Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF007	A. BUILDING: _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POINTE FRONTIER RETIREMENT COMMUNITY	1406 PRAIRIE AVENUE CHEYENNE, WY 82009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020. Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001. A licensure survey was conducted by Healthcare Licensing and Surveys from 5/27/25 to 5/28/25. Also reviewed in the course of the survey were complaint intakes LIC-23-043, LIC-24-019, LIC-24-035, and LIC-24-039. The following common abbreviations are used throughout this document: BOD: Business Office Director CNA: Certified Nursing Assistant DSD: Dining Service Director ED: Executive Director LPN: Licensed Practical Nurse RCD: Resident Care Director Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5002	Ch 12 Sec 6 (c) Personnel and Staffing Requirements (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. This State Rule and Regulation is not met as	S5002		

this plan of correction was accepted with the agreed upon changes. The revised plan of correction was received on 6/20/23. The date of correction is 7/27/25.
Jean Yennie 6/23/25

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S5002	Continued From page 1 evidenced by: Based on review of personnel records, staff interview, and policy and procedure review, the facility failed to ensure the required background checks were completed prior to direct resident contact for 2 of 5 sample employees(server #1, CNA #1) reviewed. The findings were: 1. Review of the personnel file for server #1 showed she was hired on 12/7/23. There was no evidence a Department of Family Services (DFS) Central Registry Screening had been completed. 2. Review of the personnel file for CNA #1 showed she was hired on 1/30/23. There was no evidence a DFS Central Registry Screening had been completed. 3. Interview with the BOD on 5/28/25 at 12:55 PM confirmed the DFS Central Registry Screening had not been completed as required. 4. Review of the "Hiring/Post-Offer Process" policy and procedure showed " ...All candidates who are made a conditional offer of employment are subject to successfully passing the following steps. Failure to pass any step will result in a withdrawal of the conditional offer of employment ...6. Fingerprinting/State Background check ..."	S5002	Action Step: Background Checks and DFS Verification for New Hires 1. Conduct comprehensive background checks and Department of Family Services (DFS) screenings on all newly hired employees prior to their start date. 2.The DFS Central Registry Screening will be completed for server #1 and CNA #2 3.Maintain records of all completed checks in accordance with QMPI documentation standards and confidentiality protocols. 4.Full Employee chart Audit for DFS check 5. BOD provided education on required background checks on all employees 6.30 Days of weekly monitoring QMPI, monthly monitoring for the next 90 days Target Date 7/27/25 and ongoing Individual Responsible: ED RCD and appointe designee	
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:	S5003		

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S5003	Continued From page 2 (i) Ensure a safe and sanitary environment for residents and personnel; (ii) Require tuberculin testing, or screening as appropriate; and (iii) Prohibit any person with an airborne, contagious, or infectious disease from being employed until a work release is obtained. (A) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents and their food, if direct contact will transmit a disease. (B) The facility shall require staff to follow universal precautions when performing direct resident care. This State Rule and Regulation is not met as evidenced by: Based on personnel file review, policy and procedure review, and staff interview, the facility failed to ensure 4 of 5 sample employees (server #1, DSD, LPN #1, CNA #2) reviewed were tested for tuberculosis (TB) upon hire as required, and 2 out of 5 sample employees (server #1, CNA #1) reviewed were tested or screened annually. The findings were: 1. Review of the personnel file for server #1 showed she was hired on 12/7/23. Further review showed the server completed step one of the two-step tuberculin testing process with a negative result on 12/9/23 and was administered step two on 9/9/24; however, there were no results recorded for the second test. There was no further documentation of TB testing available.	S5003	Action Steps: Chart Audits and TB Testing Compliance 1. Chart Audits 1. The RCD and/or ED or designee conducted a comprehensive audit of all employee and resident charts to ensure documentation accuracy and regulatory compliance. 2. Identified discrepancies or missing documentation will be addressed promptly, with corrective actions documented and tracked. 2. Tuberculosis (TB) Testing Compliance a. A TB clinic is scheduled throughout the month of June, with a designated clinic day on June 27th for employees requiring: i. Annual TB testing ii. First or second step TB tests (as applicable) b. The RCD/ED will ensure all required staff are notified and scheduled for testing. c. Documentation of TB test results will be reviewed and filed in employee health records to maintain compliance with state health regulations and QMP1 standards. 3. Education provided to RCD and BOD on TB requirements 4. New associates who have been made a conditional offer of employment will receive the 1st step TB test prior to orientation and 2nd step TB test 2 weeks later. 5. RCD and BOD will track TB testing and due dates 5. 30 Days of weekly monitoring QMP1, monthly monitoring for the next 90 Date of Correction: 7/27/2025 and on going Indivdual Responsible: ED RCD, BOD and appointed designee	

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S5003	Continued From page 3	S5003		

2. Review of the personnel file for the DSD showed he was hired on 4/23/24. The DSD completed step one of the two-step tuberculin testing process with a negative result on 4/19/23. There was no evidence step two had been administered.

3. Review of the personnel file for LPN #1 showed she was hired on 2/26/25. LPN #1 completed step one of the two-step tuberculin testing process on 2/19/25. There was no evidence step two had been administered.

4. Review of the personnel file for CNA #2 showed she was hired on 3/22/25. There was no evidence she had been tested for TB prior to resident contact.

5. Review of the personnel file for CNA #1 showed she was hired on 1/30/23 and had provided the facility with proof of TB testing dated 7/13/22. There was no evidence the CNA had received an annual test and/or was screened as appropriate for TB in 2024.

4. Interview with the BOD on 5/28/25 at 12:58 PM confirmed the TB testing had not been completed as required.

5. Review of the "Tuberculosis (TB) Screening for Associates" policy showed " ...All associates are screened for Tuberculosis (TB) at (sic) upon hire, annually and when exposed to infected individuals ...1. New associates who have been made a conditional offer of employment will be screened for the presence of infection with M. Tuberculosis using the Mantoux PPD skin test. Skin testing will employ the two-step procedure. (If reaction to the first test is less than 10 mm in duration, a second test will be given 1-3 weeks

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S5003	Continued From page 4 later) ...Annual Associate Screening Unless state guidelines specify otherwise, associates with a negative skin test history will have, at a minimum, an annual PPD skin test and depending on test results, will be followed as above ..."	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, 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;	S5004	Action Steps: Employee Orientation and Documentation Compliance 1. Chart Audit for Orientation Completion 1. The Executive Director (ED) or designee conducted a full audit of all employee files to verify completion of orientation and ensure all required documentation is properly filed. 2. Any missing or incomplete paperwork was identified and flagged for immediate follow-up. 2. Corrective Orientation Session 1. A make-up orientation session is scheduled for June 10, 2025, in collaboration with HR, to address any outstanding documentation or training requirements. 2. All employees with incomplete orientation files are required to attend to ensure full compliance. 3. Ongoing Orientation Process a. The ED and HR have implemented a standing procedure to schedule and conduct orientation for all new hires moving forward. b. Orientation completion and documentation will be verified and filed before the employee begins active duty, supporting ongoing compliance with QMPI and regulatory standards. 4. Education provided to BOD on orientation protocol to ensure state compliance 5. 30 Days of weekly monitoring QMPI, monthly monitoring for the next 90 days Date of Correction: 7/27/2025 and on going Indivdual Responsible: ED RCD, BOD and appointed designe	

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S5004	Continued From page 5	S5004		

(I) I-9, (Employment Eligibility Verification);

(J) W-4, (Employee's Withholding Allowance Certificate);

(K) Licensure, Certification, or Credentials; (e.g., RN, LPN, CNA, etc.);

(L) Documentation of all completed background and Central Registry background check with no offenses.

This State Rule and Regulation is not met as evidenced by:
Based on review of personnel files and staff interview, the facility failed to ensure personnel records contained all of the required documentation for 1 of 5 sample employees (CNA #1) reviewed. The findings were:

1. Review of the personnel file for CNA #1 showed the facility failed to include a signed copy of the orientation checklist which included education regarding resident rights, evacuation, and emergency procedures.

2. Interview with the BOD on 5/28/25 at 12:58 PM revealed she was unable to locate the orientation checklist for CNA #1.

S5006 Ch 12 Sec 7 (b)(I) Assisted Living Facility (ALF) Core Services — S5006

(b) Resident Assessment and Services, The staff/contract Registered Nurse (RN) shall conduct initial and, at the minimum annually, and accurate, standardized, reproducible assessment

Action Steps: 5006:

1. Resident file audit to ensure all residents have 102
2. Inservice education provided tCD on the policy and procedure for 102
3. 30 Days of weekly monitoring QMPI, monthly monitoring for the next 90 days
Date of Correction: 7/27/2025 and on going
Indivdual Responsible: ED RCD,and appointed designee

ALF 102 for resident #2 and resident #3 were updated to reflect the correct information.

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of each resident's functional capacity, physical assessment and medication review.

(I) The completion of the ALF 102.

(A) The current version of the ALF 102 is the designated screening tool. The form may be updated and /or revised periodically by the Program Division. Providers will be notified of changes in the form. The following guidelines apply to the ALF 102:

(I) The ALF 102 is only valid if completed within forty-five (45) days prior to admission and there is no change in the resident's condition.

(II) The ALF 102 must be completed and signed by an RN.

(III) The ALF 102 may be completed telephonically; however, it must be verified in person by an RN.

(IV) A new ALF 102 shall be completed at least annually, and when there is a change in the resident's condition.

This State Rule and Regulation is not met as evidenced by:
Based on review of resident records and staff interview, the facility failed to ensure the assessment of the resident's functional capacity, physical assessment, and medication review (ALF 102) was completed accurately for 2 of 6 sample residents (#2, #3) reviewed. The findings were:

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S5006	Continued From page 7 1. Review of the record for resident #2 showed a physician order for 1-to-2 liters of oxygen per nasal cannula, as needed, for shortness of breath with a start date of 3/20/25. In addition, the resident's record showed documentation the resident had received hospice services since 3/19/25. Review the ALF 102, dated 4/24/25, showed the "Services beyond Assisted Living authority" section was left blank. 2. Review of the record for resident #3 showed the resident was admitted to the facility on 2/26/25 with hospice services. Review of the ALF 102, dated 3/10/25, showed the "Services beyond Assisted Living authority" section was not included. In addition, section 8 (continence), section 9 (mobility), section 10 (behavior/motivation), and section 12 (medical care requirements) were left blank. 3. Interview with the RCD on 5/28/25 at 3:33 PM confirmed the ALF 102 forms for resident #2 and resident #3 were incorrect.	S5006		
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	S5007		

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S5007	Continued From page 8	S5007		

contraindicated. The facility must develop and implement policies and procedures to ensure the 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 on resident record review, staff interview, and policy and procedure review, the facility failed to implement their influenza and pneumococcal immunization policy and their Assisted Living Residency Agreement related to tuberculosis testing for 3 of 6 residents (#2, #3, #6) sample residents reviewed. The findings were:

1. Review of the "Influenza (Flu) Vaccine, Pneumococcal Vaccine and Flu Outbreak Management" policy and procedure showed "Procedure-Influenza Vaccine 1. Starting in October (unless another month is recommended by the Department of Public Health) and extending to March 31 (or check with local Health Department), residents are offered the influenza vaccine. Education is provided to the resident and/or representative regarding benefits and side effects or risks ...6. Education, assessment findings, administration, and monitoring are documented in the resident's medical record

Action Steps: 25007: New Resident Admission Compliance –
Vaccinations, Health Screening, and Documentation
1. Resident Admission Packet Distribution
A.The Resident Care Director (RCD) or designee will provide all new Assisted Living (AL) residents with the following upon admission:
I. Vaccine information and consent/declination forms
II.CPR status documentation
III. Tuberculosis (TB) testing forms
IV. Personal belongings inventory checklist
2.Vaccination Administration
A. Vaccines will be reviewed, in accordance with facility policy and state health regulations.
B. All vaccine-related documentation will be filed in the resident's medical record to ensure compliance.
3.TB Testing Requirement
A. TB testing is mandatory prior to move-in. If a resident refuses a TB skin test, a chest X-ray will be required and documented before admission is approved.
B. The RCD will ensure all TB-related documentation is complete and compliant with regulatory standards.
4.Education provided to RCD on refusal of TB testing by resident will result in x-ray or blood test to verify no active TB.
5.30 Days of weekly monitoring QMP1, monthly monitoring for the next 90 days

Date of Correction: 7/27/2025 and on going
Individual Responsible: ED RCD,and appointed designee

Tuberculin testing/screening will completed for resident #2, #3, and #6 by 6/18/25

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...Procedure-Pneumococcal Vaccine 1. On admission to the community, both PCV13 and PPSV23 should be routinely administered in series to all adults 65 years or older. The two pneumococcal vaccines are not administered at the same time ...On admission to the community, the pneumococcal vaccine is offered if the resident has not received it or if his/her prior vaccination status is unknown. Residents 65 years of age or older who have not received the vaccine within 5 years (and were less than 65 years of age at the time of vaccination) should receive another dose of vaccine ...Education, assessment findings, administration, and monitoring are documented in the resident's medical record ..." Review of the "Assisted Living Residency Agreement" showed " ...B. MOVE-IN ASSESSMENT. Prior to move-in, the general physical and mental state of each Resident will be evaluated and documented in Resident's file ...The physician shall document a Move-In Assessment, which much include documentation of a physical examination that includes screening for tuberculosis, and specifies that Resident is free from tuberculosis or other communicable diseases that can be transmitted to other residents or staff ..." The following concerns were identified:

a. Review of the record for resident #2 showed s/he was admitted to the facility on 10/15/24. Review of the resident's immunization record showed the resident had received a pneumococcal vaccine (type was not specified) on 9/5/20. There was no evidence the resident's immunization status had been assessed or an influenza vaccine had been offered.

b. Review of the record for resident #3 showed s/he was admitted to the facility on 2/18/25. Review of the resident's immunization record showed consent for the influenza vaccine

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S5007	Continued From page 10 was signed on 2/19/25. In addition, the resident's record showed information regarding the pneumococcal vaccination was signed on 2/19/25; however, neither the consent or the declination box was checked. There was no evidence the resident received either vaccination. c. Review of the record for resident #6 showed s/he was admitted on 1/22/25. Review of the resident's immunization record showed no documentation the resident had been offered the vaccines. In addition, the resident's record showed s/he had refused the tuberculin skin test. There was no evidence an alternative method to screen the resident for tuberculosis was implemented. 2. Interview with the RCD on 5/28/25 at 3:43 PM confirmed no further documentation was available.	S5007		
S5020	Ch 12 Sec 7 (e) Assisted Living Facility (ALF) Core Services (e) Resident Records and Reports. Each resident's records shall be current, organized and maintained in individual folders which shall be made available to the resident, the Licensing Division, or designated representative upon request. (i) Each folder shall include the following: (A) Information from the referring agent, if applicable; (B) History and physical performed by a physician or physician extender; (C) Individual admission form. This form	S5020	Action Step: S5020 Resident Inventory Documentation A. Upon admission, the Resident Care Director (RCD) will provide each new resident with a personal belongings inventory list to ensure completion. B. The inventory will be completed in collaboration with the resident, family members, and/or nursing staff to ensure accuracy. C. Once completed, the inventory list will be filed in the resident's chart as part of their admission documentation, supporting compliance with regulatory and facility standards. D. RCD provided education on importance of inventory list for all new residents E. 30 Days of weekly monitoring QMPI, monthly monitoring for the next 90 days Date of Correction: 7/27/2025 and on going Individual Responsible: ED RCD,and appointed designee An inventory of resident personal belongings will be completed for resident #1, #3, #4, #5, and #6. An audit of all resident records will be completed and an inventory list will be completed if required.	

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shall, at a minimum, contain the following information:

(I) Full name of resident and former address;

(II) Date of admission;

(III) Sex, race, date of birth, social security number, and former occupation;

(IV) Name, home address, and telephone number of relative, friend, Power of Attorney, or guardian;

(V) Name, address, and telephone number of resident's personal physician, dentist, ophthalmologist or optometrist;

(VI) Medicare number or other medical insurance identifying data;

(VII) A written inventory of all personal possessions; however, this inventory need not include personal clothing;

(D) All accidents, injuries, incidents, illnesses, and allegations of abuse, neglect or exploitation shall be reported to the resident's family or responsible party and be documented in the individual resident records. All such occurrences shall also be reported to the appropriate entity for follow up and resolution. Reports of all incidents affecting the health, welfare of safety of a resident shall be provided to the Licensing Division immediately (within one business day). Reporting shall be done by telephone or fax. The facility's investigation of the incident shall be reported to the Licensing

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	ALF007	A. BUILDING: _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POINTE FRONTIER RETIREMENT COMMUNITY	1406 PRAIRIE AVENUE CHEYENNE, WY 82009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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Division and the Long Term Care Ombudsman within five (5) working days. Documentation to support the facility reporting the situation and follow up must also be present in the resident records;

(E) An accounting of all personal funds deposited with and disbursed by the facility;

(I) Upon written authorization of a client, the facility must hold, safeguard, manage and account for the personal funds of the client.

(1.) The facility must deposit any personal funds in the excess of $100 in an interest bearing account.

(2.) The facility must establish and maintain a system that assures a full and complete and separate accounting according to generally accepted accounting principles of each resident's personal funds entrusted to the facility.

(3.) Upon the death of a resident with personal funds deposited with the facility, the facility must convey, within 30 days, the resident's funds a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(4.) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid of Medicare except for applicable deductible and coinsurance amounts.

(F) A signed copy of the resident's rights;

(G) The resident's assessment and

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	ALF007	A. BUILDING: _____ B. WING _____	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POINTE FRONTIER RETIREMENT COMMUNITY	1406 PRAIRIE AVENUE CHEYENNE, WY 82009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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individualized assistance plan;

(H) Copies of al applicable resident assistance contracts, signed by both parties;

(I) Written acknowledgment of the receipt and explanation of all facility policies including admission/discharge policies;

(J) Copy of all ALF 102's; and

(K) Copy of outside contractual responsibilities, if applicable.

(ii) The resident shall be assured of confidential treatment of all information in the record, and the resident's written consent (or the consent of the guardian) shall be required for the release of information to persons not otherwise authorized for receive it.

(iii) All residents' records shall be retained in a physically secure area for a minimum of six (6) years after the resident has left the facility and may be disposed of, by shredding or burning, after that time.

(iv) In the event of dissolution of the facility, the manager shall notify the Licensing Division as to the location of all residents' records.

(v) All records shall be protected from damage by fire, water and other hazards.

(vi) All entries in each resident's record shall be made in ink, signed and dated.

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	ALF007	A. BUILDING: _____ B. WING _____	06/28/2025

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S5020	Continued From page 14 This State Rule and Regulation is not met as evidenced by: Based on review of resident records and staff interview, the facility failed to ensure the residents' record included a written inventory of the residents' personal possessions with the exception of personal clothing for 5 of 6 sample residents (#1, #3, #4, #5, #6) reviewed. The findings were: 1. Review of the resident record for resident #1, #3, #4, #5, and #6 showed no evidence a written inventory of the residents' belongings had been obtained. 2. Interview with the RCD on 5/28/25 at 3:47 PM confirmed no further documentation was available.	S5020		
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;	S5041	Action Steps for S5041: 1. Self-Assessment performed from 6.2.2025-6.11.2025 auditing all employee/resident charts to ensure compliance with state regulations. 2. Survey readiness binder updated with current requirements/regulations 3. Annual self-assessments surveys will be performed in compliance with regulations 4. Inservice provided to ED to ensure understanding/ compliance with state requirments Date of Correction: 6/11/2025 and will be performed again in June 2026 Indivdual Responsible: ED RCD,and appointed designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF007	A. BUILDING _____ B. WING _____	05/28/2025

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(II) Problem areas identified;

(III) Monitor identification;

(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 complete a self-assessment survey of compliance with the regulations on an annual basis. The census was 44. The findings were:

1. Review of the facility's documentation showed no evidence a self-assessment survey of compliance with the regulations had been completed.

2. Interview with the ED on 5/28/25 at 3:23 PM revealed the quality assurance committee met on a monthly basis and discussed various topics and

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	ALF007	A. BUILDING: _____ B. WING _____	05/28/2025

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S5041	Continued From page 16 developed a performance improvement plan if needed; however, the ED was unable to locate documentation a self-assessment survey of compliance with the state rules had been completed.	S5041		
S5042	Ch 12 Sec 7 (m) Assisted Living Facility (ALF) Core Services (m) Facility Policies and Procedures (i) Management shall develop policies and procedures that are available to residents and staff, including but not limited to: (A) Resident rights; (B) Disciplinary procedures surrounding substantiated cases of resident abuse; (C) Admission, transfer, bed hold days, and discharge of residents; (D) Medication management; (E) Emergency care of residents (including missing resident, blizzard, water outage, etc.); (F) Fire/disaster plan; (G) Departure and return; (H) Smoking; (I) Visiting hours; (J) Activities;	S5042	Action Steps for S5042: 1.Requested ~~contracts through cooperate~~ policy and procedure the corporate office regarding required agreements: contracts required to be signed by deadline: Email sent 5/29/25 2.Education performed with RCD on contracts required with 3rd party vendors 3. New resident orientation performed monthly: PP attached 3.30 Days of weekly monitoring QMP1, monthly monitoring for the next 90 days Target Date: ~~8/1/2025~~ 7/27/25 and ongoing Indivdual Responsible: ED RCD,and appointed designee agreed upon changes with the ED on 6/23/25 sy ~~Attached Compliance proces~~	

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(K) Management of resident trust accounts;

(L) Personnel policies;

(M) Grievance procedure;

(N) Per Diem rate/charges/fees, to include a listing of what is included in the established charges;

(O) Incident reports;

(P) Notification of change in established per diem rate/charges/fees;

(Q) Outside contractual responsibilities; and

(R) Identification and notification of change in resident's condition.

This State Rule and Regulation is not met as evidenced by:
Based on review of policies and procedures and staff interview, the facility failed to develop 1 of 18 required policies and procedures. The findings were:

1. Review of the facility's policy and procedures failed to include a policy for contractual care services provided by third party entities.

2. Interview with the ED on 5/28/25 at 3:23 PM revealed the policy could not be located.

S5046	Ch 12 Sec 7 (o)(iii) Assisted Living Facility (ALF) Core Services	S5046		

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S5046	Continued From page 18 (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. (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)	S5046	Action Steps for S5046: 1. Full chart audit performed on all residents to ensure required documents are reviewed with all residents 2. 30 Days of weekly monitoring QMP1, monthly monitoring for the next 90 days 3. Inservice education provided to nursing staff on required documentation needed to be reviewed with all new moves on DAY ONE. Date of Correction: 7/27/2025 and on going Indivdual Responsible: ED RCD,and appointed designee Resident #1, #3, #4, #5, and #6 were educated on the fire emergency plan. Resident #2 expired.	

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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 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:

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Based on review of resident records and staff interview, the facility failed to instruct 6 of 6 sample residents (#1, #2, #3, #4, #5, #6) reviewed on the fire emergency plan on the first day of occupancy. The findings were:

1. Review of the resident record for resident #1 showed s/he was admitted to the facility on 1/18/23. 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.

2. Review of the resident record for resident #2 showed s/he was admitted to the facility on 10/15/24. 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.

3. Review of the resident record for resident #3 showed s/he was admitted to the facility on 2/18/25. 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 #4 showed s/he was admitted to the facility on 5/12/25. 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.

5. Review of the resident record for resident #5 showed s/he was admitted to the facility on 10/25/24. 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.

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6. Review of the resident record for resident #6 showed s/he was admitted to the facility on 1/22/25. 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.

7. Interview with the ED on 5/28/25 at 3:50 PM revealed upon lease signing residents were asked to read the General Disaster Policy; however, the facility did not provide education to the residents on the first day of occupancy on the proper action of the fire emergency plan and the location of all the exits.

S5048 Ch 12 Sec 9 (a)(i) Contractual Svcs Provided Outside ALF Auth — S5048

(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;

Action Steps S5048:
1.Requested contracts through cooperate office regarding required contracts
2.Education performed with RCD on contracts requiredwith 3rd party vendors
3.Outside care service contracts were obtained for resident #1 and resident #3. Resident #2 expired.
3.30 Days of weekly monitoring QMPI, monthly monitoring for the next 90 days
4.Audit of all resident records who is receiving outside services by RCD

]Date of Correction: 7/27/2025 and on going
Indivdual Responsible: ED RCD,and appointed designee

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(E) How the service(s) will be provided; and

This State Rule and Regulation is not met as evidenced by:
Based on review of resident records and staff interview, the facility failed to ensure a service contract was developed which included all required components for 3 of 3 sample residents (#1, #2, #3) reviewed who received services from an outside entity. The findings were:

1. Review of resident records showed resident #1 received physical therapy services; resident #2 received hospice and oxygen services; and resident #3 received 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. Interview with the ED on 5/28/25 at 3:23 PM confirmed no further documentation was available.