Buffalo

Survey Date: February 21, 2024

Corporate office Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by Willow Creek Community, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. The POC shall only be a required effort to respond to the unsubstantiated and subjectively biased allegations alleged in the survey document. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by Willow Creek Community of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Willow Buffalo 2/21/24

Deficiency: Manager Qualifications (S5000)

- Regulatory Requirement: The facility manager must pass an open book test on Assisted Living Facility Licensure and Program Rules with a score of 85% or higher.
- Plan of Correction:
    - Corrective Action: The facility manager will retake the Assisted Living Manager Test, ensuring the test is submitted to the state survey agency for grading. The manager will achieve a passing score of 85% or greater.
    - Monitoring: Upon completion, the manager's test results will be documented and kept in the personnel file, with the submission and receipt of results confirmed with the state licensing authority.
    - Completion Date: Within 10 days of receiving the statement of deficiencies.

Deficiency: Background Checks (S5002) (S5004)

- Regulatory Requirement: All staff must successfully complete a State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check and Department of Family Services (DFS) Central Registry screening before direct resident contact.
- Plan of Correction:
    - Corrective Action: Background checks and DFS Central Registry screenings will be completed immediately for all staff who did not undergo these checks before resident contact.
    - Preventative Action: The facility will revise its onboarding process to ensure no staff member has resident contact before the completion of required background checks and screenings.

10/23/24- 1:30 pm- Spoke with owner, Eric McMillan, POC Accepted & agreed upon changes. Alleged date of compliance is 10/30/24.

- Monitoring: Human Resources will maintain an audit system to ensure compliance with background check requirements for new hires. Monthly reviews will be conducted to verify compliance.
- Completion Date: All required screenings and checks will be completed within 30 days.

Deficiency: Maintenance and Environmental Safety (S5005)

- Regulatory Requirement: The facility must maintain a safe and clean environment for residents, including repairs to damaged linoleum.
- Plan of Correction:
  - Corrective Action: The damaged linoleum in the kitchen area will be repaired or replaced immediately to prevent trip hazards and ensure a clean, safe environment.
  - Preventative Action: A routine maintenance inspection schedule will be implemented to identify and address facility repair needs proactively.
  - Monitoring: Weekly maintenance checks will be conducted by the facility's maintenance staff, and a report will be submitted to the Director of Nursing (DON) or designee to ensure ongoing compliance with safety standards.
  - Completion Date: Repairs will be completed within 14 days.

Deficiency: Medication Assistance (S5018)

- Regulatory Requirement: An RN must assess each resident's ability to self-administer medication. This assessment was not completed for several residents.
- Plan of Correction:
  - Corrective Action: The RN will conduct medication self-administration assessments for all residents to determine their ability to safely self-administer medications.
  - Preventative Action: A protocol will be established to ensure that all new residents receive an RN assessment for medication self-administration upon admission. The protocol will also ensure regular re-assessments every two months or upon changes in the resident's condition.
  - Monitoring: The DON or designee will audit resident files monthly to verify that assessments are up to date and properly documented.
  - Completion Date: All resident assessments will be completed within 30 days.

Deficiency: Medication Storage (S5019)

- Regulatory Requirement: Medications requiring refrigeration were improperly stored alongside food items in the kitchen.
- Plan of Correction:
  - Corrective Action: All medications requiring refrigeration will be moved to a dedicated medication refrigerator in the office to prevent contamination with food.

- Preventative Action: Staff will be retrained on proper medication storage procedures, including temperature monitoring and segregation of medications from food.
- Monitoring: The temperature of the medication refrigerator will be checked daily, with results logged and reviewed by the DON or designee. Weekly audits will ensure proper storage practices are followed.
- Completion Date: Storage corrections will be completed within 7 days.

Deficiency: Resident Activities Program (S5021)

- Regulatory Requirement: The facility must provide a structured activities program to enhance residents' physical, psychosocial, and spiritual well-being. No organized activities were being offered.
- Plan of Correction:
  - Corrective Action: A dedicated activities coordinator will be appointed to develop and implement a structured activities program, including social, physical, and recreational activities tailored to residents' interests and abilities.
  - Preventative Action: A monthly activities calendar will be created, distributed, and posted in common areas. Resident feedback will be incorporated into the program.
  - Monitoring: The activities coordinator will submit weekly reports on program participation and resident engagement to the DON or designee, and the effectiveness of the activities program will be reviewed during monthly QAPI meetings.
  - Completion Date: A fully implemented activities program will be in place within 30 days.

Deficiency: Grievance Procedure (S5022)

- Regulatory Requirement: The facility must have a written grievance procedure in place and post it in a conspicuous location.
- Plan of Correction:
  - Corrective Action: The facility's written grievance procedure will be updated, posted in a prominent location, and distributed to all residents. Staff will be retrained on how to handle grievances in accordance with this procedure.
  - Monitoring: The DON or designee will review the grievance log monthly to ensure all grievances are properly documented and addressed in a timely manner.
  - Completion Date: The updated grievance procedure will be posted within 7 days.

Completion Timeline:

- Immediate actions will be completed within 7-14 days, depending on the severity of the deficiency.
- Follow-up audits and assessments will continue for three months to ensure sustained compliance.

Date of compliance via telephone was 10/30/24.

10/23/24 - 1:30 PM - Spoke with Eric McMillan. Plan to be accepted with agreed upon changes.

Willow Creek
Elder Care Communities

Responsible Party: Manager or designee will be responsible for overseeing all corrective actions, implementing system changes, and conducting regular audits to ensure compliance with state regulations.

DOC: 10/30/24

Eric McMillan, President

Date

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF024	A. BUILDING: _____ B. WING _____	C 02/21/2024

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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 1/24/24 through 2/21/24. Also reviewed in the course of the survey were complaint intakes LIC-23-049, LIC-24-003, and LIC-24-021. Abbreviations used in this document: CNA: Certified Nurse Aide RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5000	Ch 12 Sec 6 (a) Personnel and Staffing Requirements (a) Management. If the assisted living facility has a governing body, it must designate a manager. If there is no governing body, the owner shall appoint a manager. (i) The Manager shall: (A) Be at least twenty-one (21) years of age; (B) Assume the overall responsibility for the day-to-day operation of the facility; (C) Direct the work of others, including	S5000		

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S5000	Continued From page 1 the training and development of staff; (D) Be able to read, write, and speak English; (E) Maintain financial and other records; (F) Have a telephone with a listed number in the phone directory under the name of the assisted living facility; (G) Be familiar with and follow the State's promulgated Assisted Living Facility Licensure and Program Administration Rules; (H) Pass an open book test on the same. The open book test shall be administered by the Program Division. The passing score will be 85% or greater. Those individuals who successfully completed the examination administered by the Licensing Division shall have their test scores honored; (I) The manager shall provide an acceptable plan of correction to the Licensing Division within ten (10) days of the date when a statement of deficiencies is received by the assisted living facility; (J) The manager shall not act as, or become the legal guardian or conservator of, or have power of attorney for any resident of the facility; and (K) The manager shall meet one or more of the following requirements: (I) The manager shall have completed at least forty-eight (48) semester	S5000		

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S5000	Continued From page 2 hours or seventy-two (72) quarter hours of post-secondary education in healthcare, elderly care, health case management, facility management, or other related field from an accredited college or institution; or (II) Have completed at least two (2) years' experience working with elderly or disabled individuals. This experience may have been paid, full-time employment, or time equivalent in part-time employment or volunteer work that is directly involved with the elderly or disabled. This State Rule and Regulation is not met as evidenced by: Based on personnel record review and staff interview, the facility failed to ensure the facility manager was familiar with and successfully completed a test on the Assisted Living Facility (ALF) Licensure and Program rules. The census was 8. The findings were: 1. Review of the facility manager's personnel records, provided by the facility on 2/14/24, showed a completed "Assisted Living Manager Test" dated 7/7/23. There was no evidence the test had been submitted to the state survey agency and no evidence the manager received a passing score. 2. Review of state survey agency records showed no evidence an "Assisted Living Manager Test" was submitted for the current facility manager. 3. Interview with the facility manager on 2/21/23 at 11:43 AM revealed she was unsure if the "Assisted Living Manger Test" was submitted to the survey agency or if the facility had evidence of a passing score for the test. In addition, the	S5000		

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S5000	Continued From page 3 manager revealed she would need to contact the owner for additional information; however, no additional information was provided by the facility manager.	S5000		
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 evidenced by: Based on review of the personnel records, staff interview, and policy review, the facility failed to ensure a State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check and/or Department of Family Services (DFS) Central Registry screening was completed for 4 of 4 sample employees (CNA #2, CNA #3, caregiver #1, RN #1) prior to resident contact. The findings were: 1. Review of the employee records for CNA #2, provided by the facility on 2/14/24, showed the CNA completed new employee orientation on 3/8/23; however, a DCI fingerprint background check was not completed until 5/16/23. 2. Review of the employee records for CNA #3, provided by the facility on 2/14/24, showed the CNA completed new employee orientation on 3/1/23; however, a DFS Central Registry screening was not performed until 2/12/24.	S5002		

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S5002	Continued From page 4 3. Review of the employee records for caregiver #1, provided by the facility on 2/14/24, showed the caregiver completed general orientation on 7/20/23; however, there was no evidence of a DCI fingerprint background check and the DFS Central Registry screen was not completed until 2/12/24. 4. Review of the employee records for RN #1, provided by the facility on 2/14/24, showed no evidence of a DCI fingerprint background check and the DFS Central Registry screen was completed 2/22/24. 5. Interview with the facility manager on 2/21/24 at 11:43 AM revealed she did not have any records for RN #1 as they were all stored with the facility owner. The manager revealed DFS screening for CNA #3 and caregiver #1 was completed prior; however, the facility was unable to obtain the records. She revealed screening and background checks should be performed prior to an employee's first day of work and confirmed they did not have evidence they were completed for all employees. Further interview confirmed all the employees had resident contact before the completion of background checks or Central Registry screening was completed.	S5002		
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	S5004		

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S5004	Continued From page 5 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. This State Rule and Regulation is not met as evidenced by:	S5004		

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S5004	Continued From page 6 Based on review of the personnel records, staff interview, and policy review, the facility failed to ensure a State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check and and/or Department of Family Services (DFS) Central Registry screening maintained in personnel files for 4 of 4 sample employees (CNA #2, CNA #3, caregiver #1, RN #1) prior to resident contact. The findings were: 1. Review of the employee records for CNA #2, provided by the facility on 2/14/24, showed the CNA completed new employee orientation on 3/8/23; however, a DCI fingerprint background check was not completed until 5/16/23. 2. Review of the employee records for CNA #3, provided by the facility on 2/14/24, showed the CNA completed new employee orientation on 3/1/23; however, a DFS Central Registry screening was not performed until 2/12/24. 3. Review of the employee records for caregiver #1, provided by the facility on 2/14/24, showed the caregiver completed general orientation on 7/20/23; however, there was no evidence of a DCI fingerprint background check and the DFS Central Registry screen was not completed until 2/12/24. 4. Review of the employee records for RN #1, provided by the facility on 2/14/24, showed no evidence of a DCI fingerprint background check and the DFS Central Registry screen was completed 2/22/24. 5. Interview with the facility manager on 2/21/24 at 11:43 AM revealed she did not have any records for RN #1 as they were all stored with the facility owner. The manager revealed DFS	S5004		

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S5004	Continued From page 7 screening for CNA #3 and caregiver #1 was completed prior; however, the facility was unable to obtain the records. She revealed screening and background checks should be performed prior to an employee's first day of work and confirmed they did not have evidence they were completed for all employees. Further interview confirmed all the employees had resident contact before the completion of background checks or Central Registry screening was completed.	S5004		
S5005	Ch 12 Sec 7 (a) Assisted Living Facility (ALF) Core Services (a) The assisted living facility core services include the following: (i) Meals, housekeeping, personal and other laundry services; (A) Provision of mechanically altered diets and dietary supplements, if required. (ii) A safe and clean environment; (iii) Assistance with local transportation; (iv) Assistance with obtaining medical, dental, and optometric care, in addition to social services; (v) Assistance in adjusting to group living activities; (vi) Maintenance of a personal fund account, if requested by the resident or resident's responsible party, showing any and all deposits, withdrawals, and transactions of the account;	S5005		

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S5005	Continued From page 8 (vii) Provision of appropriate recreational activities in/out of the assisted living facility; (viii) Care of individuals who require any or all of the following services: (A) Partial assistance with personal care, e.g. bathing, shampoos; (B) Limited assistance with dressing; (C) Minor non-sterile dressing changes; (D) Stage I skin care - skin integrity intact; (E) Infrequent assistance with mobility. The resident may use an assistive device; e.g., wheel chair, walker, cane; (F) Cuing guidance with ADLs for the visually impaired resident, or the intermittently confused and/or agitated resident requiring occasional reminders to time, place and person; (G) Care of the resident who can independently manage his own catheter or ostomy, e.g., resident who can change his own catheter bags, able to clean and care for his ostomy; (H) Care of the resident incontinent of bowel or bladder if the condition can be managed independently; (ix) Assessments completed by a Registered Nurse; (A) Registered Nurse medication review	S5005		

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S5005	Continued From page 9 every two (2) months or sixty-two (62) days or whenever new medication is prescribed or the residents' medication is changed; (x) Twenty-four (24) hour monitoring of each resident. This State Rule and Regulation is not met as evidenced by: Based on observation and resident and staff interview, the facility failed to ensure a safe and clean environment in 1 of 1 kitchen. The census was 8. The findings were: 1. Observation on 1/24/24 at 9:15 AM of the facility's kitchen showed a piece of linoleum, approximately 12 inches long, was peeling and curling in front of the General Electric side-by-side refrigerator/freezer which was for resident use. In addition, the linoleum had multiple gouges, which were black in color, between the refrigerator/freezer and the central island. 2. Interview with the facility manager on 2/21/24 at 11:43 AM revealed she was not aware of a tear in the linoleum and there were no incidents of residents tripping in the area. Further interview revealed the staff clean the area with bleach water and there were no plans to fix the torn linoleum.	S5005		
S5014	Ch 12 Sec 7 (c) Assisted Living Facility (ALF) Core Services (c) Resident Rights. The facility shall adopt and follow a written policy of resident rights. The policy shall be posted in a conspicuous place,	S5014		

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S5014	Continued From page 10 and there shall be documentation in the resident's record that the resident read, or management explained, the policy. This policy shall not exclude, take precedence over, or in any way abrogate the legal and constitutional rights enjoyed by all adult citizens and shall include, but is not limited to the following: (i) Be treated with respect and dignity; (ii) Privacy; (iii) Free from physical or chemical restraints not required to treat the resident's medical symptoms. No chemical or physical restraints will be used except by order of a physician; (iv) Not to be isolated or kept apart from other resident's (v) Not to be physically, psychologically, sexually, or verbally abused, humiliated, intimidated, or punished. (vi) Live free from involuntary confinement or financial exploitation; (vii) Full use of the facility's common areas; (viii) Voice grievances and recommend changes in policies and services; (ix) Communicate privately, including, but not limited to, communicating by mail or telephone with anyone; (x) Reasonable use of the telephone, which includes access to operator assistance for placing collect telephone calls;	S5014		

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S5014	Continued From page 11 (xi) Have visitors, including the right to privacy during such visits; (xii) Make visits outside the facility. The facility manager and the resident shall share responsibility for communicating with respect to scheduling such visits; (xiii) Make decisions and choices in the management of personal affairs, assistance plans, funds, or property; (A) Including choice of home health agencies, pharmacies, personal care providers and any other private pay provider. (xiv) Except the cooperation of the provider in achieving the maximum degree of benefit from those services which are made available by the facility; (xv) Exercise choice in attending and participating in religious activities; (xvi) Reimbursed at an appropriate rate for work performed on the premises for the benefit of the operator, staff, or other residents, in accordance with the resident's assistance plan; (xvii) Informed by the facility thirty (30) days in advance of changes in services or charges; (xviii) Have advocates visit, including members of community organizations whose purpose include rendering assistance to the residents;	S5014		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK HOMES OF BUFFALO	1 NORTH KLONDIKE BUFFALO, WY 82834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5014	Continued From page 12 (xix) Wear clothing of choice unless otherwise indicated in the resident's plan, and in accordance with reasonable dress code; (xx) Participate in social activities, in accordance with the assistance plan; and (xxi) Examine survey results. This State Rule and Regulation is not met as evidenced by: Based on observation, resident and staff interview, and policy review, the facility failed to ensure the residents' right to examine survey results. The census was 8. The findings were: 1. Observation on 1/24/24 at 12:14 PM showed a binder with survey results located in a file bin near the door of the manager's office. The binder failed to include the most recent licensure/complaint survey which was conducted on 12/29/21. 2. Review of the policy "Resident Rights" showed "It will be the Policy of Willow Creek Communities to administer to the best of our ability, the following rights to our residents: ... (22) Examine survey results." 3. Interview with the facility manager on 2/21/24 at 11:43 AM revealed she was not at the facility when the previous survey occurred and she had a binder in the facility office which had all survey results in it. 4. Observation on 1/24/24 from 8:30 AM until 5 PM and again on 1/25/24 from 8:15 AM until 8:45 AM showed the office door containing the residents' records was locked with the office manager not present.	S5014		

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S5014	Continued From page 13 5. Interview on 1/24/24 at 4:42 PM with CNA #3 revealed the office manager had taken away her keys to the office on 1/23/24. 6. Interview on 1/25/24 at 8:23 AM with CNA #2 revealed the office manager had taken away her keys to the office because confidential files were kept in there. 7. Interview with on 1/24/24 at 4:42 PM with CNA #3 and caregiver #1 revealed the office manager was not in the facility on a regular basis. 8. Interview on 1/24/24 at 10:20 AM with resident #2 revealed the office manager was rarely in the facility. 9. Interview with the facility manager 2/21/24 at 11:43 AM revealed the office was "unlocked now" and she had previously kept it locked because of documents that were out on the desk. Further review revealed her hire date was 7/10/23.	S5014		
S5018	Ch 12 Sec 7 (d)(iv) Assisted Living Facility (ALF) Core Services (d) (iv) Medication assistance. (A) The staff shall be responsible for providing necessary assistance to residents deemed capable of self-medicating, but are unable to do so because of a functional disability, in taking oral medications. Non-licensed staff can only assist with oral medications. Medication assistance may include: (I) Reminding resident to take medications;	S5018		

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S5018	Continued From page 14 (II) Removing medication containers from storage; (III) Assisting with removal of cap: (IV) Assisting with the removal of a medication from a container for residents with a disability which prevents independence in this act; (V) Observing the resident take the medication; and (VI) Documentation of observation. This State Rule and Regulation is not met as evidenced by: Based on observation, resident record review, and staff interview, the facility failed to ensure medication self-administration assessments had been completed for 8 of 8 residents (#1, #2, #3, #4, #5, #6, #7, #8). The findings were: 1. Observation on 1/24/24 at 9:11 AM showed resident #7 was seated at the dining room table when CNA #2 approached him/her with a medication organizer. CNA #2 opened the organizer and poured the medications onto a napkin in front of the resident. The resident took the medication and the CNA had the resident initial the medication administration record. 2. Observation on 1/24/24 at 2:29 PM showed a locked cabinet in the kitchen area where each resident's medication was stored. A Medication/Vitals book was located on the kitchen counter which included a medication administration record for each resident. 3. Interview on 1/24/24 at 10:05 AM with resident	S5018		

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S5018	Continued From page 15 #3 revealed s/he self-administered his/her medication. 4. Interview on 1/24/24 at 10:20 AM with resident #6 revealed s/he self-administered his/her medication. 5. Review of the medical record for resident #1 on 1/29/24 showed no evidence the RN had deemed the resident capable to self-administer medications. 6. Review of the medical record for resident #2 on 1/29/24 showed no evidence the RN had deemed the resident capable to self-administer medications. 7. Review of the medical record for resident #3 on 1/29/24 showed no evidence the RN had deemed the resident capable to self-administer medications. 8. Review of the medical record for resident #4 on 1/29/24 showed no evidence the RN had deemed the resident capable to self-administer medications. 9. Review of the medical record for resident #5 on 1/29/24 showed no evidence the RN had deemed the resident capable to self-administer medications. 10. Review of the medical record for resident #6 on 1/29/24 showed no evidence the RN had deemed the resident capable to self-administer medications. 11. Review of the medical record for resident #7 on 1/29/24 showed no evidence the RN had deemed the resident capable to self-administer	S5018		

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S5018	Continued From page 16 medications. 12. Review of the medical record for resident #8 on 1/29/24 showed no evidence the RN had deemed the resident capable to self-administer medications. 13. Interview with the facility manager on 2/21/23 at 11:43 AM confirmed the facility did not have any evidence the residents were deemed capable of self-administration. Further interview revealed she did not know the records did not have the assessments.	S5018		
S5019	Ch 12 Sec 7 (d)(v) Assisted Living Facility (ALF) Core Services (d) (v) Medication Administration (A) An RN shall be responsible for the supervision and management of all medication administration as required by the Wyoming Nurse Practice Act, and the Wyoming Board of Nursing Rules and Regulations. This State Rule and Regulation is not met as evidenced by: Based on observation, review of refrigerator/freezer temperature logs, review of the 2022 USDA Food Code, and staff interview, the facility failed to ensure medications which require refrigeration were stored appropriately. The census was 8. The findings were: 1. Observation on 1/24/24 at 8:30 AM showed boxes of Ozempic and Trulicity (medications used to manage diabetes) were stored in the door of the Whirlpool upright refrigerator/freezer in the kitchen. This refrigerator/freezer contained food	S5019		

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S5019	Continued From page 17 items available to staff and residents. 2. Review of the manufacturer's instructions for Ozempic and Trulicity show they must be stored between 36 and 48 degrees Fahrenheit (F). 3. Review of the "WILLOW CREEK ELDER CARE TEMPATURE (sic) LOG" from May 2023 through December 2023 showed the following concerns: a. The May 2023 temperature log sheet showed the temperature of the Whirlpool refrigerator was not recorded from 5/12 through 5/22. In addition, the temperature of the refrigerator was recorded at 49 degrees F on 5/9/23 and 50 degrees F on 5/23 and 5/24. b. The June 2023 temperature log sheet showed the temperature of the Whirlpool refrigerator was not recorded from 6/20 through 6/27 and on 6/30. c. The July 2023 temperature log sheet showed the temperature of the Whirlpool refrigerator was not recorded from 7/6 through 7/11 and on 7/22 and 7/29. The temperature of the refrigerator was recorded as 49 degrees F on 7/23 and 7/26; 51 degrees F on 7/24; 52 degrees F on 7/25; and 50 degrees F on 7/30. d. Review of the August 2023 temperature log sheet showed the temperature of the Whirlpool refrigerator was not recorded from 8/4 through 8/5; 8/18 through 8/19; and 8/25 through 8/26. The temperature of the refrigerator was recorded as 49 degrees F on 8/6, 8/9, 8/15, 8/17, 8/22, and 8/27; 50 degrees F on 8/8 and 8/21; 51 degrees F on 8/10 and 8/11; and 52 degrees F on 8/12. e. Review of the September 2023 temperature log sheet showed the temperature was not recorded on 9/7. The temperature of the refrigerator was recorded as 54 degrees F on 9/6; 49 degrees F on 9/12, 9/24, 9/25, and 9/27; 54	S5019		

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S5019	Continued From page 18 degrees F on 9/6; and 50 degrees F on 9/17. f. Review of the October 2023 temperature log sheet showed the temperature was not recorded on 10/6. g. Review of the November 2023 temperature log sheet showed the temperature was not recorded from 11/7 through 11/10. h. Review of the December 2023 temperature log sheet showed the temperature was not recorded on 12/15. i. The facility was unable to locate the January 2024 temperature log sheet. 4. Interview with the facility manager on 2/21/23 at 11:43 AM revealed that no medications should be stored in the resident food refrigerators. She revealed there was a refrigerator in the office for medication storage. In addition, she revealed refrigerator temperatures should be checked daily, adjusted if temperatures were outside the appropriate range, and re-checked if necessary. 5. Observation on 1/24/24 from 8:30 AM until 5 PM and again on 1/25/24 from 8:15 AM until 8:45 AM showed the office door containing the residents' records was locked with the facility manager not present. 6. Interview on 1/24/24 at 4:42 PM with CNA #3 revealed the facility manager had taken away her keys to the office on 1/23/24. 7. Interview on 1/25/24 at 8:23 AM with CNA #2 revealed the facility manager had taken away her keys to the office because confidential files were kept in there. 8. Interview with on 1/24/24 at 4:42 PM with CNA #3 and caregiver #1 revealed the facility manager was not in the facility on a regular basis.	S5019		

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S5019	Continued From page 19 9. Interview with the facility manager 2/21/24 at 11:43 AM revealed the office was "unlocked now" and she had previously kept it locked because of documents that were out on the desk. 10. Review of the 2022 Food Code showed "7-207.11 Restriction and Storage. Medicines that are not necessary for the health of employees present an unjustified risk to the health of other employees and consumers due to misuse and/or improper storage. There are circumstances that require employees or children in a day care center to have personal medications on hand in the establishment. To prevent misuse, personal medications must be labeled and stored in accordance with the requirements stated for poisonous or toxic materials. Proper labeling and storage of medicines to ensure that they are not accidentally misused or otherwise contaminate food or food-contact surfaces."	S5019		
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;	S5020		

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S5020	Continued From page 20 (C) Individual admission form. This form 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	S5020		

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S5020	Continued From page 21 telephone or fax. The facility's investigation of the incident shall be reported to the Licensing 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;	S5020		

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S5020	Continued From page 22 (G) The resident's assessment and 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.	S5020		

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S5020	Continued From page 23 This State Rule and Regulation is not met as evidenced by: Based on observation, and resident and staff interview, the facility failed to ensure resident records were available for 8 of 8 sample residents (#1, #2, #3, #4, #5, #6, #7, #8). The findings were: 1. Observation on 1/24/24 from 8:30 AM until 5 PM and again on 1/25/24 from 8:15 AM until 8:45 AM showed the office door containing the residents' records was locked with the facility manager not present. 2. Interview on 1/24/24 at 4:42 PM with CNA #3 revealed the facility manager had taken away her keys to the office on 1/23/24. 3. Interview on 1/25/24 at 8:23 AM with CNA #2 revealed the facility manager had taken away her keys to the office because confidential files were kept in there. 4. Interview with on 1/24/24 at 4:42 PM with CNA #3 and caregiver #1 revealed the facility manager was not in the facility on a regular basis. 5. Interview on 1/24/24 at 10:20 AM with resident #2 revealed the facility manager was rarely in the facility. 6 Interview with CNA #2, CNA #3, and CNA #4 on 1/29/24 at 3:20 PM revealed all resident records were locked up when the manager was not at the facility and there was no way to access resident records. 7. Interview with the facility manager 2/21/24 at	S5020		

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S5020	Continued From page 24 11:43 AM revealed the office was "unlocked now" and she had previously kept it locked because of documents that were out on the desk.	S5020		
S5021	Ch 12 Sec 7 (f) Assisted Living Facility (ALF) Core Services (f) Resident Activities. An activities program shall be available to the resident and shall be designed to enhance each resident's sense of physical, psychosocial, and spiritual well-being. (i) A member of the facility's staff shall be designated as responsible for the resident activities program; (ii) Space, equipment, and supplies for the activities program shall be adequate for individual and/or group activities; and (iii) There shall be regularly scheduled activities during weekdays, evenings and weekends. This State Rule and Regulation is not met as evidenced by: Based on observation, resident interview, review of activity schedules, and staff interview, the facility failed to provide an activity program designed to enhance each resident's sense of physical, psychosocial, and spiritual well-being for 8 of 8 months reviewed. The findings were: 1. Observation during the survey timeframe showed no organized activities were offered to the residents. 2. Interview with resident #1 on 1/24/24 at 9:33 AM revealed s/he only came out of his/her room	S5021		

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S5021	Continued From page 25 for meals. 3. Interview with resident #5 on 1/24/24 at 9:55 AM revealed s/he stayed in his/her room the majority of the time; however, did enjoy Bingo. 4. Interview with resident #4 on 1/24/24 at 10 AM revealed s/he only came out of his/her room for meals. 5. Interview with resident #3 on 1/24/24 at 10:05 AM revealed s/he stayed in his/her room the majority of the time. 6. Interview with resident #6 on 1/24/24 at 10:20 AM revealed s/he the activities in the facility were "lacking". 7. Review of the December 2023 activity calendar provided by the facility on 1/25/24 showed 1 activity planned daily. Review of the February 2024 activity calendar provided by the facility on 1/25/24 showed no activities were planned at that time. There was no January 2024 activity calendar provided. 8. Interview with CNA #1 and CNA #2 on 1/24/24 at 2:07 PM revealed the facility does not have organized activities because the residents "don't want to." 9. Interview with the facility manager on 2/21/24 at 11:43 AM revealed activities were offered daily after dinner. She revealed she completed the calendars prior to the beginning of a new month. She revealed she did not provide completed activity calendars for any month except December 2023 because she did not realize they needed to be reviewed. Further interview revealed she would provide additional activity	S5021		

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WILLOW CREEK HOMES OF BUFFALO	1 NORTH KLONDIKE BUFFALO, WY 82834

(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
S5021	Continued From page 26 calendars; however, the additional calendars were not received.	S5021		
S5022	Ch 12 Sec 7 (g) Assisted Living Facility (ALF) Core Services (g) Grievance Procedure. (i) The written grievance procedure shall establish a system of receiving, reviewing, and alleviating concerns, complaints, and allegations of resident rights violations, and poor service provided to include, but not limited to: (A) Resident's method to express and document grievances; (B) Documentation of the provider's response to verbal and written resident grievances; (C) List of agencies, with address and telephone numbers for residents to contact if grievances are not addressed satisfactorily (e.g. State Long Term Care Ombudsman and the Department of Health, Office of Licensing and Surveys); and (D) The facility shall provide written reports of the grievances and resolutions to the Ombudsman and the Licensing Division within ten (10) days after the grievance is filed. (ii) The written grievance procedure shall be posted in a conspicuous place within the facility. This ELEMENT is not met as evidenced by: Based on observation, resident interview, policy and procedure review, and staff interview, the	S5022		

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S5022	Continued From page 27 facility failed to ensure grievances were reviewed and the response documented. In addition, the facility failed to ensure the written grievance procedure was posted in a conspicuous place. The findings were: 1. Observation of the facility on 1/24/24 at 12:14 PM showed no evidence the written grievance procedure was posted. 2. Interview on 1/24/24 at 10:46 AM with resident #6 revealed in November of 2023 s/he had sent a letter to the facility's owner with a list of concerns; however, no response had been received. In addition, the resident revealed his/her family had sent a letter to both the facility manager and the facility's owner with no response received. 3. Interview with resident #2 on 2:30 PM revealed s/he had voiced concerns about the heat and had to buy a space heater because his/her room was cold and s/he did not like the food. The resident revealed s/he voiced concerns about the heat and food to staff and nothing was resolved. Further interview revealed other residents had verbalized concerns to the facility owner without resolution. 4. Interview with the facility manager on 1/29/24 at 2:04 PM revealed no resident grievances had been filed at the facility. 5. Interview with the facility manager on 2/21/24 at 11:43 AM confirmed she did not have any grievances filed by residents. She revealed food issues had been verbalized to her by a resident; however, she did not write up a grievance. Further interview revealed if a resident reported issues to the owner, she was not aware.	S5022		

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S5022	Continued From page 28 6. Review of the policy and procedure "Policies and Procedures for Grievances" showed "In the event that there is a grievance, either by residents, personal (sic), or family, the following steps should be taken. 1. The Manager of the home shall be contacted and informed of the issue. 2. Contact Assistant Manager of the home if the manager can't be reached. 3. Management shall obtain written documentation on a grievance form. 4. Corporate shall be contacted and notified with the resolution for the grievance. 5. Management shall provide Corporate with documentation that the grievance has been resolved for all parties involved. 7. If the grievance isn't resolved satisfactorily or persists, a member of corporate shall be notified as to intervein (sic) and appropriately take necessary actions."	S5022		
S5024	Ch 12 Sec 7 (i) Assisted Living Facility (ALF) Core Services (i) Adult Protection. (i) The facility must assure that all residents are protected from abuse. This includes the resident's right to be free from verbal, physical, mental, or sexual abuse in accordance with the definition of abuse as stated in Section 4(a) of these rules. (ii) The facility must adhere to written policies and procedures that prohibit the abuse of any resident. These policies and procedures must identify how the facility will screen employees before hiring, ongoing in-servicing of abuse topics with employees, and a protocol that specifies how allegations of abuse will be investigated. Each staff member must be	S5024		

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S5024	Continued From page 29 accountable to report any suspicion or knowledge of abuse to the appropriate facility personnel immediately. (iii) The facility is responsible to ensure all allegations of abuse are investigated expediently and that the resident(s) are protected from further, potential abuse while the investigation is in progress. (A) Instances of abuse, neglect, or exploitation of disabled adults shall be reported to the sheriff's department, the local police department, or to the department of family services in accordance with W.S. 35-20-103. (B) The facility must ensure that, if necessary, additional authorities are contacted if there is an allegation of abuse, neglect, or exploitation. These additional authorities may include the Wyoming State Board of Nursing, Office of Healthcare Licensing and Survey, and the State Long Term Care Ombudsman. This State Rule and Regulation is not met as evidenced by: Based on resident interview, review of the state survey agency incident database, and staff interview, the facility failed to ensure residents were protected from abuse for 1 of 8 sample residents (#2). The findings were: 1. Interview on 1/24/24 at 10:46 AM with resident #2 revealed after the previous office manager was terminated in August of 2023, a stack of his/her opened mail, dating back 6 months, was found behind a file cabinet in the office manager's office. The resident stated prior to the discovery of the undelivered mail s/he had calls from a credit card company because of a balance due;	S5024		

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S5024	Continued From page 30 the credit card company reissued the statement; however, that statement was not received either. The resident stated s/he felt as if s/he had been targeted. 2. Review of the Licensing Division incident data base showed no evidence an incident report had been filed. 3. Interview with the facility manager on 2/21/24 at 11:43 AM confirmed after the previous manager left, there was mail for a resident in the facility, found in the office. She stated the mail was unopened and there were no financial documents in the mail. Further interview revealed the facility did not report the incident and the mail was given to the resident.	S5024		
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, staff interview, and review of the food code, the facility failed to ensure food was stored and prepared in a safe, wholesome, and sanitary manner in 1 of 1 kitchen and 1 of 2	S5026		

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S5026	Continued From page 31 food storage areas. The census was 8. The findings were: 1. Observation on 1/24/24 starting at 8:30 AM and 1/25/24 from 8:15 AM to 8:45 AM showed the following sanitary issues: a. The interior freezer section of the upright Whirlpool refrigerator/freezer was visibly soiled with a brown and yellow substance and crumbles of debris. The freezer compartment contained an undated plastic storage bag of what appeared to be rolls that showed signs of freezer burn. In addition, the freezer contained a plastic storage bag of pancakes which was dated 8/17/23. b. The interior of the upright Whirlpool refrigerator was soiled with spilled food substances. In addition, the refrigerator contained a jar of salsa verde with mold growing on its surface and eleven condiment containers with use-by dates ranging from 3/19/16 to 8/28/23. c. The interior of the GE side-by-side refrigerator showed a red sticky juice-like substance had spilled from the top shelf down 4 shelves to the base. The red substance had dripped down into the vegetable and fruit bins. At 12:40 PM caregiver #1 was observed to clean the red substance out of the refrigerator; however, at 4:03 PM and on 1/25/24 at 8:35 AM the refrigerator was again soiled with the red substance. In addition, a bag of undated grapes was observed in the fruit bin which appeared brown and spoiled. d. Observation of the large freezer in the back storage room showed the freezer had 3 to 4 inches of ice build-up on all of the shelves. In addition, the freezer contained undated bags of vegetables, antelope burger, frozen baked goods, and bags of cheese which appeared to be have freezer burn. The interior of the freezer was soiled with food substances.	S5026		

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S5026	Continued From page 32 e. Observation of meal preparation activities during the survey timeframe show no hair restraints were use during food preparation. f. Observation of meal preparation activities during the survey timeframe showed the temperature of the food was not monitored. g. Review of the Willow Creek Elder Care Temperature Logs for the upright, side-by-side, and large freezer from May 2023 to December 2023 showed gaps of time where the temperature was not recorded. In addition, many of the recorded temperatures were outside of the established range as noted on the log sheet. The facility could not locate the January 2024 temperature log. h. Observation on 1/24/24 at 4:03 PM showed caregiver #2 washed her hands in the food preparation sink instead of the handwashing sink located next to the GE side-by-side refrigerator freezer. i. Observation of the Euhomy Ice Machine located underneath the kitchen countertop showed a stainless-steel scoop was lying directly on the wooden shelf. j. Interview with CNA #3 on 1/24/24 at 11:40 AM revealed she had been informed that additional training for food service was not required because they were an assisted living facility. In addition, CNA #3 stated they use the nutritionist's guidelines; however, that book was locked in the manager's office. k. Interview with CNA #3 on 1/24/24 at 4:03 PM confirmed the refrigerator/freezers in the main kitchen were soiled and the large freezer in the storage room had a large build-up of ice. CNA #3 discarded some of the outdated condiments at that time. 2. According to Food Code 22, U.S. Public Health Service: 2-301.15 Where to Wash. "Effective	S5026		

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S5026	Continued From page 33 handwashing is essential for minimizing the likelihood of the hands becoming a vehicle of cross contamination. It is important that handwashing be done only at a properly equipped handwashing facility in order to help ensure that food employees effectively clean their hands. Handwashing sinks are to be conveniently located, always accessible for handwashing, maintained so they provide proper water temperatures and pressure, and equipped with suitable hand cleansers, nail brushes, and disposable towels and waste containers, or hand dryers. It is inappropriate to wash hands in a food preparation sink since this may result in avoidable contamination of the sink and the food prepared therein. Service sinks may not be used for food employee handwashing since this practice may introduce additional hand contaminants because these sinks may be used for the disposal of mop water, toxic chemicals, and a variety of other liquid wastes. Such wastes may contain pathogens from cleaning the floors of food preparation areas and toilet rooms and discharges from ill persons..." 3. According to Food Code 22, U.S. Public Health Service: 2-402 Hair Restraint 2-402.11 "Effectiveness. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from FDA Food Code 2022 Chapter 2. Management and Personnel Chapter 2 - 22 contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES." 4. According to Food Code 22, U.S. Public Health	S5026		

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S5026	Continued From page 34 Service: 4-302.12 Food Temperature Measuring Devices. "The presence and accessibility of food temperature measuring devices is critical to the effective monitoring of food temperatures. Proper use of such devices provides the operator or person in charge with important information with which to determine if temperatures should be adjusted or if foods should be discarded. When determining the temperature of thin foods, those having a thickness less than 13 mm (1/2 inch), it is particularly important to use a temperature sensing probe designed for that purpose. Bimetal, bayonet style thermometers are not suitable for accurately measuring the temperature of thin foods such as hamburger patties because of the large diameter of the probe and the inability to accurately sense the temperature at the tip of the probe. However, temperature measurements in thin foods can be FDA Food Code 2022 Annex 3. Public Health Reasons/Administrative Guidelines Annex 3 - 169 accurately determined using a small-diameter probe 1.5 mm (0.059 inch), or less, connected to a device such as thermocouple thermometer..." 5. According to Food Code 22, U.S. Public Health Service: "43. In-use utensils; properly stored Based on the type of operation, there are a number of methods available for storage of in-use utensils during pauses in food preparation or dispensing, such as in the food, clean and protected, or under running water to prevent bacterial growth. If stored in a container of water, the water temperature must be at least 135°F. In-use utensils may not be stored in chemical sanitizer or ice between uses. Ice scoops may be stored handles up in an ice bin except for an ice machine."	S5026		

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S5026	Continued From page 35 6. According to Food Code 22, U.S. Public Health Service: 3-501.11 Frozen Food. "Stored frozen FOODS shall be maintained frozen. 3-501.12 Time/Temperature Control for Safety Food, Slacking. FDA Food Code 2022 Chapter 3. Food Chapter 3 - 26 Frozen TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is slacked to moderate the temperature shall be held: (A) Under refrigeration that maintains the FOOD temperature at 5oC (41oF) or less; or (B) At any temperature if the FOOD remains frozen."	S5026		
S5028	Ch 12 Sec 7 (j)(iv) Assisted Living Facility (ALF) Core Services (j) (iv) A minimum of three meals in a twenty-four (24) hour period shall be provided to each resident during normal dining hours. In addition, meals and between meal snacks shall be palatable, attractive in appearance, consist of a variety of foods, and shall be served at the proper temperature. (A) Menus shall be planned based on recognized national dietary standards recommended by a Regional Dietitian. Menus shall be prepared at least two weeks in advance and posted in the kitchen. Reasonable substitutions of similar nutritive value must be available to residents who refuse or/ are unable to eat the food served. The daily menus shall be corrected to show the food actually served, and the corrected copy kept on file and available for inspection for one (1) year. A current diet manual shall be approved by the Registered Dietitian, and sufficient copies of the approved manual must be available to dietary and nursing staff in the assisted living facility.	S5028		

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S5028	Continued From page 36 This State Rule and Regulation is not met as evidenced by: Based on observation, resident and staff interview, and review of the prepared menus, the facility failed to provide menus based on recognized national dietary standards recommended by a Registered Dietitian. In addition, the facility failed to prepare menus at least two weeks in advance and post in the kitchen. The census was 8. The findings were: 1. Observation on 1/24/24 at 9:15 AM showed the white board in the dining room failed to include what was on the menu for the evening meal. 2. Review of the facility recipe binder on 1/29/22 at 1:22 PM showed a binder of food recipes was stored in the facility office and the recipes were printed from various internet sites. There was no evidence the recipes had been approved by a dietitian. 3. Review of the menus provided by the facility showed the menus were hand written on lined notebook paper. The last planned menu was for the evening meal on 1/20/24. Menus prior to 1/13/24 were unavailable. 4. Interview on 1/24/24 at 10:20 AM with resident #2 revealed sometimes the portions of food were "skimpy" depending on the cook. 5. Interview on 1/24/24 at 11:30 AM with CNA #2 revealed the menus were not available onsite because the manager was unable to come into the facility. CNA #2 stated when there was not a menu available, she would call the manager and inform her what food was on hand and the manager would tell her what to cook.	S5028		

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S5028	Continued From page 37 6. Interview on 1/24/24 at 12 PM with CNA #3 revealed there were not any recipes available to go with what was on the menu. In addition, CNA #3 stated she thought a nutritionist reviewed the menus; however, she did not know who the nutritionist was and only the manager was in contact with him/her. 7. Interview with the facility manager on 1/29/24 at 1:22 PM revealed the facility has not had a dietitian employed since 2016 and confirmed some recipes in the binder were obtained after the dietitian left the facility. Further interview confirmed menus were created for one week at a time. 8. Observation on 1/24/24 from 8:30 AM until 5 PM and again on 1/25/24 from 8:15 AM until 8:45 AM showed the office door containing the residents' records was locked with the office manager not present. 9. Interview on 1/24/24 at 4:42 PM with CNA #3 revealed the office manager had taken away her keys to the office on 1/23/24. 10. Interview on 1/25/24 at 8:23 AM with CNA #2 revealed the office manager had taken away her keys to the office because confidential files were kept in there. 11. Interview with on 1/24/24 at 4:42 PM with CNA #3 and caregiver #1 revealed the office manager was not in the facility on a regular basis. 12. Interview on 1/24/24 at 10:20 AM with resident #2 revealed the office manager was rarely in the facility.	S5028		

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S5028	Continued From page 38 13. Interview with the facility manager 2/21/24 at 11:43 AM revealed the office was "unlocked now" and she had previously kept it locked because of documents that were out on the desk.	S5028		
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. (I) On the first day of admission, each resident shall be instructed in the proper	S5046		

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S5046	Continued From page 39 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 for each facility shall be listed on the form; (7.) Comments on the factors	S5046		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF024	A. BUILDING: _____ B. WING _____	C 02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S5046	Continued From page 40 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 resident record review and staff interview, the facility failed to ensure a record of instruction for the fire emergency plan was completed on the first date of admission for 8 of 8 sample residents (#1, #2, #3, #4, #5 #6, #7, #8) and stored in the resident's file. The findings were: 1. Review of the medical record for resident #1 on 1/29/24 showed the resident admitted to the facility on 5/22/23 and there was no evidence the resident was instructed on the facility's fire emergency plan on the day of admission. Review of an "Evacuation Orientation" provided by the facility on 2/14/24 showed it was signed by the resident and the current facility manager; however, there was no date indicated on the form. 2. Review of the medical record for resident #2 on 1/29/24 showed the resident admitted to the facility on 11/24/21 and there was no evidence the resident was instructed on the facility's fire emergency plan on the day of admission. Review of an "Evacuation Orientation" provided by the facility on 2/14/24 showed it was signed by the resident and the current facility manager; however, there was no date indicated on the form. 3. Review of the medical record for resident #3 on	S5046		

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S5046	Continued From page 41 1/29/24 showed the resident admitted to the facility on 4/22/22 and there was no evidence the resident was instructed on the facility's fire emergency plan on the day of admission. Review of an "Evacuation Orientation" provided by the facility on 2/14/24 showed it was signed by the resident and the current facility manager; however, there was no date indicated on the form. 4. Review of the medical record for resident #4 on 1/29/24 showed the resident admitted to the facility on 2/3/18 and there was no evidence the resident was instructed on the facility's fire emergency plan on the day of admission. Review of an "Evacuation Orientation" provided by the facility on 2/14/24 showed it was signed by the resident and the current facility manager; however, there was no date indicated on the form. 5. Review of the medical record for resident #5 on 1/29/24 showed the resident admitted to the facility on 4/24/17 and there was no evidence the resident was instructed on the facility's fire emergency plan on the day of admission. Review of an "Evacuation Orientation" provided by the facility on 2/14/24 showed it was signed by the resident and the current facility manager; however, there was no date indicated on the form. 6. Review of the medical record for resident #6 on 1/29/24 showed the resident admitted to the facility on 9/3/21 and there was no evidence the resident was instructed on the facility's fire emergency plan on the day of admission. Review of an "Evacuation Orientation" provided by the facility on 2/14/24 showed it was signed by the resident and the current facility manager;	S5046		

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S5046	Continued From page 42 however, there was no date indicated on the form. 7. Review of the medical record for resident #7 on 1/29/24 showed the resident admitted to the facility on 10/5/21 and there was no evidence the resident was instructed on the facility's fire emergency plan on the day of admission. Review of an "Evacuation Orientation" provided by the facility on 2/14/24 showed it was signed by the resident and the current facility manager; however, there was no date indicated on the form. 8. Review of the medical record for resident #8 on 1/29/24 showed the resident admitted to the facility on 6/25/23 and there was no evidence the resident was instructed on the facility's fire emergency plan on the day of admission. Review of an "Evacuation Orientation" provided by the facility on 2/14/24 showed it was signed by the resident and the current facility manager; however, there was no date indicated on the form. 9. Interview with the facility manager on 2/21/24 at 11:43 AM revealed the documents were in the resident's files; however, they were not signed by the previous manager. She confirmed she signed the documents before she sent them and revealed her hire date was 7/10/23.	S5046		