

PRINTED: 02/17/2026
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/04/2026
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN PLAZA ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 4154 TALON DRIVE CASPER, WY 82604
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S 000	<p>OPENING COMMENTS</p> <p>Rules and Regulations utilized for this survey are:</p> <p>Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020.</p> <p>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 2/3/26 through 2/4/26. Also reviewed in the course of the survey were complaint intakes LIC-25-065 and LIC-26-021.</p> <p>The following common abbreviations are used throughout this document:</p> <p>CNA: Certified Nursing Assistant DON: Director of Nursing ED: Executive Director LPN: Licensed Practical Nurse RN: Registered Nurse</p> <p>Less commonly used abbreviations will be annotated in each deficiency.</p>	S 000		
S5002	<p>Ch 12 Sec 6 (c) Personnel and Staffing Requirements</p> <p>(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.</p> <p>This State Rule and Regulation is not met as</p>	S5002		

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Kenye Brown 2/25/26 Admin (X6) DATE

The plan of correction received on 3/5/26 was accepted on 3/6/26. Kenye Brown was notified via email on 3/6/26 at 2:56 pm.

Jamie Jannis
3/6/26

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S5002	Continued From page 1 evidenced by: Based on review of personnel records, staff interview, and policy and procedure review, the facility failed to ensure the required background checks were completed prior to direct resident contact for 1 of 6 sample employees (RN #1) reviewed. The findings were: 1. Review of the personnel file for RN #1 showed she was hired on 8/15/25. There was no evidence a Department of Family Services (DFS) Central Registry Screening had been completed. 2. Interview with the ED on 2/3/26 at 12:14 PM confirmed the DFS Central Registry Screening had not been completed as required. 3. Review of the "Abuse and Neglect Policy", last reviewed 5/19/25, showed "Mountain Plaza Assisted Living will conduct pre-employment screening for each potential employee to ensure they have no prior history of abuse/neglect related arrests or complaints. The screening will include DCI [Department of Criminal Investigation] background assessments with fingerprinting; Central Registry screening...and reference checks."	S5002		
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		

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S5003	<p>Continued From page 2 for residents and personnel;</p> <p>(ii) Require tuberculin testing, or screening as appropriate; and</p> <p>(iii) Prohibit any person with an airborne, contagious, or infectious disease from being employed until a work release is obtained.</p> <p>(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.</p> <p>(B) The facility shall require staff to follow universal precautions when performing direct resident care.</p> <p>This State Rule and Regulation is not met as evidenced by: Based on personnel file review, policy and procedure review, staff interview, and review of professional standards, the facility failed to ensure 6 of 6 sample employees reviewed (transportation aide #1, housekeeper #1, CNA #1, CNA #2, RN #1, LPN #1) were tested for tuberculosis (TB) upon hire as required, and 3 of 7 employees (transportation aide #1, housekeeper #1, CNA #1) were tested or screened annually. The findings were:</p> <ol style="list-style-type: none"> 1. Review of the personnel file for transportation aide #1 showed he was hired on 8/25/23. There was no evidence transportation aide #1 was tested for TB upon hire. Further review showed a TB test was performed on 5/30/25; however, there was no evidence the transportation aide was tested or screened for TB in 2024. 2. Review of the personnel file for housekeeper 	S5003		
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S5003	<p>Continued From page 3</p> <p>#1 showed she was hired on 3/16/18. There was no evidence housekeeper #1 was tested for TB upon hire. Further review showed a TB test was performed on 2/8/20; however, there was no evidence the housekeeper was tested or screened for TB in 2019, 2021, 2022, 2023, 2024, or 2025.</p> <p>3. Review of the personnel file for CNA #1 showed she was hired on 2/2/23. There was no evidence CNA #1 was tested for TB upon hire. Further review showed the CNA had a chest x-ray on 5/19/25; however, there was no evidence the CNA was tested or screened for TB in 2024.</p> <p>4. Review of the personnel file for CNA #2 showed he was hired on 8/14/25. The CNA was not tested for TB until 9/30/25.</p> <p>5. Review of the personnel file for RN #1 showed she was hired on 8/15/25. The RN was not tested for TB until 10/7/25.</p> <p>6. Review of the personnel file for LPN #1 showed she was hired on 12/4/25. The LPN was not tested for TB until 1/16/26.</p> <p>7. Interview with the ED and DON on 2/4/26 at 4:38 PM confirmed no further documentation was available.</p> <p>8. Review of the "Infection Control, Employee Health, including Tuberculin Testing and Communicable Disease Information" policy, last reviewed 5/8/25, showed "PREREQUISITES" Mountain Plaza Assisted Living adheres to the policy of the Center for Disease Control and Prevention (CDC) when considering the time of testing. Every employee and volunteer shall have a negative Tuberculosis (TB) test or a certificate</p>	S5003		
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S5003	Continued From page 4 of non-infectiousness and/or documentation of appropriate treatment if need, or a negative chest x-ray...PROCEDURE Written policies shall 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." 9. Review of the "Wyoming Communicable Disease Tuberculosis Program Guidance for Long Term Care and Other Residential Facilities" retrieved on 2/6/26 from https://health.wyo.gov/wp-content/uploads/2023/11/11.20.2023-Guidance-LTC-Residential-Facilities.pdf showed "...Employees The facility should complete a Facility TB Risk Assessment initially and on an annual basis to determine how often facility staff should be screened for TB infection... Upon hire (i.e., preplacement) and prior to their first day of work, employees should receive a patient TB risk assessment, symptom evaluation, and tuberculin skin test (TST) or interferon gamma release assay (IGRA) blood test in accordance with current CDC guidance for health care personnel. Current employees should receive a patient TB risk assessment and symptom evaluation annually and as needed based on risk since the last patient TB risk assessment. The employee should be TB tested in accordance with the annual TB Facility Risk Assessment results and if the employee has new risk factors for TB infection since their last patient TB risk assessment."	S5003		
S5005	Ch 12 Sec 7 (a) Assisted Living Facility (ALF) Core Services (a) The assisted living facility core services include the following:	S5005		

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S5005	<p>Continued From page 5</p> <p>(i) Meals, housekeeping, personal and other laundry services;</p> <p>(A) Provision of mechanically altered diets and dietary supplements, if required.</p> <p>(ii) A safe and clean environment;</p> <p>(iii) Assistance with local transportation;</p> <p>(iv) Assistance with obtaining medical, dental, and optometric care, in addition to social services;</p> <p>(v) Assistance in adjusting to group living activities;</p> <p>(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;</p> <p>(vii) Provision of appropriate recreational activities in/out of the assisted living facility;</p> <p>(viii) Care of individuals who require any or all of the following services:</p> <p>(A) Partial assistance with personal care, e.g. bathing, shampoos;</p> <p>(B) Limited assistance with dressing;</p> <p>(C) Minor non-sterile dressing changes;</p> <p>(D) Stage I skin care - skin integrity intact;</p>	S5005		

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S5005	<p>Continued From page 6</p> <p>(E) Infrequent assistance with mobility. The resident may use an assistive device; e.g., wheel chair, walker, cane;</p> <p>(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;</p> <p>(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;</p> <p>(H) Care of the resident incontinent of bowel or bladder if the condition can be managed independently;</p> <p>(ix) Assessments completed by a Registered Nurse;</p> <p>(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;</p> <p>(x) Twenty-four (24) hour monitoring of each resident.</p> <p>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 6 of 7 sample residents (#1, #2, #3, #4, #5, #6) reviewed for medications. The findings were:</p>	S5005		

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S5005	Continued From page 7 1. Review of the records for resident #1, #2, #3, #4, #5, and #6 showed no evidence a RN had conducted a medication review every 62 days as required. 2. Interview with the DON on 2/4/26 at 9:41 AM revealed she was new to the position and was unaware of the requirement. 3. Review of the "Medications, Medication Assistance, Self-medication and Medication Administration" policy and procedure, last reviewed 5/9/25, showed "...A registered nurse will review medication every two months or 62 days or whenever a new medication is prescribed, or a current medication is changed."	S5005		
S5006	Ch 12 Sec 7 (b)(i) Assisted Living Facility (ALF) Core Services (b) Resident Assessment and Services, The staff/contract Registered Nurse (RN) shall conduct initial and, at the minimum annually, and accurate, standardized, reproducible assessment of each resident's functional capacity, physical assessment and medication review. (i) The completion of the ALF 102. (A) The current version of the ALF 102 is the designated screening tool. The form may be updated and /or revised periodically by the Program Division. Providers will be notified of changes in the form. The following guidelines apply to the ALF 102: (I) The ALF 102 is only valid if completed within forty-five (45) days prior to admission and there is no change in the	S5006		

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S5006	<p>Continued From page 8</p> <p>resident's condition.</p> <p>(II) The ALF 102 must be completed and signed by an RN.</p> <p>(III) The ALF 102 may be completed telephonically; however, it must be verified in person by an RN.</p> <p>(IV) A new ALF 102 shall be completed at least annually, and when there is a change in the resident's condition.</p> <p>This State Rule and Regulation is not met as evidenced by: Based on review of resident records, staff interview, and review of policy and procedure, the facility failed to conduct an assessment of each resident's functional capacity, physical assessment, and medication review (ALF 102) on an annual basis and/or with a resident's change of condition for 4 of 7 sample residents (#2, #3, #4 #5) reviewed. The findings were:</p> <p>1. Review of the record for resident #2 showed s/he was admitted to the facility on 4/8/25 with an admission ALF 102 completed on 3/11/25. Further review showed the resident was transferred to the memory care unit on 6/16/25. There was no evidence a ALF-102 had been completed at the time of the resident's transfer to the memory care unit.</p> <p>2. Review of the record for resident #3 showed an admission ALF-102 was completed on 3/4/22, and an annual ALF-102 was completed on 4/24/23 and 7/28/25. There was no evidence an ALF 102 had been completed in 2024.</p>	S5006		

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S5006	<p>Continued From page 9</p> <p>3. Review of the record for resident #4 showed an admission ALF 102 was completed on 1/29/25. Further review of the resident's record showed s/he had a fall on 2/20/25 and on 2/26/25 which resulted in the resident becoming wheelchair bound. There was no evidence an ALF 102 had been completed after the resident's change of condition.</p> <p>4. Review of the record for resident #5 showed an admission ALF 102 was completed on 4/11/23, and a follow-up ALF 102 was completed on 4/19/23. There was no evidence an annual ALF-102 was completed until 10/16/24 (18 months).</p> <p>5. Interview with the DON on 2/4/26 at 9:14 AM confirmed no further documentation could be located.</p> <p>6. Review of the "Level 2 Resident Placement Assessments and other Assessments" policy, last reviewed 5/23/25, showed "A registered nurse (RN or other with RN sign-off) will conduct an initial assessment, and at minimum, an annual assessment (ALF 102). An accurate, standardized, reproducible assessment of each resident's functional capacity, medication review and physical assessment will be conducted per year, unless indicated more often by the resident's medical condition(s)."</p>	S5006		
S5007	<p>Ch 12 Sec 7 (b)(ii) Assisted Living Facility (ALF) Core Services</p> <p>(b) (ii) Admission orders. A resident shall be admitted only if accompanied by a history and physical completed by a physician or physician</p>	S5007		

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S5007	<p>Continued From page 10</p> <p>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.</p> <p>(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:</p> <p>(I) Residents, or their legal representative are educated regarding the risks and benefits of these immunizations.</p> <p>(II) The immunizations are offered unless medically contraindicated or the resident is currently immunized.</p> <p>(III) If the resident is not vaccinated, the medical record must reflect the reason, such as medical contraindication or refusal.</p> <p>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 healthcare provider history and physical completed within 90 days prior to admission for 1 of 7 sample residents (#7) reviewed; failed to ensure testing for tuberculosis was completed prior to admission for 1 of 7 sample residents (#3); and failed to ensure residents were educated and offered immunizations for 4 of 7 sample residents (#1, #2, #4, #6) reviewed. The findings were:</p>	S5007		

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S5007	<p>Continued From page 11</p> <ol style="list-style-type: none"> 1. Review of the record for resident #1 showed s/he was admitted to the facility on 8/19/25 and had signed a consent form to receive the influenza vaccination on 8/20/25. There was no evidence the resident had received the vaccination. 2. Review of the record for resident #2 showed the resident had a move-in date of 4/8/25 and s/he had signed a consent form to receive the pneumococcal and influenza vaccination on 3/19/25. There was no evidence the resident had received the vaccinations. 3. Review of the record for resident #3 showed the resident had a move-in date of 3/26/22. There was no evidence the resident had been tested for tuberculosis prior to admission. 4. Review of the record for resident #4 showed a move-in date of 2/11/25 and s/he had signed a consent form to receive the influenza vaccination on 1/30/25. There was no evidence of the resident had received the vaccination. 5. Review of the record for resident #6 showed a move-in date of 2/28/24. Further review showed unsigned and undated consent forms for both the influenza and pneumococcal vaccinations. There was no evidence the resident's immunization status. 6. Review of the record for resident #7 showed a move-in date of 12/8/25. Further review showed no evidence a healthcare provider's history and physical had been completed prior to admission. 7. Interview with the DON on 2/4/26 at 9:14 AM confirmed no further documentation was available. 	S5007		

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S5007	Continued From page 12 8. Review of the "Level 1 Admission and Discharge Criteria (Transfer and Discharge) policy, last reviewed 5/19/25, showed "...3. Physician's orders (NP and PAC acceptable) and History and Physical (within the last 90 days) have been received. Physician orders should include orders for TB Screening, influenza and pneumococcal immunization status and orders for immunization if required, unless contraindicated. a. If residents are unsure about the risks and benefits of immunizations, they should contact their referring physician. b. Immunizations are offered within the community on an annual basis and may be offered semi-annually if needed. c. If the resident is not vaccinated, the medical record should reflect the reason..." 9. Review of the "Level 2 Resident Placement Assessments and other Assessments" policy, last reviewed 5/23/25, showed "...TB screening, influenza and pneumococcal vaccines, and orders for immunizations as needed, will accompany the resident on admission. Vaccines and TB screening will be provided by Home Health Agency or resident's physician. If the resident declines immunizations, the medical record must reflect the reason, as such with refused medications."	S5007		
S5009	Ch 12 Sec 7 (b)(iv) Assisted Living Facility (ALF) Core Services (b) (iv) Frequency of assessment. An assessment must be conducted: (A) No earlier than one (1) week prior to admission;	S5009		

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN PLAZA ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 4154 TALON DRIVE CASPER, WY 82604
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(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
S5009	<p>Continued From page 13</p> <p>(B) Immediately upon any significant change in the resident's mental or physical condition; or</p> <p>(C) No less than once every twelve (12) months.</p> <p>This State Rule and Regulation is not met as evidenced by: Based on resident record review, staff interview, review of the policy and procedure, and review of the "Resident Handbook", the facility failed to complete a resident assessment immediately upon any significant change in the resident's mental or physical condition and/or no less than every 12 months for 2 of 7 sample residents (#2, #5) reviewed. The findings were:</p> <ol style="list-style-type: none"> 1. Review of the record for resident #2 showed s/he had a move-in date of 4/8/25. Further review showed the resident was transferred to the memory care unit on 6/16/25. There was no evidence a RN had assessed the resident following the resident's change of condition. 2. Review of the record for resident #5 showed s/he had a move-in date of 4/11/23. Further review showed the resident was transferred to the memory care unit on 2/3/25. There was no evidence a RN had assessed the resident following the resident's change of condition. In addition, there was no evidence an assessment had been completed by a RN in 2024. 3. Interview with the DON on 2/4/26 at 9:14 AM revealed no further documentation was available. 4. Review of the "Level 1 Admission and Discharge Criteria (Transfer and Discharge) 	S5009		

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2026
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S5009	Continued From page 14 policy, last reviewed, 5/19/25, showed "...The Nursing Staff implements the Resident Assistance Plan...Re-assessment to be initiated immediately upon any significant change in the resident's mental or physical condition and no less than every 12 months." 5. Review of the "Resident Handbook" showed "...A comprehensive care assessment is performed during the initial move-in period, thirty (30) days after move-in, and annually thereafter and/or as needed so that we may determine your care needs and preferences. The information obtained during the assessment is used to develop a personalized Plan of Care in cooperation with you, others representing you and key care staff at Mountain Plaza..."	S5009		
S5012	Ch 12 Sec 7 (b)(vii) Assisted Living Facility (ALF) Core Services (b) (vii) The assistance plan shall be reviewed and updated by the RN at least annually or when a significant change occurs, with input from direct care-givers, the resident, and others as designated by the resident. This State Rule and Regulation is not met as evidenced by: Based on resident record review, staff interview, review of policy and procedure, and review of the "Resident Handbook", the facility failed to ensure a RN reviewed and updated the resident's assistance plan at least annually or when a significant change occurred for 2 of 7 sample residents (#2, #7) reviewed. The findings were: 1. Review of the record for resident #2 showed s/he had a move-in date of 4/8/25. Further review	S5012		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER MOUNTAIN PLAZA ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 4154 TALON DRIVE CASPER, WY 82604		
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S5012	Continued From page 15 showed the resident was transferred to the memory care unit on 6/16/25. There was no evidence a RN had assessed the resident and updated the resident assistance plan following the resident's change of condition. 2. Review of the record for resident #5 showed s/he had a move-in date of 4/11/23. Further review showed the resident was transferred to the memory care unit on 2/3/25. There was no evidence a RN had assessed the resident and updated the resident's assistance plan following the resident's change of condition. 3. Interview with the DON on 2/4/26 at 9:14 AM revealed no further documentation was available. 4. Review of the "Level 1 Admission and Discharge Criteria (Transfer and Discharge) policy, last reviewed, 5/19/25, showed "...The Nursing Staff implements the Resident Assistance Plan...Re-assessment to be initiated immediately upon any significant change in the resident's mental or physical condition and no less than every 12 months." 5. Review of the "Resident Handbook" showed "...A comprehensive care assessment is performed during the initial move-in period, thirty (30) days after move-in, and annually thereafter and/or as needed so that we may determine your care needs and preferences. The information obtained during the assessment is used to develop a personalized Plan of Care in cooperation with you, others representing you and key care staff at Mountain Plaza..."	S5012			
S5020	Ch 12 Sec 7 (e) Assisted Living Facility (ALF) Core Services	S5020			

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S5020	<p>Continued From page 16</p> <p>(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.</p> <p>(i) Each folder shall include the following:</p> <p>(A) Information from the referring agent, if applicable;</p> <p>(B) History and physical performed by a physician or physician extender;</p> <p>(C) Individual admission form. This form shall, at a minimum, contain the following information:</p> <p>(I) Full name of resident and former address;</p> <p>(II) Date of admission;</p> <p>(III) Sex, race, date of birth, social security number, and former occupation;</p> <p>(IV) Name, home address, and telephone number of relative, friend, Power of Attorney, or guardian;</p> <p>(V) Name, address, and telephone number of resident's personal physician, dentist, ophthalmologist or optometrist;</p> <p>(VI) Medicare number or other medical insurance identifying data;</p>	S5020		
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S5020	<p>Continued From page 17</p> <p>(VII) A written inventory of all personal possessions; however, this inventory need not include personal clothing;</p> <p>(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;</p> <p>(E) An accounting of all personal funds deposited with and disbursed by the facility;</p> <p>(I) Upon written authorization of a client, the facility must hold, safeguard, manage and account for the personal funds of the client.</p> <p>(1.) The facility must deposit any personal funds in the excess of \$100 in an interest bearing account.</p> <p>(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.</p>	S5020		
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Healthcare Licensing and Surveys

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S5020	<p>Continued From page 18</p> <p>(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.</p> <p>(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.</p> <p>(F) A signed copy of the resident's rights;</p> <p>(G) The resident's assessment and individualized assistance plan;</p> <p>(H) Copies of al applicable resident assistance contracts, signed by both parties;</p> <p>(I) Written acknowledgment of the receipt and explanation of all facility policies including admission/discharge policies;</p> <p>(J) Copy of all ALF 102's; and</p> <p>(K) Copy of outside contractual responsibilities, if applicable.</p> <p>(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.</p> <p>(iii) All residents' records shall be retained in</p>	S5020		
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Healthcare Licensing and Surveys

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S5020	<p>Continued From page 19</p> <p>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.</p> <p>(iv) In the event of dissolution of the facility, the manager shall notify the Licensing Division as to the location of all residents' records.</p> <p>(v) All records shall be protected from damage by fire, water and other hazards.</p> <p>(vi) All entries in each resident's record shall be made in ink, signed and dated.</p> <p>This State Rule and Regulation is not met as evidenced by: Based on review of resident records, State Survey Agency incident database review, and staff interview, the facility failed to ensure the residents' record included a written inventory of the residents' personal possessions, with the exception of personal clothing, for 6 of 7 sample residents (#1, #2, #4, #5, #6, #7) reviewed; in addition the facility failed to report to the Licensing Division 2 of 9 incidents (which affected resident #5) reviewed which affected the health, welfare, or safety of residents. The findings were:</p> <p>1. Review of the resident record for resident #1, #2, #4, #5, #6, and #7 showed no evidence a written inventory of the residents' belongings had been obtained.</p> <p>2. Review of the resident record for resident #5 showed an incident report, dated 2/23/24, which showed "Resident was found lying on [his/her] bathroom floor at approx 4:15 PM. [The resident]</p>	S5020		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2026	
NAME OF PROVIDER OR SUPPLIER MOUNTAIN PLAZA ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 4154 TALON DRIVE CASPER, WY 82604		
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S5020	Continued From page 20 had vomited on [his/her] bathroom floor and does not remember falling unsure if resident hit head. EMS was called and resident was transported by ambulance to the hospital." The incident report was marked as not being reported to the state. Further review showed an incident report, dated 6/12/25, which showed "Resident noted on floor beside toilet. Bleeding from laceration to eyebrow above R [right] eye. Transported to [the hospital] received 4 stitches." Further review of the incident report showed the section "For Wellness Director Use Only", which included a section on if the incident had been reported to the state, was left blank. 3. Review of the state survey agency incident data base showed no evidence the incidents had been reported as required. 4. Interview with the ED on 2/4/26 at 10:11 AM confirmed the incidents had not been reported to the state agency. In addition, the ED was unable to locate a policy and procedure related to reporting incidents which affected the health, welfare, and safety of a resident.	S5020		
S5042	Ch 12 Sec 7 (m) Assisted Living Facility (ALF) Core Services (m) Facility Policies and Procedures. (i) Management shall develop policies and procedures that are available to residents and staff, including but not limited to: (A) Resident rights; (B) Disciplinary procedures surrounding substantiated cases of resident abuse;	S5042		

Healthcare Licensing and Surveys

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S5042	<p>Continued From page 21</p> <p>(C) Admission, transfer, bed hold days, and discharge of residents;</p> <p>(D) Medication management;</p> <p>(E) Emergency care of residents (including missing resident, blizzard, water outage, etc.);</p> <p>(F) Fire/disaster plan;</p> <p>(G) Departure and return;</p> <p>(H) Smoking;</p> <p>(I) Visiting hours;</p> <p>(J) Activities;</p> <p>(K) Management of resident trust accounts;</p> <p>(L) Personnel policies;</p> <p>(M) Grievance procedure;</p> <p>(N) Per Diem rate/charges/fees, to include a listing of what is included in the established charges;</p> <p>(O) Incident reports;</p> <p>(P) Notification of change in established per diem rate/charges/fees;</p> <p>(Q) Outside contractual responsibilities;</p> <p>and</p>	S5042		
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Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2026
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S5042	Continued From page 22 (R) Identification and notification of change in resident's condition. This State Rule and Regulation is not met as evidenced by: Based on review of policies and procedures and staff interview, the facility failed to develop 1 of 18 required policies and procedures. The findings were: 1. Review of the facility's policy and procedures failed to include a policy related to incident reports. 2. Interview with the ED on 2/4/26 at 4:27 PM confirmed a policy related to incident reports could not be located.	S5042		
S5054	Ch 12 Sec 10 (a)(iii) Secure Dementia Units (a) (iii) Level 2 Direct Care Staff. In addition to meeting all other requirements for direct care staff stated in this Chapter, assisted living Level 2 direct care staff must receive additional documented training in: (A) The facility or units philosophy and approaches to providing care and supervision or persons with severe cognitive impairments; (B) The skills necessary to care for, intervene, and direct residents who are unable to independently perform activities of daily living; (C) Techniques for minimizing challenging behaviors; (I) Wandering;	S5054		

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S5054	Continued From page 23 (II) Hallucinations, illusions, and delusions; and (III) Impairments of senses; (D) Therapeutic programming to support the highest level of residents function including: (I) Large motor activity; (II) Small motor activity; (III) Appropriate level cognitive tasks; and (IV) Social/emotional stimulation; (E) Promoting residents dignity, independence, individuality, privacy, and choice; (F) Identifying and alleviating safety risks to residents; (G) Recognizing common side effects and reactions to medications; (H) Techniques for dealing with bowel and bladder aberrant behavior. (I) At least one staff member with this specialized training must be available on the unit at all times to provide supervision and care to the residents, as well as to assist the residents in evacuation of the facility. (J) Staff must have at least twelve (12) hours of continuing education annually related to care of persons with dementia.	S5054		

Healthcare Licensing and Surveys

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S5054	<p>Continued From page 24</p> <p>This State Rule and Regulation is not met as evidenced by: Based on review of personnel records, staff interview, and policy and procedure review, the facility failed to ensure 3 of 7 sample Level 2 direct care staff employees (CNA #3, RN #2, DON) received the required 12 hours of continuing education related to care of persons with dementia on an annual basis. The census of the memory care unit was 11. The findings were:</p> <ol style="list-style-type: none"> Review of the direct care staff continuing education credits for 2025 showed the following concerns: <ol style="list-style-type: none"> CNA #3 completed 9.75 hours of continuing education credit. RN #2 completed 8.25 hours of continuing education credit. The DON completed 8.25 hours of continuing education credit. Interview with the ED on 2/4/26 at 4:27 PM revealed no further documentation could be located. Review of the policy and procedure "Level 2 Direct Care Staff Requirements", last reviewed 5/23/25, showed "...Staff of the Memory Care Unit will complete twelve (12) hours of continuing education annually specifically related to the care of its residents with early stages of dementia." 	S5054		
S5060	<p>Ch 4 Sec 5 (j)(e) Licensure</p> <p>(j) (E) The Assisted Living Facility shall post the survey results in a manner conducive for public view.</p> <p>This State Rule and Regulation is not met as</p>	S5060		

Healthcare Licensing and Surveys

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S5060	Continued From page 25 evidenced by: Based on observation and staff interview, the facility failed to post the state licensure survey results in a manner conducive to public view. The census was 54. The findings were: 1. Observation of the facility on 2/3/26 showed no evidence the state licensure survey results were available for public view. 2. Interview with the ED on 2/3/26 at 2:40 PM revealed the survey results binder was kept in a cupboard in her office.	S5060		
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PLAN OF CORRECTION – 02/25/2026

Mountain Plaza Assisted Living
4154 Talon Drive
Casper, WY 82604
Inspection Date: 02/04/2026



S5002 – Ch 12 Sec 6 (c) Personnel and Staffing Requirements

Deficiency 1: Employee background check was missing.

Responsibility: Office Manager

Corrective Action: The Office Manager will ensure all new employees have completed background checks in the employee file prior to direct resident contact. A new employee checklist will be developed to track the receipt and completion all employee-related documents. The State of Wyoming’s Chapter 12 Rules and Regulations pertaining to background checks and Mountain Plaza Assisted Abuse and Neglect Policy were reviewed by the Office Manager and Administrator for training and educational purposes. The item above was added to the Quality Assurance Review to be included in the quality assurance process.

- RN #1’s background check was submitted to the Central Registry on 2/16/24. A follow-up email was sent to the State of Wyoming Central Registry 3/3/26 to inquire the status of the background and a return email on 3/4/26 stated it was in process.

Identification of Others: A full audit of employee files will be completed to identify any other missing background checks and any deficiencies identified will be corrected.

Completion Date: by 4/1/26

accepted 3/6/26
Jean Jennis

PLAN OF CORRECTION – 02/25/2026

Mountain Plaza Assisted Living
4154 Talon Drive
Casper, WY 82604
Inspection Date: 02/04/2026

S5003 – Ch 12 Sec 6 (d) Personnel and Staffing Requirements

Deficiency 2: Tuberculin testing upon hire and annual tuberculin risk assessments missing.

Responsibility: Director of Nursing, and Office Manager

Corrective Action: The Director of Nursing and Office Manager will ensure all TB tests have been completed prior to the first day of actual work for new employees and subsequent annual risk assessments are completed for all current employees. A new Tuberculosis testing policy will be developed based on the State of Wyoming’s document titled “Wyoming Communicable Disease Tuberculosis Program Guidance for Long Term Care and Other Residential Facilities.” All current employees will complete the “Patient Tuberculosis Risk Assessment” form. The new policy will be distributed to the team for educational purposes and the State of Wyoming Chapter 12 Rules and Regulations section 6 (d) pertaining to personnel and staffing requirements was reviewed. TB testing and annual TB risk assessments was added to the Quality Assurance Review form and will be included in the quality assurance process.

- Transportation aide #1 – completed Patient Tuberculosis Risk Assessment on 2/18/26
- Housekeeper #1 - completed Patient Tuberculosis Risk Assessment on 2/18/26
- CNA #1 - completed Patient Tuberculosis Risk Assessment on 2/19/26
- CNA #2 – no longer employed with MPAL
- RN #1 - completed Patient Tuberculosis Risk Assessment in progress
- LPN #1 - completed Patient Tuberculosis Risk Assessment on 2/18/26

Identification of Others: A full audit of employee files will be completed to identify any other missing TB tests and any deficiencies identified will be corrected.

Completion Date: by 4/1/26

accepted 3/6/26
Jeanne Jennie

PLAN OF CORRECTION – 02/25/2026

Mountain Plaza Assisted Living
4154 Talon Drive
Casper, WY 82604
Inspection Date: 02/04/2026

S5005 – Ch 12 Sec 7 (a) ALF Core Services

Deficiency 3: 62-day medication reviews were not completed.

Responsibility: Director of Nursing

Corrective Action: The Director of Nursing will ensure all 62-day medication reviews are completed every 62 days, whenever there is a medication change, and/or when a new medication is added. The 62-day medication review will be completed on all residents to bring each resident's file up to date. The State of Wyoming Chapter 12 Rules and Regulations pertaining to 62-day medication reviews and MPAL's policy titled "Medications, Medication Assistance, Self-Medication and Medication Administration" were reviewed for employee training and education about the requirements for 62-day medication reviews. The Quality Assurance Review form was updated with a specific section for 62-day medication reviews as part of the quality assurance program.

- Resident #1 - 62-day medication review completed on 3/5/25
- Resident #2 - 62-day medication review completed on 2/19/26
- Resident #3 - 62-day medication review completed on 2/6/26
- Resident #4 - 62-day medication review completed on 2/9/26
- Resident #5 - 62-day medication review completed on 2/6/26
- Resident #6 - 62-day medication review completed on 2/5/26

Identification of Others: 62-day medication reviews will be completed on all residents to ensure all resident files are up to date.

Completion Date: by 4/1/26

accepted 3/6/26
Jenn Yarnie

PLAN OF CORRECTION – 02/25/2026

Mountain Plaza Assisted Living
4154 Talon Drive
Casper, WY 82604
Inspection Date: 02/04/2026

S5006 – Ch 12 Sec 7 (b)(i) ALF Core Services

Deficiency 4: After residents' change of condition, the ALF 102 was not completed.

Responsibility: Director of Nursing

Corrective Action: The Director of Nursing will ensure the ALF 102 is completed for the resident upon admission, change of condition, and annually. The State of Wyoming Chapter 12 Rules and Regulations section pertaining to resident assessments and services was reviewed along with MPAL's policy titled "Level 2 Resident Placement Assessments and Other Assessments" for training and educational purposes. The task was added to the Quality Assurance Review document as part of the quality assurance process.

- Resident #2 – ALF 102 completed on 3/5/26
- Resident #3 – ALF 102 completed on 7/28/25
- Resident #4 – ALF 102 completed on 1/29/25
- Resident #5 - ALF 102 completed on 3/4/26

Identification of Others: A complete audit of all resident files will be completed to identify any other missing ALF 102 forms.

Completion Date: by 4/1/26

Accepted 3/6/26
Jean Yonnie

PLAN OF CORRECTION – 02/25/2026

Mountain Plaza Assisted Living
4154 Talon Drive
Casper, WY 82604
Inspection Date: 02/04/2026

S5007 – Ch 12 Sec 7 (b)(ii) ALF Core Services

Deficiency 5: One missing history and physical, one missing TB test, and did not educate/offer immunizations outside of MPAL’s annual immunization clinic.

Responsibility: Administrator and Director of Nursing

Corrective Action: The Director of Nursing will ensure the following documents/information is present in all resident medical files: physician history and physical, TB test, and proof of vaccination/vaccination education. The influenza and pneumococcal vaccination consent forms will be revised to include additional educational material pertaining to the importance of vaccinations, along with the recommendation for residents to see their primary care physician for immunizations outside of the annual MPAL vaccination clinic. The above documents have been added to the Quality Assurance Review form as part of the quality assurance process.

- Resident #1 – influenza vaccination on 9/30/24, refusal 9/2025
- Resident #2 – received covid shot 9/23/25 but family refused all other vaccinations for personal preference
- Resident #3 – TB test in progress
- Resident #4 – refused flu shot 9/23/25, received pneumonia shot 5/6/25
- Resident #6 – refused vaccinations secondary to being on hospice services.
- Resident #7 – the H&P was received 2/11/26

Identification of Others: A full audit of all resident charts will be completed to identify any additional missing documents and any deficiencies found will be corrected.

Completion Date: by 4/1/26

Accepted 3/6/26
Jean Yanni

PLAN OF CORRECTION – 02/25/2026

Mountain Plaza Assisted Living
4154 Talon Drive
Casper, WY 82604
Inspection Date: 02/04/2026

S5009 – Ch 12 Sec 7 (b)(iv) ALF Core Services

Deficiency 6: Missing change of condition assessments for two residents that transferred to Memory Care (frequency of assessment).

Responsibility: Director of Nursing

Corrective Action: The Director of Nursing will ensure all residents have a nurse assessment upon move-in, change of condition, and annually. The State of Wyoming Chapter 12 Rules and Regulations pertaining to the frequency of assessments and the Level 1 Admission and Discharge Criteria policy were reviewed for training and educational purposes. The Quality Assurance Review form was updated as part of the quality assurance process.

- Resident #2 – updated assessment was completed on 2/16/26
- Resident #5 - updated assessment was completed on 6/4/24, 12/4/24, and 12/16/25

Identification of Others: A full resident chart audit will be completed to identify any other change of conditions that require a new ALF 102 assessment and any deficiencies noted at the time will be corrected.

Completion Date: by 4/1/26

Accepted 3/6/26
Jenna Yennie

PLAN OF CORRECTION – 02/25/2026

Mountain Plaza Assisted Living
4154 Talon Drive
Casper, WY 82604
Inspection Date: 02/04/2026

S5012 – Ch 12 Sec 7 (b)(vii) ALF Core Services

Deficiency 7: Missing plan of care due to change of condition for two residents that transferred to Memory Care.

Responsibility: Director of Nursing

Corrective Action: The Director of Nursing will ensure that the resident's plan of care is updated upon any change of condition and annually. The State of Wyoming Chapter 12 Rules and Regulations Section 7 and the Level 1 Admission and Discharge Criteria policy were reviewed for training and educational purposes. The Quality Assurance Review form was updated as part of the quality assurance process.

- Resident #2 – updated plan of care was completed on 2/16/26
- Resident #5 - updated plan of care was completed on 6/4/24, 12/4/24, and 12/16/25

Identification of Others: A full resident chart audit will be completed to identify any other change of conditions or annual assessments missing and any deficiencies noted at the time will be corrected.

Completion Date: by 4/1/26

Accepted 3/16/26
Jean Yarnin

PLAN OF CORRECTION – 02/25/2026

Mountain Plaza Assisted Living
4154 Talon Drive
Casper, WY 82604
Inspection Date: 02/04/2026

S5020 – Ch 12 Sec 7 (e) ALF Core Services

Deficiency 8: Missing written inventories of personal possessions; two incident reports not reported to the state.

Responsibility: Administrator and Director of Nursing

Corrective Action: An incident reporting policy with reporting matrix will be created to clarify what incident reports are required to be reported to the State of Wyoming. The Administrator and Director of Nursing will ensure the required incidents are reported as directed by the new policy. Chapter 12, section 7(e) was reviewed for training and educational purposes.

The Director of Nursing will ensure all new residents have a completed inventory of personal possessions located in their medical file. The State of Wyoming Chapter 12 Rules and Regulations Section 7 was reviewed for training and educational purposes.

- Resident #5 incident report created for incident 2/23/24 in progress
- Resident #5 incident report created for incident 6/12/25 in progress
- Resident #1 – working on completed inventory
- Resident #2- completed inventory on 2/17/26
- Resident #4 - working on completed inventory
- Resident #5 - completed inventory on 2/11/26
- Resident #6 – working on completed inventory

Identification of Others: A full resident chart audit will be completed to identify any other missing resident inventory forms and any deficiencies noted at the time will be corrected.

Completion Date: by 4/1/26

Accepted 3/6/26
Jean Jennie

PLAN OF CORRECTION – 02/25/2026

Mountain Plaza Assisted Living
4154 Talon Drive
Casper, WY 82604
Inspection Date: 02/04/2026

S5042 – Ch 12 Sec 7 (m) ALF Core Services

Deficiency 9: Failed to have an incident report policy.

Responsibility: Administrator and Director of Nursing

Corrective Action: An incident reporting policy with reporting matrix will be created to clarify what incident reports are required to be reported to the State of Wyoming. The Administrator and Director of Nursing will ensure the required incidents are reported as directed by the new policy. Chapter 12, section 7(e) was reviewed for training and educational purposes. A section was added to the Quality Assurance Review form to add to the quality assurance process.

Identification of Others: An audit of the past 30 days of incident reports will be completed and any deficiencies identified will be corrected.

Completion Date: by 4/1/26

Accepted 3/6/26
Jill Yarnie

PLAN OF CORRECTION – 02/25/2026

Mountain Plaza Assisted Living
4154 Talon Drive
Casper, WY 82604
Inspection Date: 02/04/2026

S5054 – Ch 12 Sec 10 (a)(iii) Secure Dementia Units

Deficiency 10: Failed to ensure memory care direct care staff had 12 hours of education (Employee 1 had 9.75, Employee 2 had 8.25 and Employee 3 had 8.25 hours.)

Responsibility: Administrator, Director of Nursing, Office Manager

Corrective Action: The Administrator, Director of Nursing, and/or Office Manager will ensure direct care staff in memory care complete 12 hours of continuing education annually. Chapter 12, Section 10 and the policy Level 2 Direct Care Staff Requirements were reviewed for training and educational purposes. A line was added to the Quality Assurance Review form to be included in the quality assurance process.

Identification of Others: An audit of all direct care staff working in memory care will be completed to ensure 12 hours of continuing education have been completed.

Completion Date: by 4/1/26

accepted 3/6/26

Jean Yarnis

PLAN OF CORRECTION – 02/25/2026

Mountain Plaza Assisted Living
4154 Talon Drive
Casper, WY 82604
Inspection Date: 02/04/2026

S5060 – Ch 4 Sec 5 (j)(e) Licensure

Deficiency 11: Survey results binder was not in public view.

Responsibility: Administrator

Corrective Action: The Administrator will ensure the state survey results are posted in a manner conducive to public view. Chapter 4 Section 5 was reviewed for training and educational purposes. A 3-ring binder was placed at the front desk, in view of the public, containing past survey results.

Identification of Others: NA

Completion Date: 02/25/2026

Accepted 3/6/26
John Jennie