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Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF026	A. BUILDING: _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER TRAIL ASSISTED LIVING	2360 REAGAN AVENUE ROCK SPRINGS, WY 82901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020. Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001. A licensure survey was conducted by Healthcare Licensing and Surveys from 5/6/25 to 5/8/25. Also reviewed in the course of the survey were complaint intakes LIC-23-041, LIC-23-050, and LIC-24-036. The following common abbreviations are used throughout this document: 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 for residents and personnel; (ii) Require tuberculin testing, or screening	S5003		

This plan of correction was accepted with the agreed upon changes on 6/9/25.
Jean Hennie MT(ASCP)

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S5003	Continued From page 1 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, personnel file review, policy and procedure review, and staff interview, the facility failed to ensure infection prevention practices were implemented during meal delivery for 1 of 1 meal observation in the memory care dining room. In addition, the facility failed to ensure 3 out of 3 employees reviewed (CNA #1, CNA #2, LPN #1) were tested for tuberculosis (TB) prior to patient contact and 2 out of 2 employees reviewed (housekeeper #1, food service director) were tested or screened annually. The findings were: 1. Observation on 5/0/25 from 4:10 PM until 4:30 PM showed CNA #3 was wearing gloves and assisting with meal service in the memory care dining room. The following concerns were identified. a. At 4:23 PM the CNA was observed using resident #1's utensils to cut food on the resident's plate. Without removing her gloves, the CNA assisted resident #2 into the dining room by holding the resident's hand and guiding him/her	S5003		

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S5003	Continued From page 2 into a chair by placing her gloved hands on the resident's buttocks. Further observation showed the CNA sat in resident #3's walker, touched the hand grips, brushed food off of the resident's sweater, and picked up the resident's utensils. Using the same gloves, the CNA touched resident #4's beverage cup and then served a plate of food to resident #5. The CNA picked up the top of a bun with the same gloved hands to assist resident #5 with a condiment. At 4:32 PM the CNA left the dining room and entered resident #6's room returning with the resident and carrying a tote bag; resident #6 was served a plate of food at 4:34 PM. At 4:35 PM the CNA was again observed sitting on resident's #3's walker; picked up the resident's beverage glass to refill it with water and returned the glass to the resident. The CNA doffed her gloves at 4:36 PM. b. Interview with CNA #3 on 5/6/25 at 4:47 PM revealed she had not received any education related to glove use during meal service and was only required to remove her gloves if she left the dining area. c. Interview with the food service director on 5/7/25 at 9:45 AM revealed she was not responsible for overseeing the CNAs during meal service. d. Interview with the wellness program director on 5/7/25 at 3:13 PM confirmed she was responsible for educating CNAs on the proper use of gloves during meal service. In addition, the facility's expectation was gloves be changed and hand hygiene performed between tasks. 2. Review of personnel files showed the following concerns related to TB testing. a. Review of the personnel file for CNA #1 showed she had a rehire date of 4/6/22. There was no evidence the staff member had been tested for TB prior to resident contact.	S5003		

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S5003	Continued From page 3 b. Review of the personnel file for CNA #2 showed she was hired on 8/14/24. There was no evidence the staff member had been tested for TB prior to resident contact. c. Review of the personnel file for LPN #1 showed she was hired on 5/1/23. There was no evidence the staff member had been tested for TB prior to resident contact. d. Review of the personnel file for housekeeper #1 showed no evidence the staff member had received an annual test and/or was screened as appropriate for TB in 2024. e. Review of the personnel file for the food service director showed her last TB test was dated 9/15/22. f. Interview with the ED and the wellness program director on 5/7/25 at 4:08 PM confirmed no further documentation was available. 3. Review of the "Infection Control, Employee Health, including Tuberculin Testing and Communicable Disease Information" policy, last reviewed 4/10/24, showed " ...Every employee and volunteer shall have a negative Tuberculosis (TB) test or a certificate of non-infectiousness and/or documentation of appropriate treatment if needed, or a negative chest x-ray..." In addition, "All employees should follow hand washing guidelines to prevent the spread of infection or germs..."	S5003		
S5004	Ch 12 Sec 6 (e) Personnel and Staffing Requirements (e) Personnel Policies and Records. (i) Management shall provide new employee orientation and education regarding resident rights, evacuation, and emergency procedures,	S5004		

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S5004	Continued From page 4 as well as training and supervision designed to improve resident care. (ii) A record for the manager and each employee shall be maintained and contain at a minimum, the following information: (A) Name, current address and telephone number; (B) Social Security Number; (C) Education; (D) Work experience, documentation of reference checks; (E) Date of employment; (F) Position in the assisted living facility (job description); (G) Documentation of tuberculin testing; (H) Orientation checklist; (I) I-9, (Employment Eligibility Verification); (J) W-4, (Employee's Withholding Allowance Certificate); (K) Licensure, Certification, or Credentials; (e.g., RN, LPN, CNA, etc.); (L) Documentation of all completed background and Central Registry background check with no offenses.	S5004		

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S5004	Continued From page 5 This State Rule and Regulation is not met as evidenced by: Based on review of personnel files and staff interview, the facility failed to ensure personnel records contained all of the required documentation for 3 of 5 employees reviewed (CNA #1, CNA #2, LPN #1). The findings were: 1. Review of the personnel file for CNA #1, CNA #2, and LPN #1 failed to include documentation of the results of the Central Registry background check completed prior to employment. In addition, the personnel file for LPN #1 failed to include a copy of the orientation checklist. 2. Interview with the ED and the wellness program director on 5/8/25 at 8:44 AM confirmed no further documentation was available; however, the facility was in the process of retrieving a copy of the missing Central Registry background checks.	S5004		
S5007	Ch 12 Sec 7 (b)(ii) Assisted Living Facility (ALF) Core Services (b) (ii) Admission orders. A resident shall be admitted only if accompanied by a history and physical completed by a physician or physician extender within ninety (90) days prior to admission. The facility shall confirm the resident's medication regimen and special treatment orders at the time of admission. (A) Admission orders shall include an order for TB screening, influenza and pneumococcal immunization status and orders for immunization if required, unless contraindicated. The facility must develop and implement policies and procedures to ensure the	S5007		

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S5007	Continued From page 6 following: (I) Residents, or their legal representative are educated regarding the risks and benefits of these immunizations. (II) The immunizations are offered unless medically contraindicated or the resident is currently immunized. (III) If the resident is not vaccinated, the medical record must reflect the reason, such as medical contraindication or refusal. This State Rule and Regulation is not met as evidenced by: Based upon resident record review and staff interview, the facility failed to have a health care provider history and physical completed within 90 days prior to admission for 2 of 5 residents reviewed (#7, #8). In addition, the facility failed to develop policy and procedures related to tuberculosis screening of residents upon admission and influenza and pneumococcal immunizations which included all of the required elements. The census was 57. The findings were: 1. Review of the record for resident #7 showed s/he was admitted to the facility on 11/11/24; however, a history and physical had not been completed until 11/14/24. In addition, the resident's record showed information regarding the influenza and pneumococcal vaccinations were signed by the resident's representative; however, neither the consent or declination box was checked. 2. Review of the record for resident #8 showed s/he was admitted to the facility on 8/10/23;	S5007		

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S5007	Continued From page 7 however, a history and physical had not been completed until 9/22/23. 3. Review of the record for resident #9 showed s/he was admitted to the facility on 3/11/25. Review of the admission order showed a section "Perform PPD"; however, the resident's record showed no evidence a tuberculosis screening test had been performed. 4. Review of the record for resident #10 showed s/he was admitted to the facility on 3/24/23. Review of the admission order showed a section "Perform PPD"; however, the resident's record showed no evidence a tuberculosis screening test had been performed. 5. Review of the record for resident #11 showed s/he was admitted to the facility on 1/6/24. Review of the admission order showed a section "Perform PPD"; however, the resident's record showed no evidence a tuberculosis screening test had been performed. In addition, the resident's record showed a consent to receive immunizations, dated 1/17/24; however, there was no evidence the immunizations were administered. 6. Interview with the wellness program director on 5/7/25 at 10:22 AM revealed the TB test for resident #9 had not been completed because she wanted to do all of the new admissions together. 7. Interview with the ED on 5/7/25 at 4:08 PM confirmed a policy and procedure for influenza and pneumococcal immunizations and tuberculosis screening had not been developed. 6. Interview with the wellness program director on 5/7/25 at 4:08 PM revealed the facility did not	S5007		

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S5007	Continued From page 8 document immunization declinations in the resident's record.	S5007		
S5025	Ch 12 Sec 7 (j)(i) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (i) Assisted Living Facilities that choose to admit residents who need therapeutic or mechanically modified diets must employ or contract with a Registered Dietitian who shall approve written menus and dietary modifications, approve special diet needs, plan individual diets, and provide guidance to dietary staff in areas of preparation, service, and monitoring. The frequency of visits is determined by the residents' needs and the competency of the dietary staff but must include at least a monthly onsite review of dietary services. This State Rule and Regulation is not met as evidenced by: Based on resident record review and staff interview, the facility failed to employ or contract with a registered dietitian (RD) to approve special diet needs, plan individual diets, and provide guidance to dietary staff in areas of preparation, service, and monitoring which affected resident #9, #11, #12, #13, and #14. The findings were: 1. Review of the dietary order, dated 3/6/25, showed resident #9 required a "Low FODMAP" [a dietary approach designed to help gastrointestinal issues], diabetic, and "Psoriatic" diet. 2. Review of the dietary order, dated 1/5/24, showed resident #11 required a 2000 kilocalorie	S5025		

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S5025	Continued From page 9 per day diabetic diet. 3. Review of the dietary order, dated 4/14/25, showed resident #12 required a diabetic diet. 4. Review of the dietary order, dated 2/11/25, showed resident #13 required a diabetic diet with no-added-salt of less than 2000 milligrams. 5. Review of the dietary order, dated 10/1/20, showed resident #14 required a diabetic, cardiac, and low sodium diet. 6. Interview with the ED on 5/7/25 at 4:08 PM revealed the facility contracted with an RD to review and approve the menus; however, the RD did not make onsite visits to the facility.	S5025		
S5026	Ch 12 Sec 7 (j)(ii) Assisted Living Facility (ALF) Core Services (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 Reference Intakes (DRI) for adults. This State Rule and Regulation is not met as evidenced by: Based on observation, review of facility documentation, staff interview, review of manufacturer's instructions, and review of the 2022 FDA Food Code, the facility failed to ensure	S5026		

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S5026	Continued From page 10 a sanitary environment in 1 of 1 kitchen and failed to ensure temperatures were monitored for 7 of 7 refrigerator/freezers. The census was 57. The findings were: 1. Observation of the facility showed the following food storage units had food available for resident use. a. A small Edgestar refrigerator was located on the counter near the dining room. b. In the kitchen was a walk-in refrigerator, a walk-in freezer, a Frigidaire side-by-side refrigerator/freezer, and 2 refrigerated cold food tables. c. A Whirlpool refrigerator/freezer was located in the memory care unit. 2. Review of the facility's documentation showed no evidence the temperatures of the food storage units were monitored. 3. Interview with the food service director on 5/6/25 at 2:15 PM revealed the temperatures of the food storage units were not documented. 4. 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..." Related to the sanitary environment of the kitchen: 1. Observation of the kitchen showed a Jackson automatic dishwasher was used for warewashing.	S5026		

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S5026	Continued From page 11 A metal plaque on the dishwasher showed the minimum temperature for the wash cycle was 150 degrees Fahrenheit and the minimum temperature for the rinse cycle was 180 degrees Fahrenheit. The following concerns were identified: a. Review of the facility's documentation showed no evidence the temperatures of the rinse or wash water were monitored. 2. Review of the dietary services documentation showed no evidence the temperature of the food was monitored. 3. Interview with the food service director on 5/6/25 at 2:15 PM revealed the temperature of dishwasher's rinse and wash water and the temperatures of the food were not documented. 4. Review of the 2022 FDA Food Code showed "4-703.11 Hot Water and Chemical. Efficacious sanitization depends on warewashing being conducted within certain parameters. Time is a parameter applicable to both chemical and hot water sanitization. The time hot water or chemicals contact utensils or food-contact surfaces must be sufficient to destroy pathogens that may remain on surfaces after cleaning. Other parameters, such as rinse pressure, temperature, and chemical concentration are used in combination with time to achieve sanitization. When surface temperatures of utensils passing through warewashing machines using hot water for sanitizing do not reach the required 71°C (160°F), it is important to understand the factors affecting the decreased surface temperature. A comparison should be made between the machine manufacturer's operating instructions and the machine's actual wash and rinse	S5026		

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S5026	Continued From page 12 temperatures and final rinse pressure. The actual temperatures and rinse pressure should be consistent with the machine manufacturer's operating instructions and within limits specified in §§ 4-501.112 and 4-501.113. If either the temperature or pressure of the final rinse spray is higher than the specified upper limit, spray droplets may disperse and begin to vaporize resulting in less heat delivery to utensil surfaces. Temperatures below the specified limit will not convey the needed heat to surfaces. Pressures below the specified limit will result in incomplete coverage of the heat-conveying sanitizing rinse across utensil surfaces."	S5026		
S5041	Ch 12 Sec 7 (l) Assisted Living Facility (ALF) Core Services (l) Quality Improvement. (i) The facility shall have an active quality improvement program to ensure effective utilization and delivery of resident care services. (A) A member of the facility's staff shall be designated to coordinate the quality improvement program. (B) The quality improvement program shall encompass a review of all services and programs provided for all residents. the program shall have: (I) A written description; (II) Problem areas identified; (III) Monitor identification;	S5041		

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S5041	Continued From page 13 (IV) Frequency of monitoring; (V) A provision requiring the facility to complete annually a self-assessment survey of compliance with the regulations; and (VI) A satisfaction survey shall be provided to the resident, resident's family, or resident's responsible party at least annually. (C) Problems identified during the annual survey or the quality improvement process shall be addressed with appropriate written corrective actions. (D) The quality improvement program shall be re-evaluated at least annually. This State Rule and Regulation is not met as evidenced by: Based on review of facility documentation and staff interview, the facility failed to have an effective quality improvement program. The census was 57. The findings were: 1. Review of the facility's quality improvement documentation showed an annual self-assessment survey for compliance was completed in August of 2024. The following concerns were identified: a. Review of the dietary services self-assessment showed the "not met" box was marked for "Food service temp log completed with cold foods at 45 degrees or below and hot foods at 140 degrees or above" and "Refrigerator and freezer temperature logs completed and all thermometers in place". The plan of correction was to "print log sheets and start logging";	S5041		

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	ALF026	A. BUILDING: _____ B. WING _____	05/08/2025

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S5041	Continued From page 14 however, there was no evidence the quality improvement committee had monitored the corrective action to ensure the problem area had been resolved. b. Interview with the ED on 5/8/25 at 8:44 AM confirmed no further documentation was available.	S5041		
S5046	Ch 12 Sec 7 (o)(iii) Assisted Living Facility (ALF) Core Services (o) (iii) Fire Safety. (A) Portable fire extinguishers shall be installed, inspected, and maintained according with NFPA 10, Standard for Portable Fire Extinguishers. (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. (B) Readily available and clearly readable telephone numbers for emergency contacts shall be located near all telephones. (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. (D) Residents training for the fire emergency plan shall be in accordance with the Life Safety Code Operating Features sections.	S5046		

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S5046	Continued From page 15 (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. (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. (I) The facility shall be responsible 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	S5046		

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S5046	Continued From page 16 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 5 of 5 residents (#7, #8, #9, #10, #11) reviewed on the fire emergency plan on the first day of occupancy. The findings were: 1. Review of the resident record for resident #7 showed s/he was admitted on 11/11/24. 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. 2. Review of the resident record for resident #8 showed s/he was admitted on 8/10/23. 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. 3. Review of the resident record for resident #9 showed s/he was admitted on 3/11/25. 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. 4. Review of the resident record for resident #10 showed s/he was admitted on 3/24/23. There was no evidence the resident had been instructed in the proper action of the fire emergency plan,	S5046		

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S5046	Continued From page 17 including the location of all the exits. 5. Review of the resident record for resident #11 showed s/he was admitted on 1/6/24. 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. 4. Interview with the ED on 5/7/25 at 4:08 PM confirmed no further documentation was available.	S5046		
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	S5048		

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S5048	Continued From page 18 This State Rule and Regulation is not met as evidenced by: Based on resident record and policy and procedure review, and staff interview, the facility failed to ensure a service contract was developed which included all required components for 3 of 3 residents (#7, #9, #11) reviewed which required outside services. The findings were: 1. Review of the resident record for resident #9 and #11 showed the residents required oxygen therapy. Review of the resident record for resident #7 showed s/he was receiving hospice services. Further review of the residents' records showed no evidence a contract had been developed between the outside care entity and the facility. 2. Review of the "Contractual Services" policy and procedure, approved by the quality assurance committee on 6/11/24, showed "...The contract between the resident, Deer Trail Assisted Living, and all outside service providers must: Be in place prior to the time of service delivery. Clearly identify the delineations of services. Specifically state the responsibilities of the resident and the Deer Trail Assisted Living staff. Comply with the Evacuation Capability, Emergency Procedures, and Fire Safety requirement in these rules for State of Wyoming. All residents regardless of the type of service must be able to evacuate, or be evacuated..."	S5048		
S5052	Ch 12 Sec 10 (a)(i) Secure Dementia Units (a) Level 2 assisted living facilities require adherence to all Level 1 requirements with the following additional criteria for a Level 2 Assisted Living Facility License.	S5052		

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S5052	Continued From page 19 (i) Level 2 Core Management requirements. (A) The facility manager shall have at least three (3) years experience in working in the field of geriatrics or caring for disabled residents in a licensed facility; (B) Certified as a residential care/assisted living facility administrator or have equivalent training. (I) Certification requirements include a training program covering topics referenced in the regulations. The course work must take place in a college, vocational training, state or national certification program, which is approved by the Department of Health. Licensed nursing home administrators, for the purpose of these rules, meet the qualifications. (II) Administrators must complete at least sixteen (16) hours of continuing education annually. At least eight (8) of the 16 hours of annual continuing education shall pertain to caring persons with severe cognitive impairments. (III) A full time manager with the above qualifications must be on duty, on the premises. This State Rule and Regulation is not met as evidenced by: Based on review of the facility manager's continuing education documentation and staff interview, the facility failed to ensure the facility manager (ED) completed the required annual continuing education requirement for a Level 2 assisted living facility. The census of the memory	S5052		

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S5052	Continued From page 20 care unit was 13.The findings were: 1. Review of the facility manager's continuing education documentation showed he received 6 continuing education credits (CEUs) in 2024. 1.5 of the 6 CEUs were related to dementia care. There was no evidence CEUs were obtained in 2023. 2. Interview with the ED on 5/8/25 at 8:44 AM confirmed no further documentation was available.	S5052		
S5054	Ch 12 Sec 10 (a)(iii) Secure Dementia Units (a) (iii) Level 2 Direct Care Staff. In addition to meeting all other requirements for direct care staff stated in this Chapter, assisted living Level 2 direct care staff must receive additional documented training in: (A) The facility or units philosophy and approaches to providing care and supervision or persons with severe cognitive impairments; (B) The skills necessary to care for, intervene, and direct residents who are unable to independently perform activities of daily living; (C) Techniques for minimizing challenging behaviors; (I) Wandering; (II) Hallucinations, illusions, and delusions; and (III) Impairments of senses;	S5054		

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S5054	Continued From page 21 (D) Therapeutic programming to support the highest level of residents function including: (I) Large motor activity; (II) Small motor activity; (III) Appropriate level cognitive tasks; and (IV) Social/emotional stimulation; (E) Promoting residents dignity, independence, individuality, privacy, and choice; (F) Identifying and alleviating safety risks to residents; (G) Recognizing common side effects and reactions to medications; (H) Techniques for dealing with bowel and bladder aberrant behavior. (I) At least one staff member with this specialized training must be available on the unit at all times to provide supervision and care to the residents, as well as to assist the residents in evacuation of the facility. (J) Staff must have at least twelve (12) hours of continuing education annually related to care of persons with dementia. This State Rule and Regulation is not met as evidenced by: Based on review of personnel records and staff interview, the facility failed to ensure 13 of 18 (CNA #1, CNA #3, CNA #4, CNA #5, CNA #6, CNA #8, CNA #9, CNA #11, CNA #13, LPN #2,	S5054		

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S5054	Continued From page 22 LPN #3, RN #1, RN #2) Level 2 direct care staff received the required 12 hours of continuing education related to care of persons with dementia on an annual basis. The census of the memory care unit was 13. The findings were: 1. Review of the direct care staff continuing education credits for 2024 showed the following concerns: a. CNA #1 completed 9.25 hours of continuing education credit. b. CNA #3 completed 4.5 hours of continuing education credit. c. CNA #4 completed 1.75 hours of continuing education credit. d. CNA #5 completed 4 hours of continuing education credit. e. CNA #6 completed 11.5 hours of continuing education credit. f. CNA #8 completed 3 hours of continuing education credit. g. CNA #9 completed 1.75 hours of continuing education credit. h. CNA #11 completed 3.25 hours of continuing education credit. i. CNA #13 completed 0 hours of continuing education credit. j. LPN #2 completed 6 hours of continuing education credit. k. LPN #3 completed 6 hours of continuing education credit. l. RN #1 completed 10 hours of continuing education credit. m. RN #2 completed 0 hours of continuing education credit. 2. Interview with the wellness program director on 5/8/25 at 9:28 AM confirmed the required continuing education had not been completed.	S5054		

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S5060	Continued From page 23	S5060		
S5060	Ch 4 Sec 5 (j)(e) Licensure (j) (E) The Assisted Living Facility shall post the survey results in a manner conducive for public view. This State Rule and Regulation is not met as evidenced by: 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 57. The findings were: 1. Observation of the facility on 5/7/25 at 1:15 PM showed no evidence the state licensure survey results were available for public view. 2. Interview with the ED on 5/8/25 at 9:15 AM revealed the survey results were kept in a closed cupboard next to the receptionist's desk and were available upon request.	S5060		

DEER TRAIL
ASSISTED LIVING & MEMORY CARE

Response to Survey of
Deer Trail Assisted Living & Memory Care
Conducted May 6-8, 2025 v.2

ID Prefix Tag S5003

1.

a. All residents who were impacted by the deficient glove-changing practice have been assessed for infection due to the improper glove use. No infections have been identified.
b. No other residents have been identified as being affected by the improper glove use.
c. Mandatory training for all staff on proper glove usage and infection control procedures will be completed and documented.
d. The Wellness Manager will observe staff at meals and throughout shifts to monitor compliance with proper glove usage. The Wellness Manager will also solicit feedback from staff and family members about compliance of coworkers. Staff found in non-compliance will be required to complete training again. Sustained non-compliance will be documented and may result in termination. Compliance will be monitored during the quality assurance process conducted quarterly.
e. Compliance will be accomplished by June 30, 2025.

2.

a. CNA #1, CNA #2, LPN #1, and housekeeper #1 will receive a test and/or be screened as appropriate for TB.
b. A full review of current employee files will be conducted to identify any employee whose TB testing was not properly completed and filed. Any staff found to be non-compliant will receive a TB test and/or be screened as appropriate.
c. The Administrative Assistant will verify TB tests are completed upon hire and the Wellness Manager will ensure compliance annually. Both will be educated on the use of the move-in checklist.
d. Compliance will be added to the quality assurance checklist and reviewed at quality assurance meetings held at lease quarterly.
e. All TB testing and/or screening will be complete by June 30, 2025.

ID Prefix Tag S5004

1.

a. Central Registry checks for CNA #1 and LPN #1 are located and filed in their personnel files. A Central Registry check for CNA #2 is complete and now filed in their personnel file. No issues were noted on any of the Central Registry checks. Additionally, a copy of the orientation checklist is complete and in LPN #1's personnel file.

Jean Yenni 6/9/25

DEER TRAIL
ASSISTED LIVING & MEMORY CARE

b. A full review of current employee files will be conducted to identify any employees whose Central Registry checks were not properly completed and filed. Those who are found to be missing a Central Registry check will have a new check submitted and filed in their personnel file once received.
c. A new hire checklist will be completed upon hire which will include completion of and filing of a Central Registry check for each new hire. The move-in checklist will be utilized by the Administrative Assistant to ensure compliance for the Central Registry checks. The Administrative Assistant will be educated on the use of the move-in checklist.
d. This item will be added to the quality assurance checklist. The checklist will be reviewed at the quality assurance meeting held at least quarterly.
e. The review of current employees and the quality assurance checklist will be complete by June 30, 2025.

ID Prefix Tag S5007

1.

a. There is no corrective action that will remedy the previous actions of admitting resident #7 when not having a history and physical within 90 days prior to admission.
b. A review of resident records is complete. No other residents were found to have been admitted without a history and physical within 90 days prior to admission.
c. The new move in checklist will be followed, which includes completing a history and physical within 90 days prior to admission.
d. The new move in checklist will be reviewed by the Wellness Manager and the Executive Director before moving to ensure all tasks are complete prior to move in. Both will be educated on the use of the move-in checklist. Compliance will be monitored by the quality assurance committee.
e. This corrective action will be implemented by to June 30, 2025.

2.

a. There is no corrective action that will remedy the previous actions of admitting resident #8 when not having a history and physical within 90 days prior to admission.
b. A review of resident records is complete. No other residents were found to have been admitted without a history and physical within 90 days prior to admission.
c. The new move in checklist will be followed, which includes completing a history and physical within 90 days prior to admission.
d. The new move in checklist will be reviewed by the Wellness Manager and the Executive Director before moving to ensure all tasks are complete prior to move in. Both will be educated on the use of the move-in checklist. Compliance will be monitored by the quality assurance committee.
e. This corrective action will be implemented by to June 30, 2025.

3.

a. Resident #9 will have a tuberculosis screening test performed.
b. A review of resident records will be completed to determine any other residents who were admitted without completion of a tuberculosis screening. If other residents are discovered, they will also have a tuberculosis screening test performed.

Jean Yanni
6/4/25

DEER TRAIL
ASSISTED LIVING & MEMORY CARE

c. The new move in checklist will be followed, which includes completing a tuberculosis screening of all new residents.
d. The new move in checklist will be reviewed by the Wellness Manager and the Executive Director to ensure all tasks are complete. Both will be educated on the use of the move-in checklist. Compliance will be monitored by the quality assurance committee.
e. This corrective action will be implemented by to June 30, 2025.

4.

a. Resident #10 will have a tuberculosis screening test performed.
b. A review of resident records will be completed to determine any other residents who were admitted without completion of a tuberculosis screening. If other residents are discovered, they will also have a tuberculosis screening test performed.
c. The new move in checklist will be followed, which includes completing a tuberculosis screening of all new residents.
d. The new move in checklist will be reviewed by the Wellness Manager and the Executive Director to ensure all tasks are complete. Both will be educated on the use of the move-in checklist. Compliance will be monitored by the quality assurance committee.
e. This corrective action will be implemented by to June 30, 2025.

5.

a. Resident #11 will have a tuberculosis screening test performed. Additionally, resident #11 will have influenza and pneumococcal immunization status identified and immunizations administered if indicated.
b. A review of resident records will be completed to determine any other residents who were admitted without completion of a tuberculosis screening or influenza and pneumococcal immunizations. If other residents are discovered, they will also have a tuberculosis screening test performed and influenza and pneumococcal immunizations administered if indicated.
c. The new move in checklist will be followed, which includes completing a tuberculosis screening of all new residents and verification of influenza and pneumococcal immunizations status.
d. The new move in checklist will be reviewed by the Wellness Manager and the Executive Director to ensure all tasks are complete. Both will be educated on the use of the move-in checklist. Compliance will be monitored by the quality assurance committee.
e. This corrective action will be implemented by to June 30, 2025.

6.

a. Tuberculosis screening tests will be performed when a resident moves in. The screenings will be completed individually, and we will not wait to do several new residents together.

7.

a. An influenza and pneumococcal immunizations and tuberculosis screening policy and procedure are already part of our policy and procedures. They are found in Policy 9, (12) Level 1 Admission and Discharge Criteria page 2, "ALL

Jean Jennie 6/9/25

DEER TRAIL
ASSISTED LIVING & MEMORY CARE

resident admission orders shall include an order for TB screening, COVID-19, influenza, and pneumococcal immunization status and resulting orders for immunization if required, unless contraindicated." This policy will be better/fully implemented from June 1, 2025, and monitored by the quality assurance committee.

8.

a. Residents who decline immunizations will be documented as being offered the immunization but declining the opportunity and the reason they decline.
b. This corrective action will be implemented by June 30, 2025, and monitored by the quality assurance committee.

ID Prefix Tag 5025

1.

a. Deer Trail will contract with a registered dietitian to provide regular evaluations and consultations on special diets.
b. All residents who have orders for a therapeutic or mechanically modified diet have been identified.
c. Deer Trail will contract with a registered dietitian to provide support to residents who need therapeutic or mechanically modified diets.
d. The Dietary Director will ensure contracting with a registered dietitian allowing us to continue offering therapeutic or mechanically modified diets for residents.
e. This corrective action will be implemented by June 30, 2025, and will be monitored by the quality assurance committee.

2.

a. Deer Trail will contract with a registered dietitian to provide regular evaluations and consultations for residents with special diets.
b. All residents who have orders for a therapeutic or mechanically modified diet have been identified.
c. Deer Trail will contract with a registered dietitian to allow admitting residents who need therapeutic or mechanically modified diets.
d. The Dietary Director will ensure implementation of a registered dietitian for residents who need therapeutic or mechanically modified diets.
e. This corrective action will be implemented by June 30, 2025, and will be monitored by the quality assurance committee.

3.

a. Deer Trail will contract with a registered dietitian to provide regular evaluations and consultations for residents with special diets.
b. All residents who have orders for a therapeutic or mechanically modified diet have been identified.
c. Deer Trail will contract with a registered dietitian to allow admission of residents who need therapeutic or mechanically modified diets.
d. The Dietary Director will ensure implementation of contracting with a registered dietitian to allow therapeutic or mechanically modified diets for residents.
e. This corrective action will be implemented by June 30, 2025, and will be monitored by the quality assurance committee.

Jean Hennie
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4.

a. Deer Trail will contract with a registered dietitian to provide regular evaluations and consultations for residents in need of special diets.
b. All residents who have orders for a therapeutic or mechanically modified diet have been identified.
c. Deer Trail will contract with a registered dietitian to allow admission of residents who need therapeutic or mechanically modified diets.
d. The Dietary Director will ensure implementation of contracting with a registered dietitian to offering therapeutic or mechanically modified diets for residents.
e. This corrective action will be implemented by June 30, 2025, and will be monitored by the quality assurance committee.

5.

a. Deer Trail will contract with a registered dietitian to provide regular evaluations and consultations for residents in need of special diets.
b. All residents who have orders for a therapeutic or mechanically modified diet have been identified.
c. Deer Trail will contract with a registered dietitian allowing admission of residents who need therapeutic or mechanically modified diets.
d. The Dietary Director will ensure implementation of contracting with a registered dietitian or discontinue offering therapeutic or mechanically modified diets for residents.
e. This corrective action will be implemented by June 30, 2025, and will be monitored by the quality assurance committee.

ID Prefix Tag 5026

1.

a. Temperature logs have been made and are being used for the cold table, walk-in fridge and freezer, side-by-side fridge and freezer, the memory care fridge and freezer, and the Bistro fridge and freezer. The Jackson dishwasher is also added to the log to monitor the rinse and wash cycle temperatures. Food temperatures following food preparation and the holding temperature on the steam table will also be documented.
b. All residents have been affected by this deficiency. The implementation of temperature logs will alleviate the issue.
c. The Dietary Director will monitor the temperature logs to ensure staff are completing them.
d. The completion temperature logs will be added to the quality checklist to be reviewed at quality assurance meetings held at least quarterly.
e. This corrective action is already implemented.

Date of Correction is 6/9/25 per Jeff Smith via telephone on 6/9/25 at 4 PM. JY

ID Prefix Tag 5041

1.

a. The quality assurance committee will monitor corrective action that is identified by the committee during meetings.

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b. All residents were affected by the lack of follow up regarding temperature logs in the dietary department. The quality assurance committee will monitor corrective action that is identified by the committee during meetings.
c. Follow up on needed corrective actions will not wait until the next meeting but will be addressed by the committee depending upon their severity, as well as at regular meetings.
d. Follow up on corrective actions will be identified and a timeframe for correction will be determined by the severity of the action needed. That determination and the completion of the corrective action will be monitored by the quality assurance committee. The quality assurance committee will be educated on this process.
e. A quality assurance committee meeting and follow up on corrective actions will be completed by June 10, 2025.

ID Prefix Tag 5046

1.

a. Training for resident #7, resident #8, resident #9, resident #10, and resident #11 the community fire emergency plan is complete.
b. A review of records identified all residents who had not received the community fire emergency plan training, including the location of all the exits. Those residents have received the training, and it is documented.
c. Training residents on the community fire emergency plan, including the location of all the exits, will be included on the new move in checklist.
d. The Safety Committee will review the documented training at their monthly meetings to ensure training is complete when residents move in. The quality assurance committee will review the completion of this training at its meetings held at least quarterly.
e. A safety committee meeting will be held May 30, 2025, with this training on its agenda. The new move in checklist will be completed and implemented by June 30, 2025.

ID Prefix Tag 5048

1.

a. An outside service contract is now developed by the administrative assistant who was educated on the process.
b. A review to identify all residents receiving outside services is complete.
c. The administrative assistant will acquire updated contracts and new contracts from providers as needed and ensure they are filed.
d. The quality assurance committee will review what residents are receiving outside services and ensure a contract is in place between that provider and the community.
e. Outside services contracts will be completed with providers by June 30, 2025, and new contracts completed as needed.

ID Prefix Tag 5052

1.

a. The manager's continuing education for 2023 cannot be procured.

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b. The manager's continuing education for 2024 is now in the manager's employee file.
c. That continuing education includes eight (8) hours of continuing education pertaining to the care of persons with severe cognitive impairments.
d. Fourteen (14) hours of continuing education are completed by the manager so far for 2025.
e. Sixteen (16) hours, including eight (8) hours of continuing education pertaining to the care of persons with severe cognitive impairments will be completed and documented in 2025 and annually thereafter. The quality assurance committee will review the completion of this training at it's meetings held at least quarterly.

The date of correction is 6/2/25 per Jeff Smith via telephone on 6/9/25 at 4 PM JY

ID Prefix Tag 5054

1.

a. To immediately address the deficiency, all wellness department staff will undergo focused dementia care training. The training will include evidence-based approaches for managing dementia-related behaviors, communication techniques, and person-centered care strategies. Any affected resident who experienced a decline due to improper dementia care will receive an assessment and modifications to their care plan to ensure their needs are met.
b. Memory Care residents will be reviewed to identify any who may have been impacted by gaps in dementia care knowledge among our staff. Any identified residents will be reassessed and their care plans adjusted as indicated.
c. To ensure this deficiency does not occur again we will conduct mandatory annual dementia training with all wellness staff, onboarding dementia education for newly hired nursing staff, routine competency evaluations where verbal feedback is given to ensure proper dementia care techniques are consistently applied, and dementia care competency checks will be incorporated into our quality assurance program which will be reviewed at each quality assurance meeting.
d. Staff training focused on dementia care will be incorporated into our quality assurance checklist for the Wellness Department. The checklist will ensure staff training is current while observations from the entire quality assurance team will be discussed.
e. Training for staff will be up to date by June 30, 2025. A quality assurance meeting will be held by June 10, 2025, where observations of proper training and techniques will be discussed.

ID Prefix Tag5060

1.

a. The state licensure survey results are housed in a bright green binder labeled "State Surveys" on the exterior spine.
b. This binder is now kept in the common area Game Room on a shelf in plain view and accessible to the public for their perusal. All managers are educated on the requirement that the binder must be placed in a public area.

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c. The State Surveys binder will be continually updated as state surveys are completed. The quality assurance committee will ensure the state survey binder remains in a public location.

The date of correction is 6/2/25 per Jeff Smith via telephone on 6/9/25 at 4 PM JY

Respectfully submitted,

Jeffrey Smith
Executive Director
Deer Trail Assisted Living

Jean Yennie 6/9/25