STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF006	A. BUILDING ______ B. WING ______	10/10/2025

NAME OF PROVIDER OR SUPPLIER: ASPEN WIND ASSISTED LIVING COMMUNITY

STREET ADDRESS, CITY, STATE, ZIP CODE: 4010 NORTH COLLEGE DRIVE, CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020 Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001 A licensure survey was conducted by Healthcare Licensing and Surveys from 10/8/25 through 10/10/25. Also reviewed in the course of the survey were complaint intakes LIC-25-048, LIC-25-067, LIC-26-002, LIC-26-004, LIC-26-005, and LIC-26-006 The following common abbreviations are used throughout this document. CNA Certified Nursing Assistant DSD Dining Services Director ED Executive Director LPN Licensed Practical Nurse RN Registered Nurse Less commonly used abbreviations will be annotated in each deficiency	S 000		
S5003	Ch 12 Sec 6 (d) Personnel and Staffing Requirements (d) Infection Control. Written policies must be in effect to ensure that newly hired and current employees do not spread a communicable disease that could be transmitted through usual job duties. These written polices must, at a minimum: (i) Ensure a safe and sanitary environment	S5003		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]

TITLE: Assistant Executive Director

(X6) DATE: 12/2/25

This plan of correction was accepted on 12/5/25. Michele McDonald was notified via email on 12/5/25 at 3:49 pm.

[signature] 12/5/25

Healthcare Licensing and Surveys

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S5003	Continued From page 1 for residents and personnel, (ii) Require tuberculin testing, or screening as appropriate; and (iii) Prohibit any person with an airborne, contagious, or infectious disease from being employed until a work release is obtained. (A) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents and their food, if direct contact will transmit a disease (B) The facility shall require staff to follow universal precautions when performing direct resident care. This State Rule and Regulation is not met as evidenced by: Based on personnel file review, policy and procedure review, and staff interview, the facility failed to ensure 1 of 5 newly hired employees reviewed (CNA #1) was tested for tuberculosis (TB) upon hire as required. The findings were: 1. Review of the personnel file for CNA #1 showed she was hired on 3/26/25. Review of the "Mantoux (TB) Consent Form" showed "I consent to have a two-step tuberculin skin test to be administered by the Community contracted Licensed Nurse." and was signed by CNA #1. Further review of the consent form showed the first-step of the two-step tuberculin test was administered on 3/26/25; however, there were no results documented of the test and there was no evidence the second injection of purified protein derivative (PPD) was administered 2. Interview on 10/8/25 at 2:28 PM with the	S5003	**S5003**-CNA #1 will participate in the TB Clinic scheduled for 12/3/2025. All staff members identified as not being up to date on TB testing will also participate in this clinic. Beginning this year, the facility will conduct an annual TB clinic every November to ensure compliance with yearly TB testing requirements. This clinic will be organized by the Assistant Executive Director (AED) and the Clinical Services Director (CSD). The AED will be responsible for TB testing for all new hires. On onboarding day, each new hire will receive the first step of the two-step TB test. The AED will follow up to ensure the first step is read and that the employee receives the second step within two weeks of the first. Calendar reminders will be added to both the AED and Executive Director calendars to support timely follow-up. The CSD will oversee TB testing for all new admissions. The CSD will use the facility's Admissions Checklist, complete their portion, and then forward the checklist to the AED, who will complete their section. The checklist will then be reviewed by the Executive Director for final verification to ensure the admission process is fully completed. All new hires and new admissions will also be reviewed weekly times 3 months, monthly times 3 months then quarterly times 6 months during the Quality Assurance review conducted by the Executive Director and the Clinical Services Director. Any missing TB testing will be reported to the QA committee immediately. QA committee will track results and update compliance log.	12/03/2025

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S5003	Continued From page 2 assistant executive director confirmed no further information was available 3 Review of the "TB Screening Wyoming-Resident and Employee" policy showed ". All residents and employees should have a patient TB risk assessment, symptom evaluation, and TB test performed prior to admission to the community or prior to the employee's first day of work "	S5003		
S5004	Ch 12 Sec 6 (e) Personnel and Staffing Requirements (e) Personnel Policies and Records. (i) Management shall provide new employee orientation and education regarding resident rights, evacuation, and emergency procedures, as well as training and supervision designed to improve resident care (ii) A record for the manager and each employee shall be maintained and contain at a minimum, the following information (A) Name, current address and telephone number, (B) Social Security Number; (C) Education, (D) Work experience, documentation of reference checks, (E) Date of employment (F) Position in the assisted living facility	S5004	**S5004**- Orientation dates for CNA #1, CNA #2, RN #1, and LPN #1 have been scheduled and will be completed by 12/8/2025. Employee chart audit has been performed, and other employees who were missing the New Hire Orientation training have also been scheduled to complete the training by 12/8/2025. Assistant Executive Director will be responsible for tracking and preforming all employee trainings moving forward. All new hires will not start job specific training until completing new hire orientation with the Assistant Executive Director, EVS Director and the Clinical Services Director. All new hires trainings will also be reviewed weekly times 3 months, monthly times 3 months then quarterly times 6 months during the Quality Assurance review conducted by the Executive Director and the Clinical Services Director. Any missing new hire training will be reported to the QA committee immediately. QA committee will track results and update compliance log.	12/08/2025

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S5004	Continued From page 3 (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: Based on review of personnel files, staff interview, and policy and procedure review the facility failed to ensure personnel records contained all of the required documentation for 4 of 5 sample employees (CNA #1, CNA #2, RN #1, LPN #1) reviewed. The findings were: 1. Review of the personnel files for CNA #1, CNA #2, RN #1, and LPN #1 failed to include a signed copy of the orientation checklist which included education regarding resident rights, evacuation, and emergency procedures. 2. Review of the personnel file for RN #1 failed to include a copy of the nurse's license. 3. Interview with the assistant executive director on 10/8/25 at 2:28 PM confirmed the personnel files were incomplete.	S5004		

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S5004	Continued From page 4 4. Review of the "Delegated Nursing Services" policy showed "A. Orientation for New Employees (Direct Care Staff) 1. Orientation, consisting of classroom (online or in-person) and on-the-job training, is provided to new employees prior to job placement...4. An orientation checklist is developed and includes orientation and educational topics discussed with the employee. This is retained in the employee's personnel file..."	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	**S5005**-A RN will complete a medication review for residents #1, #2, #3, #4, #5, #6, #7, #8 by 11/20/25. An audit will be preformed of all residents will be conducted by an RN and a medication review will be completed for any resident that is overdue. Executive Director and Clinical Services Director were educated by Regional Nursing Director. A medication review log is being built by room number and will be performed every 60 days. The log will be monitored by the Executive Director for completion weekly times 3 months and monthly times 3 months then quarterly times 6 months. Any missed or late reviews will be reported immediately to the QA committee. QA committee will track results and update compliance log.	11/20/2025

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S5005	Continued From page 5	S5005		

(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,

(C) 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;

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S5005	Continued From page 6 (A) Registered Nurse medication review 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 resident record review, staff interview, and policy and procedure review, the facility failed to have a system in place for documenting the RN's medication review for 8 of 8 sample residents (#1, #2, #3, #4, #5, #6 #7, #8) reviewed for medications. The findings were: 1. Review of the records for resident #1, #2 #3, #4, #5, #6 #7, and #8 showed no evidence a RN had conducted a medication review every 62 days or whenever new medication was prescribed or the residents medication was changed. 2. Interview with the ED on 10/9/25 at 12:07 PM, after consulting with the district consultant, revealed medication reconciliation was done with the "cycle check-in" once a month. The ED provided a medication administration summary which showed when a resident's medication was administered and by whom; however, there was no documentation a registered nurse had performed a medication review as required. 3. Review of the "Medication Administration" policy and procedure showed "...B. When medication management is provided by the Community: 1. The resident's medication regimen is reviewed at least annually by a licensed health care professional (more frequently if required by	S5005		

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S5005	Continued From page 7 state regulation) . "	S5005		12/03/2025
S5007	Ch 12 Sec 7 (b)(ii) Assisted Living Facility (ALF) Core Services (b) (ii) Admission orders. A resident shall be admitted only if accompanied by a history and physical completed by a physician or physician extender within ninety (90) days prior to admission. The facility shall confirm the resident's medication regimen and special treatment orders at the time of admission. (A) Admission orders shall include an order for TB screening, influenza and pneumococcal immunization status and orders for immunization if required, unless contraindicated. The facility must develop and implement policies and procedures to ensure the following: (I) Residents, or their legal representative are educated regarding the risks and benefits of these immunizations. (II) The immunizations are offered unless medically contraindicated or the resident is currently immunized. (III) If the resident is not vaccinated, the medical record must reflect the reason, such as medical contraindication or refusal. This State Rule and Regulation is not met as evidenced by: Based on resident record review, staff interview, and policy and procedure review, the facility failed to implement their influenza and pneumococcal	S5007	**S5007-** Resident #1, resident #2, resident #3, resident #4, resident #5, resident #6, resident #7 and resident #8 all received updated TB tests on 11/17/25. These have all been checked with in the 48–72-hour period and uploaded into their electronic health chart and into their paper chart as well. The Clinical Services Director will complete a chart audit of all residents and their vaccination status. They will request vaccination records from resident's PCPs. If the resident is missing any vaccinations per the policy and state regulations for admission, Aspen Wind will make arrangements for the resident to receive these vaccines. If the resident refuses or cannot receive the vaccine due to health issues, they will be educated, and it will be charted in their EMR with the reason they cannot receive the vaccine. The Clinical Services Director has also requested access to Wyoming Immunization Registry (WyIR). The facility will continue to offer yearly vaccine clinic to residents offering Flu, Covid and RSV.	

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S5007	Continued From page 8 immunization policy for 8 of 8 sample residents (#1, #2, #3, #4, #5, #6, #7 #8) reviewed. The facility failed to implement their tuberculosis (TB) screening policy for 6 of 8 sample residents (#1, #2, #3, #5, #7, #8) reviewed. In addition, the facility failed to have a health care provider history and physical completed within 90 days prior to admission for 1 of 8 sample residents (#7) reviewed. The findings were: 1. Review of the record for resident #1 showed s/he was admitted to the facility on 7/17/25. Review of the resident's 7/17/25 admission assessment and 8/21/25 30-day assessment showed the resident's vaccination status was unknown. There was no evidence a tuberculin test had been performed. 2. Review of the record for resident #2 showed s/he was admitted to the facility on 10/17/24. Review of the resident's 10/18/24 admission assessment and 11/29/24 30-day assessment showed the resident's vaccination status was unknown. A tuberculin test was performed on 10/25/24 (8 days post admission). No further documentation was available. 3. Review of the record for resident #3 showed s/he was admitted to the facility on 3/19/24. Review of the resident's 7/31/25 master care plan showed a tuberculin test was performed on 6/9/25; however, the resident's record failed to show a TB test had been performed prior to admission. Review of the resident's 3/20/24 admission assessment, 4/30/24 30-day assessment, and 5/5/25 annual assessment showed the resident's vaccination status was unknown. 4. Review of the record for resident #4 showed	S5007	Resident #7's admit orders, history and prior to admission assessment were located in a paper file the former ACSD had. The paperwork was uploaded into residents EMR on 12/1/2025.Moving forward, the CSD will use the facility's Admissions Checklist, complete their portion, and then forward the checklist to the AED, who will complete their section. The checklist will then be reviewed by the Executive Director for final verification to ensure the admission process is fully completed. All new admissions will also be reviewed weekly times 3 months, monthly times 3 months then quarterly times 6 months during the Quality Assurance review conducted by the Executive Director and the Clinical Services Director. Any missing prior to admissions pieces will be reported to the QA committee immediately. QA committee will track results and update compliance log. ED, AED and CSD have been educated on this process by regional nursing director.	

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S5007	Continued From page 9 s/he was admitted to the facility on 8/12/19. Review of the resident's vaccination history showed no evidence the resident had received or been offered an influenza vaccine in 2022 or in 2024 There was no evidence the resident had been offered or received a pneumococcal vaccine since admission 5. Review of the record for resident #5 showed s/he was admitted to the facility on 12/30/24 and was administered the tuberculin skin test on 12/30/24 Review of the resident's 12/30/24 admission assessment and the 2/20/25 assessment showed the resident's vaccination status was unknown. 6 Review of the record for resident #6 showed s/he was admitted to the facility on 5/15/25, discharged to the hospital on 6/13/25, and readmitted to the facility on 9/24/25. Review of the 5/15/25 admission assessment and the 9/24/25 admission assessment showed the resident's vaccination status was unknown 7. Review of the record for resident #7 showed s/he was admitted to the facility on 3/3/25 Review of the resident's 7/31/25 master care plan showed a tuberculin test was performed on 6/9/25, however, the resident's record failed to show a TB test had been performed prior to admission Review of the resident's 3/5/25 admission assessment and the 4/23/25 clinical update assessment showed the resident's vaccination status was unknown In addition, the resident's record failed to include a health care provider history and physical 8. Review of the record for resident #8 showed s/he was admitted to the facility on 1/6/25 Review of the 5/16/25 master care plan showed a	S5007		

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S5007	Continued From page 10	S5007		

tuberculin test was performed on 6/9/25 however, the resident's record failed to show a TB test had been performed prior to admission Review of the 2/20/25 clinical update assessment showed the resident's vaccination status was unknown

9 Interview with the ED on 10/10/25 at 1 27 PM confirmed no further information was available

10. Review of facility policy and procedures showed the following

a Review of the "Admission Policy-Assisted Living/Independent Living" policy and procedure showed " c Admission Process 1 Upon admission, the resident and or responsible party complete, sign, and/or review the following c Other consents/authorizations/releases, i Immunization "

b Review of the "TB Screening Wyoming Resident and Employment" policy and procedure showed " All residents and employees should have a patient TB risk assessment, symptom evaluation, and TB test performed prior to admission to the community . "

c Review of the "Immunization" policy showed "With the licensed Nurse or Executive Director (if applicable), health services staff is responsible to establish and manage processes in the Community for infection control according to all regulations that apply Staff and residents must meet designated testing and immunization requirements related to infectious diseases Executive Directors and/or Clinical Services Directors are responsible for arranging vaccination clinics for their community. The community shall identify and fulfill the regulations that apply for resident and staff infectious disease vaccinations As regulations require, the community shall offer or coordinate with an

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S5007	Continued From page 11 outside provider for resident vaccinations and shall maintain related documentation in the electronic health record. the community shall determine resident's vaccination status at time of admission After admission, the community shall coordinate for residents to receive vaccinations as required or requested Appropriate consent (and/or refusal if required) must be obtained from resident, resident's representative, or staff member "	S5007		
S5020	Ch 12 Sec 7 (e) Assisted Living Facility (ALF) Core Services (e) Resident Records and Reports Each resident's records shall be current, organized and maintained in individual folders which shall be made available to the resident, the Licensing Division, or designated representative upon request (i) Each folder shall include the following (A) Information from the referring agent, if applicable. (B) History and physical performed by a physician or physician extender; (C) Individual admission form This form 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	S5020	**S5020-** The Executive Director will work closely with the Clinical Services Director to make sure all investigations are reported to state in allotted time. The Executive Director will perform audits on all investigations to make sure it contains all the appropriate information and was submitted on time. A binder will be created by 12/10/25 on abuse reporting with a flow chart on how to report abuse and neglect, all staff will trained on how to use this binder. All staff were trained on abuse and neglect reporting on 9/10/25. The binder will be monitored and updated with new information by the Executive Director.	12/10/2025

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STREET ADDRESS, CITY, STATE, ZIP CODE: 4010 NORTH COLLEGE DRIVE, CHEYENNE, WY 82001

(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
S5020	Continued From page 12	S5020		

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 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.

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Healthcare Licensing and Surveys

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S5020	Continued From page 13 (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 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,	S5020		

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S5020	Continued From page 14 (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 This State Rule and Regulation is not met as evidenced by: Based on review of the facility's abuse investigation forms, State Survey Agency incident database review, policy and procedure review and staff interview, the facility failed to implement their policy and procedure for ensuring the investigation following an allegation of abuse or neglect was reported to the Licensing Division in a timely manner for 2 of 4 allegations of	S5020		

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S5020	Continued From page 15 abuse/neglect reviewed The findings were: 1 Review of the "Abuse Prevention, Intervention, Reporting and Investigation" policy showed " ..D. Investigation. 10 Investigative findings should be reported to the Executive Director (or designee) and others as may be required by state and local laws within the required time frame " The following concerns were identified: a Review of the facility's investigation report showed an allegation of neglect was reported to have occurred on 8/16/25 at 7:15 AM and was reported to the state survey agency on 8/18/25 at 2:44 PM; however, the results of the investigation were not reported to the state agency until 9/23/25 b Review of the facility's investigation report showed an allegation of resident-to-resident sexual abuse was reported to have occurred on 8/21/25 at 3 PM and was reported to the state survey agency on 8/22/25 at 2:44 PM, however, the results of the investigation were not reported to the state agency until 8/29/25 c Interview with the ED on 10/10/25 at 1:20 PM confirmed the investigations were not reported within 5 business days as required.	S5020		
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	S5024		

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S5024	Continued From page 16 (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 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 record review, staff and resident representative interview, policy and procedure review, and review of the state licensing division incident report forms and the facility's investigation documentation, the facility failed to protect the resident's right to be free from	S5024		

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S5024	Continued From page 17 sexual abuse by another resident for 1 of 2 residents reviewed for abuse (#2) and free from neglect for 1 of 1 resident reviewed for neglect (#9). The findings were: 1. Review of the facility's investigation related to the allegation of sexual abuse of resident #2 by resident #10 a. Review of the facility's investigation documentation showed resident #10 was walking down the hall holding resident #2's hand on 6/21/25 at 6:40 PM. CNA #4 and LPN #2 called for resident #2 to return to the dining room, however, resident #10 had him/her blocked against the wall. CNA #4 "ran down to where they were at the end of the hall near [resident #10's room]" and noted resident #10's hands were under resident #2's shirt. CNA #4 separated the residents and ensured resident #2's safety. CNA #4 was unavailable for an interview. b. Interview with resident #2's representative on 10/10/25 at 8:43 AM confirmed the resident had been involved in an incident where another resident had placed his/her hands up the resident's shirt. The resident's representative stated if the resident had been cognitively intact s/he "would never have let it happen." c. Interview with LPN #2 on 10/10/25 at 8:46 AM revealed he observed resident #10 walking down the hallway with resident #2 when resident #10 turned resident #2 towards the wall. LPN #2 stated he hurried down the hall and found resident #10 kissing resident #2 with his/her hands up resident #2's shirt. Further, LPN #2 stated the facility was aware of resident #10's inappropriate sexual behaviors upon admission and had instigated behavioral charting. d. Review of the 4/18/25 admission assessment for resident #10 showed the resident was admitted to the memory care unit, was	S5024	S5024-Resdient #10 was transferred to another facility that can provide a higher level of care. Resident #9 no longer resides here. Currently, no other residents exhibit sexually inappropriate behavior. More in-depth Abuse and neglect education was provided to staff in September, and 30-minute checks were initiated. The staff receive abuse and neglect training every January. All room checks are signed off on in a binder organized by resident, room number and date. Each room check is signed off by the CNA preforming the 30-minute check. All staff are required to wear a care predict tempo that track their movement within the building. All staff have been trained on the 30-minute room check and the tempo system as well. Clinical Services Director and Assistant Executive Director will work together to put together a "reporting abuse and neglect" binder for staff, containing step by step instructions on what steps to take when reporting abuse and neglect. This binder will be completed by 12/20/25. All 30-minute checks and tempo usage will also be reviewed weekly times 3 months, monthly times 3 months then quarterly times 6 months during the Quality Assurance review conducted by the Executive Director and the Clinical Services Director. Any discrepancies will be reported to the QA committee immediately. QA committee will track results and update compliance log.	12/20/2025

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prescribed 25 milligrams of Seroquel (antipsychotic medication) at bedtime; and 2 milligrams of Haldol (antipsychotic medication), as needed, 3 times per day; had a diagnosis of frontotemporal dementia, was "currently addicted to online pornography and has been having inappropriate relations with individuals for money." The resident's representative confiscated resident #10's phone upon admission. Review of the resident's record showed the facility began monitoring the resident for sexually inappropriate behavior on 7/9/25.

d. Interview with the ED on 10/10/25 at 9:45 AM revealed the facility was aware of resident #10's inappropriate sexual tendencies upon admission, however, Seroquel (antipsychotic medication) was added to his/her drug regimen upon admission and they thought they could handle the situation. After the incident the facility had initiated 30-minute room checks, increased supervision, provided education to staff members, and kept the resident's doors locked at all times. Resident #10 was discharged to a higher level of care on 10/6/25.

2. Review of the facility's investigation related to the allegation of neglect of resident #9

a. Review of an 8/16/25 nurse note entered by RN #2 showed "Nurse was notified at approximately 0720 that resident had sustained a fall in [his/her] apartment. CMA (certified medication aide) went into resident's apartment to give ...morning medications and found [him/her] sitting on the floor in the doorway of the bedroom and living room. Resident was wearing a t-shirt and brief. Brief was completely saturated with urine and feces with BM on the carpet as well. Resident stated 'I've been down here since 10 o'clock last night.' Staff assisted resident up off the floor. Resident complained of dizziness but

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S5024	Continued From page 19 denied pain, headache, or vision changes. ROM (range of motion) intact and at baseline. CNA helped resident to bathroom and assisted with shower. Resident was tearful, at 10.40 AM the nurse was notified by the CNA the resident's blood pressure was 86/52. The nurse reviewed post fall vitals and blood pressure's trending down. Resident also has a small area of breakdown on inner left buttocks. No bleeding noted. Advised staff to encourage increased fluid intake" At 11:15 AM the resident's representative called the facility and requested the resident be sent to the emergency department for further evaluation. The resident left the facility with emergency services at 11:36 AM. b. Review of an 8/16/25 nurse note entered by RN #3 showed "Resident noted on floor at 0715. Tempo (a tracking and monitoring device) did not detect fall, setting on "high", increased to "very high". Unclear if [resident] is able to understand use of Tempo. Was able to demonstrate use when asked "how do you use your watch" and [s/he] stated 'I should have used it last night'. It appeared that [the resident] was trying to get to the bathroom as [s/he] had a mess of loose stool around [him/her]. [The resident] was seated in the doorway between [his/her] bedroom and living room (opposite direction from the bathroom) with [his/her] back against the corner of the entryway nearest the closet, feet pointed into living room. Resident states [s/he] had been on the floor since 10pm. [The resident] also stated [s/he] got up to use the bathroom and tripped on [his/her] way back. Room Traffic Report from Care Predict shows no trips to in-suite bathroom in the previous 24 hours. Per same Tempo report, staff were last in [his/her] room at 2100 (9 PM) until located in AM.." b. Review of the facility's investigation showed CNA #3 signed the 30-minute safety	S5024		

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check form stating the resident was in his/her room from 10 PM on Friday until 6 AM on Saturday, however the facility was unable to verify the whereabouts of the CNA through the Tempo staff monitoring system

c. Interview with the resident's representative on 10/10/25 at 8:55 AM revealed she was not notified of the resident's fall until approximately 11 AM when the facility called to ask for Imodium because the resident had loose bowels The facility told her the facility had not called immediately because they wanted to investigate the incident to determine what actually had happened before informing her Further, the resident's representative revealed she had requested the resident be sent to the emergency department because the resident's blood pressure was dropping The resident was admitted to the hospital and then was discharged to a long-term care facility The resident's representative stated she felt the fall and lack of care had caused an "immense" decline in the resident's cognition and the resident's ambulation was now "non-existent"

d Interview with the ED on 10/10/25 at 9:45 AM revealed it was the facility's expectation residents be checked on every 30 minutes In addition, the ED stated CNA #3 signed off on the 30-minute log sheet as to where the resident was however, CNA #3 was not wearing her Tempo device so the facility was not able to verify her location in the facility The ED terminated CNA #3, provided education to staff through mandatory in-services, and increased supervision of the secure units to ensure the 30-minutes checks were being completed

3 Review of the "Abuse Prevention, Intervention, Reporting and Investigation" policy showed "Residents are to be free from verbal, sexual,

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S5024	Continued From page 21 physical, emotional/mental abuse, neglect, self-abuse/self-neglect, medical neglect, misappropriation of resident property, exploitation, and involuntary seclusion at all times. .Sexual abuse is defined as, but is not limited to, sexual harassment, sexual coercion, or sexual assault. Neglect is defined as failure to provide goods and services necessary to avoid physical harm mental anguish or mental illness "	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, review of facility documentation, staff interview, and review of the 2022 FDA Food Code, the facility failed to ensure a sanitary environment in 1 of 1 kitchen The census was 61. The findings were: 1 Observation of the kitchen on 10/8/25 at 10.33 AM showed the following concerns. a. A maintenance sticker on the side of the ice machine showed the ice machine had last been serviced on 6/10/25. A sign on the ice	S5026	**S5026**- The ice machine filter was cleaned; Ecolab was called out to perform maintenance on the dishwasher on 10/17/25. According to the manufacturer, the dishwasher located in the kitchen area is a low temp dishwasher that sanitizes at a temp of 100 degrees Fahrenheit in addition to the chemicals running in the dishwasher cycles. The other thermometers were calibrated by the Dining Services Director; they perform this task weekly. Staff education was provided to kitchen personal from the Dining Services Director and Executive Director related to proper hand hygiene and usage and allowing dishware to air dry. The Dining Services Director, the Executive Director and/or the Assistant Executive Director will perform weekly kitchen walk-throughs checking for cleanliness, maintenance issues and food code compliance starting 11/25/25. The Executive Director will audit the kitchen walk through forms every quarter.	11/25/2025

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machine stated "clean air filter-twice a month." Further observation showed the exterior air vents and the screen filter behind the air vents were covered with grease and debris. Interview with the DSD on 10/8/25 at 10:48 AM confirmed the ice machine's clean air filter required cleaning.

b. Observation of the automatic dishwasher showed a data plate which stated the minimum temperature of the water for both rinsing and washing was 120 degrees Fahrenheit. Review of the dish machine sanitization and temperature log sheet for October 2025 showed no temperature was logged for 10/1/25 and the temperature of the water was recorded as being 100 degrees Fahrenheit from 10/2/25 through 10/7/25 on each of the breakfast, lunch, and dinner entries. Review of the sanitation and temperature log sheets for September 2025 showed the temperature of the water was not recorded on 9/30/25, and was documented as being below 120 degrees Fahrenheit from 9/1/25 through 9/29/25 for each of the breakfast entries. Interview with the DSD on 10/8/25 at 10:53 AM confirmed the temperatures recorded were not within range.

2. Observation on 10/9/25 at 9:41 AM showed cook #1 was wearing gloves and cleaning the counter with a sanitizing cloth and gathering needed supplies for the noon meal. The cook doffed his gloves and without performing hand hygiene donned new gloves and performed various tasks throughout the kitchen before placing slices of bread on a pan to prepare sandwiches. Without doffing his gloves, the cook left the preparation of sandwiches and again performed tasks throughout the kitchen. With the same gloved hands, the cook returned to the sandwiches and added cheese, roast beef, and onions to the bread. The cook continued in this

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same manner preparing 4 pans of sandwiches until 10:17 AM when he doffed his gloves, emptied the garbage, and washed his hands. Interview with the cook at this time revealed he was expected to wash his hands every 15 minutes. Interview with the DSD at this time revealed it was his expectation gloves be doffed and hands washed when changing tasks.

3. Observation on 10/9/25 at 10:17 AM showed the DSD was drying plates with a cloth towel after the dishes came out of the dishwasher and was stacking them on a cart. Interview with the DSD at this time revealed he dried the plates because he did not want to stack the dishes while they were still wet to prevent bacterial growth.

4. According to the 2022 FDA Food Code showed "2-301.14 When to Wash FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using TOBACCO PRODUCTS, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and

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working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD, and (I) After engaging in other activities that contaminate the hands."

5. According to the 2022 FDA Food Code showed "4-703.11 Hot Water and Chemical. Efficacious sanitization depends on warewashing being conducted within certain parameters. Time is a parameter applicable to both chemical and hot water sanitization. The time hot water or chemicals contact utensils or food-contact surfaces must be sufficient to destroy pathogens that may remain on surfaces after cleaning. Other parameters, such as rinse pressure, temperature, and chemical concentration are used in combination with time to achieve sanitization. The actual temperatures and rinse pressure should be consistent with the machine manufacturer's operating instructions and within limits specified in §§ 4-501.112 and 4-501.113. If either the temperature or pressure of the final rinse spray is higher than the specified upper limit, spray droplets may disperse and begin to vaporize resulting in less heat delivery to utensil surfaces. Temperatures below the specified limit will not convey the needed heat to surfaces. Pressures below the specified limit will result in incomplete coverage of the heat-conveying sanitizing rinse across utensil surfaces."

6. According to the 2022 FDA Food Code showed "4-602.11 Equipment Food-Contact Surfaces and Utensils. Surfaces of utensils and equipment contacting food that is not time/temperature control for safety food such as iced tea dispensers, carbonated beverage dispenser nozzles, beverage dispensing circuits or lines, water vending equipment, coffee bean grinders, ice makers, and ice bins must be cleaned on a

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF006	A. BUILDING ______ B. WING ______	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN WIND ASSISTED LIVING COMMUNITY	4010 NORTH COLLEGE DRIVE CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5026	Continued From page 25 routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms. Some equipment manufacturers and industry associations, e.g., within the tea industry, develop guidelines for regular cleaning and sanitizing of equipment. If the manufacturer does not provide cleaning specifications for food-contact surfaces of equipment that are not readily visible, the person in charge should develop a cleaning regimen that is based on the soil that may accumulate in those particular items of equipment." 7. According to the 2022 FDA Food Code showed "4-901.11 Equipment and Utensils, Air-Drying Required. Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils."	S5026		
S5041	Ch 12 Sec 7 (I) Assisted Living Facility (ALF) Core Services (I) Quality Improvement. (i) The facility shall have an active quality improvement program to ensure effective utilization and delivery of resident care services. (A) A member of the facility's staff shall be designated to coordinate the quality improvement program. (B) The quality improvement program	S5041	**S5041**-QA self-assessment was completed on 11/18/2025 and will be turned in annually hereafter. The Executive Director was educated on Quality Improvement. QAPI team will be put into place by 12/15/25. The QAPI team will be headed by the Executive Director and they will monitor all systems put in place.	12/15/2025

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S5041	Continued From page 26	S5041		

shall encompass a review of all services and programs provided for all residents the program shall have

(I) A written description,

(II) Problem areas identified

(III) Monitor identification,

(IV) Frequency of monitoring.

(V) A provision requiring the facility to complete annually a self-assessment survey of compliance with the regulations, and

(VI) A satisfaction survey shall be provided to the resident, resident's family or resident's responsible party at least annually

(C) Problems identified during the annual survey or the quality improvement process shall be addressed with appropriate written corrective actions

(D) The quality improvement program shall be re-evaluated at least annually

This State Rule and Regulation is not met as evidenced by
Based on review of facility documentation and staff interview, the facility failed to complete a self-assessment survey of compliance with the regulations on an annual basis The census was 61 The findings were:

1 Review of the facility's documentation showed no evidence a self-assessment survey of

Healthcare Licensing and Surveys

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	ALF006	A. BUILDING: ______ B. WING ______	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN WIND ASSISTED LIVING COMMUNITY	4010 NORTH COLLEGE DRIVE CHEYENNE, WY 82001

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S5041	Continued From page 27 compliance with the regulations had been completed. 2. Interview with the ED on 10/10/25 at 1:20 PM revealed the quality assurance committee met on a monthly basis and discussed various topics and developed a performance improvement plan if needed; however, the ED was unable to locate documentation a self-assessment survey of compliance with the state rules had been completed.	S5041		
S5048	Ch 12 Sec 9 (a)(i) Contractual Svcs Provided Outside ALF Auth (a) Residents in an assisted living facility may receive services from an outside entity for care beyond that provided for or specified in the Assisted Living Program Administration Rules. These services must be arranged by the appropriate professional and be incorporated into the resident's assistance plan. The resident's choice of providers must be honored. (i) Components of the outside service(s) contract. (A) Who will provide service(s); (B) What service(s) will be provided; (C) When the service(s) will be provided; (D) Where the service(s) will be provided; (E) How the service(s) will be provided; and	S5048	S5048- An outside services agreement was obtained for resident #4. A resident chart audit for all residents who are on outside services will be completed by 12/15/25. Any residents who are missing outside services agreements will be reported to the Clinical Services Director and the agreements will be obtained. Going forward the Clinical Services Director and all Licensed Staff will be monitoring when a resident starts with a new outside service provider, at which point an outside services agreement will be obtained. All residents who utilize outside services, their charts will be reviewed weekly times 3 months, monthly times 3 months then quarterly times 6 months during the Quality Assurance review conducted by the Executive Director and the Clinical Services Director. Any discrepancies will be reported to the QA committee immediately. QA committee will track results and update compliance log.	12/15/2025

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	ALF006	A. BUILDING _____ B. WING _____	10/10/2025

NAME OF PROVIDER OR SUPPLIER: ASPEN WIND ASSISTED LIVING COMMUNITY

STREET ADDRESS, CITY, STATE, ZIP CODE: 4010 NORTH COLLEGE DRIVE, CHEYENNE, WY 82001

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S5048	Continued From page 28	S5048		

This State Rule and Regulation is not met as evidenced by:
Based on observation, resident record review, staff interview, and policy and procedure review, the facility failed to ensure a service contract was developed which included all required components for 1 of 3 sample residents (#4) reviewed who received services from an outside entity. The findings were:

1. Observation on 10/8/25 at 11:43 AM showed a sign posted in the room of resident #4 with instructions for the facility from a hospice provider.

2. Review of nursing notes dated 6/14/25, 7/21/25, 8/18/25, and 9/10/25 showed the hospice provider had been notified of dysuria, an unwitnessed fall, and medication changes.

3. Interview with the ED on 10/10/25 at 1:27 PM confirmed a contract with the hospice provide had not been completed.

4. Review of the "Outside Health Care Agency" policy and procedure showed "To meet resident needs, Clinical Services should coordinate with health care agencies outside the Community including those related to home health (physical therapy, occupational therapy, mental health, speech therapy, etc.), hospice care and private duty attendants. The Community can support use of providers only if they meet the policy requirements stated below... 3. Before any service begins, complete and secure signatures for the form Outside Health Care Agency Service Acknowledgment. According to instruction on the form, the Community representative who signs can be only the Executive Director, Registered Nurse, or Nurse Consultant."

Healthcare Licensing and Surveys

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S5060	Ch 4 Sec 5 (j)(e) Licensure (j) (E) The Assisted Living Facility shall post the survey results in a manner conducive for public view. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to post the state licensure survey results in a manner conducive for public view. The census was 61. The findings were: 1. Observation of the facility on 10/8/25 at 10 AM showed no evidence the state licensure survey results were available for public view. 2. Interview with the ED on 10/10/25 at 9:43 AM revealed she was unaware of the state rule	S5060	**S5060**-The 2025 survey binder was placed in the library area which is accessible to resident, staff and visitors on 11/11/25. The Executive Director and/ or the Assistant Executive Director will be the ones monitoring and keeping this binder up to date. Staff education will be provided during next staff meeting 11/24/25 about keeping the binder in a public place.	11/11/2025

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