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 _____	07/19/2024

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
S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020. Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001. A complaint survey was conducted by Healthcare Licensing and Surveys on 7/1/21. The survey was prompted by complaint intakes WY LIC-24-027, LIC-24-044, LIC-24-046, LIC-24-057, LIC-24-62, LIC-24-065, LIC-24-067, and LIC-24-068. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5001	Ch 12 Sec 6 (b) Personnel and Staffing Requirements (b) Staffing. (i) The staffing level shall be sufficient to meet the needs of all residents of the facility, and insure the appropriate level of care is provided. (ii) There shall be personnel on duty to maintain order, safety, and cleanliness of the premises, to prepare and serve meals, to keep and adequate supply of clean linens, to assist the residents in personal needs and recreational activities, and to meet the other operational needs of the facility.	S5001		

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S5001	Continued From page 1 (iii) The assisted living facility shall not employ an individual as a nurse assistant who is not currently certified by the Wyoming State Board of Nursing. Certification must be verified by the manager of the assisted living facility. (iv) There shall be at least one (1) RN, LPN, or CNA on duty every shift. There shall be at least one (1) person on duty and awake at all times. (v) If the assisted living facility does not employ an RN, the facility shall Contract with an RN to provide the initial assessment, periodic reviews, assistance plans, as well as the periodic updates of resident assessment, reviews, assistance plans, and medication management. This State Rule and Regulation is not met as evidenced by: Based on facility staffing review, and staff interview, the facility failed to ensure sufficient staffing, including 1 RN, LPN, or CNA was on duty every shift to provide resident care. The Census was 9. The findings were: 1. Interview with the facility manager on 6/20/24 revealed the facility only had 2 CNAs who currently worked at the facility which was herself and CNA #1. Further interview revealed 1 of them was always at the facility. 2. Interview with staff member #1 and staff member #2 on 6/18/24 at 5:24 PM revealed neither of them was a CNA. 3. Interview with CNA #1 on 6/19/24 at 10:30 AM revealed medication times for resident #7 were changed because the overnight shift does not have a CNA and a CNA was needed to "pass meds." CNA #1 revealed she worked 7 AM to 7	S5001		

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S5001	Continued From page 2 PM 4 days one week and 3 days the following week. She revealed on her days off, she went to the facility just to "pass meds" and left afterwards. Further interview revealed the manager said there was a nurse who came to the facility; however, she was unsure who the nurse was. 4. Review of the staff schedule from 6/1/24 through 6/18/24, provided by the manager, showed neither the manager or CNA #1 were scheduled for either shift on 6/1, 6/5, 6/17 and 6/18, were not scheduled on the 7 AM to 7 PM shift on 6/2 and 6/4, and were not scheduled for the 7 PM to 7 AM shift on 6/6, 6/7, 6/8, and 6/16. Further review showed there was no schedule provided for 6/9/2024 through 6/15/2024. 5. Additional information was requested from the facility. Communication attempts were made on 6/25/24, 6/28/24, 7/1/24, 7/2/24, 7/9/24, 7/12/24, and 7/18/24. No additional documentation was provided by the facility.	S5001		
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, 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;	S5014		

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S5014	Continued From page 3 (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; (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	S5014		

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S5014	Continued From page 4 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; (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.	S5014		

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S5014	Continued From page 5 This State Rule and Regulation is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to ensure residents rights to privacy, dignity, and respect for 9 of 9 sample residents (#1, #2, #3, #4, #5, #6, #7, #8, #9). The findings were: 1. Observation on 6/18/24 at 5:14 PM showed a camera was positioned on the wall, between the living area and dining area, facing the front door. Further observation showed no evidence of a sign indicating electronic monitoring was in use and residents in the dining room were not talking or engaging with each other. 2. Interview with resident #3 on 6/18/24 at 3:46 PM revealed she did not feel the facility treated residents well. S/he indicated the facility staff recorded conversations and there was a camera in the dining area to monitor what residents were saying. The resident alleged CNA #1 yelled at residents, including resident #3 and then retaliated against him/her with a write up. In addition, the resident revealed CNA #1 lied and said the resident was yelling at her and calling her names; however, the resident denied calling the staff member names. The resident confirmed s/he was upset because the staff member was yelling at him/her. Further interview revealed the resident felt staff "bully" residents to change medication times because there was not a CNA available on the night shift. 3. Interview with resident #5 on 6/18/24 at 4:40 PM revealed s/he observed CNA #1 raising her voice at residents during dinner. S/he revealed the other residents and the CNA were both upset; however, s/he was unsure why.	S5014		

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S5014	Continued From page 6 4. Interview with resident #7 on 6/18/24 at 4:50 PM revealed s/he felt CNA #1 was "quite cross" and talked down to him/her. The resident revealed the CNA told him/her medications time would change and when s/he asked why, CNA #1 said "You will get it at 7, do you understand," but did not answer his/her question. The resident revealed the s/he felt the facility was like jail and when s/he made that comment in front of other residents the manager got upset and said "this is not a jail and you can leave." Further interview revealed the resident's daughter was not allowed to visit the facility and the resident had to walk to the curb to get his/her medication refilled. The resident revealed his/her daughter was not allowed to visit the facility because she reported issues about the facility and staff. 5. Interview with staff member #1 on 6/19/24 at 10 AM revealed she was aware some residents felt they were mistreated by CNA #1 and did not like her. The staff member revealed she had been told the CNA's comments, tone, and actions may have resulted in residents being upset and/or fearful; however, she did not think the CNA meant to upset residents. Further interview revealed she was aware of an argument between CNA #1 and residents during dinner; however, she did not feel the residents or the staff member raised their voice. 6. Interview with resident #6 on 6/19/24 at 11 AM revealed the resident did not attend meals in the dining room; however, s/he heard a staff member "yelling" at residents and residents yelling at staff one evening; however, she was unsure what was said. The resident confirmed the facility had a camera in the common area, which s/he did not like, and staff told her to be careful what s/he said	S5014		

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S5014	Continued From page 7 because conversations were recorded. 7. Interview with CNA #1 on 6/19/24 at 10:30 AM revealed on the day of the "argument" the meal was scheduled to be a chef salad; however, groceries had not arrived and she elected to make stir fry to ensure the meal was not late. Resident #3 asked why the residents didn't receive a chef salad and when the CNA told the resident why, resident #3 called her a bitch and said she was bipolar. The CNA revealed another staff member told her to go outside. The CNA revealed she went outside and called the facility manager. The CNA revealed the facility manager asked to speak to all the residents so the CNA placed her on speaker phone, went into the facility, put her phone on the counter, and left the facility again. The CNA revealed she was unsure what the manager said to the residents. Further interview revealed she did not record the incident and she felt both the resident and the CNA were escalated at the time of the incident. 8. Review of the medical records for residents #1, #2, #3, #4, #5, #6, #7, #8, and #9 showed no evidence residents were informed or consented to the use of an electronic monitoring device at the facility in accordance with Wyoming Administrative Rules, Chapter 15: Electronic Monitoring of Long-Term Care. 9. Interview with the facility manager on 6/20/24 at 12:08 PM confirmed electronic monitoring was not posted in the facility. Further interview revealed the camera in the facility recorded both audio and visual. The manager revealed the device only recorded when she used the application on her phone and she randomly "pops in" at times. She revealed the incident between the CNA and resident #3 was not recorded;	S5014		

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S5014	Continued From page 8 however, she did provide the resident with a "write-up" following the incident. 10. Additional documents were requested via email on 6/20/24, 6/25/24, 6/28/24, and 7/1/24, which included a copy of the facility's abuse investigation; however, the information was not provided. Interview with the facility manager via telephone on 7/2/24 at 3:17 PM revealed she would have the President of Elder Care, Inc. send additional information. Interview with the facility manager on 7/9/24 at 11:17 AM revealed she sent the information to the owner and he would send them to the state licensing agency on that day; however, no documentation was received. In addition, attempts to call the manager were made on 6/25/24, 6/28/24, 7/1/24, 7/12/24, and 7/18/24 and messages were left for the manager; however, no return calls were received.	S5014		
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		

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S5020	Continued From page 9 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	S5020		

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S5020	Continued From page 10 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	S5020		

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S5020	Continued From page 11 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 12 This State Rule and Regulation is not met as evidenced by: Based on resident record review and staff interview, the facility failed to ensure allegations of abuse were documented in resident records and reported to the Licensing Division for 1 of 1 sample resident (#3) with allegations of abuse. The findings were: 1. Interview with resident #3 on 6/18/24 at 3:46 PM revealed s/he did not feel the facility treated residents well. The resident alleged CNA #1 yelled at residents, including resident #3, and then retaliated against him/her with a write up. In addition, the resident revealed CNA #1 lied and said the resident was yelling at her and calling her names; however, the resident denied calling the staff member names. The resident confirmed s/he was upset because the staff member was yelling at him/her. 2. Review of an "Incident Reporting" form dated 5/16/24 showed CNA #1 reported "So I was serving deserts to two of the residents in there [sic] room. When I came in the kitchen [resident #3] started yelling at me saying this is there [sic] house and I was being a child and then called me a bitch. [staff member name] came up the hallway and told me to go outside so I did and called [facility manager]." 3. Review of a "Resident Write up Form" dated 5/29/24 and timed 11:12 AM showed "On May 16th at 5:00 pm, resident was being loud and using profanity towards CNA [#1]. It was caused by not having the same dinner that was posted as to grocery delivery being delayed. [S/he] called her a bitch, told her she was a child and had other residents very upset." The form showed "Corrective Action Taken (be specific): This is the	S5020		

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S5020	Continued From page 13 first write up regarding this behavior. If behavior continues there may be a 30 day notice issued as this behavior is abusive. Policy will be provided." Further review showed the resident's family was not notified and the form was signed by the resident and facility manager. 4. Interview with resident #5 on 6/18/24 at 4:40 PM revealed s/he observed CNA #1 speaking to some residents with a raised voice during dinner. S/he revealed the residents and the CNA were both upset; however, s/he was unsure why. 5. Interview with resident #7 on 6/18/24 at 4:50 PM revealed s/he felt CNA #1 was "quite cross" and talked down to him/her. The resident revealed the CNA told him/her medications time would change and when s/he asked why, CNA #1 said "You will get it at 7, do you understand," but the CNA did not answer his/her question. The resident revealed the s/he felt the facility was like jail and when s/he made that comment in front of other residents the manager got upset and said "this is not a jail and you can leave." Further interview revealed the resident's daughter was not allowed to visit the facility and the resident had to walk to the curb to get his/her medication refilled. The resident revealed his/her daughter was not allowed to visit the facility because she reported issues with the facility and staff. 6. Interview with staff member #1 on 6/19/24 at 10 AM revealed she was aware some residents felt they were mistreated by CNA #1 and did not like her. The staff member revealed she had been told the CNA's comments, tone, and actions may have resulted in residents being upset and/or fearful; however, she did not think the CNA meant to upset residents. Further interview revealed she was aware of an argument between	S5020		

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 _____	07/19/2024

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

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S5020	Continued From page 14 CNA #1 and residents during dinner; however, she did not feel the residents or the staff member raised their voice. 7. Interview with resident #6 on 6/19/24 at 11 AM revealed the resident did not attend meals in the dining room; however, s/he heard a staff member "yelling" at residents and residents "yelling" at staff one evening; however, s/he was unable to hear what was said. 8. Interview with CNA #1 on 6/19/24 at 10:30 AM revealed on the day of the "argument" the meal was scheduled to be a chef salad; however, groceries had not arrived and she elected to make stir fry to ensure the meal was not late. Resident #3 asked why the residents didn't receive a chef salad and when the CNA told the resident why, resident #3 called her a bitch and said she was bipolar. The CNA revealed another staff member told her to go outside. The CNA revealed she went outside and called the facility manager. The CNA revealed the facility manager asked to speak to all the residents so the CNA placed her on speaker phone, went into the facility, put her phone on the counter, and left the facility again. The CNA revealed she was unsure what the manager said to the residents. Further interview revealed she did not record the incident and she felt both the resident and the CNA were escalated at the time of the incident. 9. Interview with the facility manager on 6/20/24 at 12:08 PM revealed the incident between the CNA and resident #3 was not recorded; however, she did provide the resident with a "write-up" following the incident. The manager stated she was not aware of an allegation of abuse until the Department of Family Services reported it to her. She confirmed the allegation was not reported to	S5020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S5020	Continued From page 15 the state survey agency. 10. Additional documents, including the facility's investigation and abuse policy, were requested via email on 6/20/24, 6/25/24, 6/28/24, and 7/1/24, which included a copy of the facility's abuse investigation; however, the information was not provided. Interview with the facility manager via telephone on 7/2/24 at 3:17 PM revealed she would have the President of Elder Care, Inc. send additional information. Interview with the facility manager on 7/9/24 at 11:17 AM revealed she sent the information to the President of Elder Care, Inc. and he would send them to the state survey agency on that day; however, no documentation was received. In addition, attempts to call the manager were made on 7/12/24, and 7/18/24 and messages were left for the manager; however, no return calls were received.	S5020		

Buffalo

Survey Date: July 19, 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 Creek 7/19/24

1. Identification of the Deficiency:

- The facility failed to maintain sufficient staffing and ensure proper personnel were on duty for every shift. This resulted in shifts being inadequately covered by Certified Nursing Assistants (CNAs), Licensed Practical Nurses (LPNs), or Registered Nurses (RNs). Additionally, the facility failed to ensure residents' rights to privacy, dignity, and respect were maintained.

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2. Corrective Actions:

- Staffing Requirements:
  - Immediate Action: The facility will ensure that a CNA, LPN, or RN is available for every shift to meet resident care needs. All shifts will be reviewed and scheduled accordingly to ensure compliance with state regulations.
  - Training: All personnel, including CNAs, will be retrained to understand the importance of adequate staffing for resident care, and their roles and responsibilities during each shift.
  - Hiring and Scheduling: If necessary, additional CNAs, LPNs, or RNs will be hired to cover shifts where staff shortages have been identified. The facility manager will ensure that a minimum of one licensed staff member is present during all shifts.
- Resident Rights:
  - Training: Staff will receive mandatory retraining on resident rights, including privacy, dignity, and respect. This will include a review of how staff behavior and communication impact residents' well-being.
  - Monitoring: Cameras that were installed without notifying residents will be removed or proper notifications and consent will be obtained as per state rules.

10/23/24 @ 1:30 PM - Spoke with Owner, Eric McMillan, POC accepted with E agreed upon changes. Alleged date of compliance is 10/30/24

- Grievance Procedure: The facility will implement a clear, written grievance procedure for residents to report concerns about mistreatment or disrespect. Residents and families will be informed of this process, and all grievances will be documented and addressed promptly.
- Documentation: A formal system will be developed to ensure that any allegations of abuse, mistreatment, or violations of resident rights are properly documented and reported to the appropriate regulatory bodies within the required timeframes.

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3. System Changes to Prevent Recurrence:

- Staffing Oversight:
  - Policy Update: The facility's staffing policy will be updated to ensure compliance with Chapter 12, Section 6(b) of Wyoming Assisted Living Facility Regulations, which mandates that appropriate personnel are available to meet resident needs at all times.
  - Scheduling Software: The facility will implement or improve the scheduling software to ensure that all shifts are adequately staffed and that no gaps occur in staffing coverage. Staff members will be held accountable for any unscheduled absences, and a backup list of on-call staff will be maintained to prevent gaps in care.
- Resident Rights and Abuse Prevention:
  - New Policy: The facility will develop and implement a comprehensive policy for maintaining and protecting residents' rights to dignity and privacy, including guidelines for camera use. This policy will be posted in common areas, and staff will be trained on how to uphold these rights.
  - Abuse Reporting System: An internal reporting and documentation system will be created to ensure timely and thorough reporting of any abuse or rights violations. The DON or designee will review all reported incidents to ensure that they are handled appropriately and reported to state authorities within required timelines.

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4. Monitoring and QAPI Involvement:

- Weekly Audits (First 4 Weeks):
  - Focus: Weekly audits will be conducted by the Director of Nursing (DON) or designee to ensure compliance with staffing requirements and resident rights. The audits will focus on:
    - Ensuring staff coverage for all shifts.
    - Reviewing staff performance to ensure proper treatment of residents.
    - Reviewing grievance logs to ensure proper documentation and follow-up.
  - Observation: Direct observation of staff-resident interactions will be conducted during these audits to ensure residents are being treated with dignity and respect.
- Monthly Audits (Following Period):
  - After the first four weeks, monthly audits will be conducted for three months to ensure ongoing compliance. These audits will continue to focus on staffing levels and resident rights.
  - All findings will be discussed in monthly Quality Assurance and Performance Improvement (QAPI) meetings, where corrective actions and system changes will be reviewed and adjusted as needed.
- QAPI Meetings:

- The QAPI committee, led by the DON or designee, will review audit results, incidents of rights violations, and staff performance issues. The committee will implement any necessary process improvements to ensure continuous compliance with regulations.
- Resident feedback will also be solicited regularly during resident council meetings to monitor the ongoing satisfaction and well-being of residents.

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5. Completion Timeline:

- Immediate Action (within 7 days):
  - Ensure proper staffing for every shift and retrain staff on proper behavior and respect towards residents.
  - Begin removal of improperly placed cameras or obtain written consent from residents for the cameras that remain.
  - Notify residents and their families of the new grievance procedure and post notices of the facility's updated resident rights policies.
- Ongoing Monitoring:
  - Weekly audits for 4 weeks, transitioning to monthly audits for 3 months.
  - QAPI meetings will take place monthly until substantial compliance is achieved.

Responsible Party: Manager or designee will be responsible for overseeing all corrective actions, system changes, and monitoring to ensure compliance with state regulations and improve overall care quality.

DOC: 10/30/24

Eric McMillan, President

Date