Ch 4 Sec 5 (j)(e) Licensure<br><br>(j) (E) The Assisted Living Facility shall post the survey results in a manner conducive for public view.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to post the state licensure survey results in a manner conducive for public view. The census was 22. The findings were:<br><br>1. Observation of the facility on 2/25/25 at 2 PM showed no evidence the state licensure survey results were available for public view.<br><br>2. Interview with the facility manager on 2/26/25 at 3:24 PM revealed the survey results were kept in her office and were available upon request. | S5060 | A binder will be created containing survey results and will be placed in the lobby so that they are available for public view. The binder will be secured in the lobby by no later than the 28th of April.<br><br>The contents of the binder will be reviewed during each self-assessment survey to ensure that the state licensure survey results are available.<br><br>Residents and staff will be notified of its location by the 28th of April. | 4/28/25 |