Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9044	A. BUILDING: _____ B. WING _____	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD CREEK OF CHEYENNE	6800 FAITH DRIVE CHEYENNE, WY 82009

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S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020. Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001. A licensure survey was conducted by Healthcare Licensing and Surveys from 4/21/26 through 4/22/26. Also reviewed in the course of the survey were complaint intakes LIC-24-054, LIC-25-006, and LIC-25-025. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant ED: Executive Director LPN: Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5002	Ch 12 Sec 6 (c) Personnel and Staffing Requirements (c) Background checks. All staff of the assisted living facility shall successfully complete, at minimum, a State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check and a Department of Family Services Central Registry Screening before direct resident contact. This State Rule and Regulation is not met as evidenced by: Based on review of personnel records and staff interview, the facility failed to ensure the required	S5002		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Sundae Clay TITLE ED (X6) DATE 6-8-26

Approved on 6/8/2026 by Jean Yennie MT (ASCP)
Sundae Clay was notified via telephone.
Jean Yennie MT (ASCP) 6/8/26

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S5002	Continued From page 1 background checks were completed prior to direct resident contact for 4 of 5 sample employees (CNA #1, CNA #2, LPN #2, LPN #3) reviewed. The findings were: 1. Review of the personnel file for CNA #1 showed she was hired on 6/11/25. There was no evidence a Department of Family Services Central Registry Screening had been completed. 2. Review of the personnel file for CNA #2 showed she was hired on 11/13/25. Review of the Wyoming Department of Family Services report showed the screening was completed on 3/17/26. 3. Review of the personnel file for LPN #2 showed she was hired on 2/10/26. There was no evidence a Department of Family Services Central Registry Screening had been completed. 4. Review of the personnel file for LPN #3 showed she was hired on 11/13/25. Review of the Wyoming Department of Family Services Central Registry Screening documentation showed the "Date of Authorization of Release" was 3/11/26. There was no evidence of the results of the screen. 5. Interview with the ED on 4/21/26 at 2:08 PM revealed she had completed the Central Registry Screening process; however, had failed to print the results and include them in the employee's personnel files.	S5002		
S5022	Ch 12 Sec 7 (g) Assisted Living Facility (ALF) Core Services (g) Grievance Procedure.	S5022		

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S5022	Continued From page 2 (i) The written grievance procedure shall establish a system of receiving, reviewing, and alleviating concerns, complaints, and allegations of resident rights violations, and poor service provided to include, but not limited to: (A) Resident's method to express and document grievances; (B) Documentation of the provider's response to verbal and written resident grievances; (C) List of agencies, with address and telephone numbers for residents to contact if grievances are not addressed satisfactorily (e.g. State Long Term Care Ombudsman and the Department of Health, Office of Licensing and Surveys); and (D) The facility shall provide written reports of the grievances and resolutions to the Ombudsman and the Licensing Division within ten (10) days after the grievance is filed. (ii) The written grievance procedure shall be posted in a conspicuous place within the facility. This ELEMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the grievance procedure in a conspicuous place within the facility. The census was 15. The findings were: 1. Observation of the facility on 4/21/26 at 9:30 AM showed no evidence grievance procedure was posted in a conspicuous place within the facility. 2. Interview with the ED on 4/22/26 at 11:18 AM	S5022		

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S5022	Continued From page 3 revealed she was unaware of the state rule.	S5022		
S5026	Ch 12 Sec 7 (j)(ii) Assisted Living Facility (ALF) Core Services (j) (ii) There must be an organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome and sanitary in accordance with the rules. The dietetic service must ensure that food prepared in nutritionally adequate in accordance with the Dietary Reference Intakes (DRI) for adults. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, and review of the FDA 2022 food code regulations, the facility failed to ensure food was prepared and distributed under sanitary conditions in 1 of 1 kitchen. The census was 15. The findings were: 1. Observation on 4/21/26 at 9:33 AM showed cook #1 was preparing the noon meal without wearing a hair restraint. Interview with cook #1 at that time revealed she "had never been asked to wear a hair restraint." 2. Observation on 4/22/26 at 8:31 AM showed CNA #1 was in the kitchen preparing and serving the morning meal. CNA #1 was not wearing a hair restraint. 3. Interview with the dietary manager on 4/22/26 at 10:26 AM revealed she had taken the Serv-Safe Food Protection Manager course	S5026		

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S5026	Continued From page 4 which stated hair needed to be pulled back; not loose; and off the shoulders. The dietary manager was not aware of the FDA food code regulation. 4. According to the 2022 FDA Food Code showed "2-402 Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES."	S5026		
S5041	Ch 12 Sec 7 (l) Assisted Living Facility (ALF) Core Services (l) Quality Improvement. (i) The facility shall have an active quality improvement program to ensure effective utilization and delivery of resident care services. (A) A member of the facility's staff shall be designated to coordinate the quality improvement program. (B) The quality improvement program shall encompass a review of all services and programs provided for all residents. the program shall have: (I) A written description; (II) Problem areas identified; (III) Monitor identification;	S5041		

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S5041	Continued From page 5 (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 15. The findings were: 1. Review of the facility's documentation showed no evidence a self-assessment survey of compliance with the regulations had been completed. 2. Interview with the ED on 4/22/26 at 9:30 AM revealed she was unaware of the state rule.	S5041		
S5054	Ch 12 Sec 10 (a)(iii) Secure Dementia Units	S5054		

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S5054	Continued From page 6 (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; (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;	S5054		

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S5054	Continued From page 7 (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. This State Rule and Regulation is not met as evidenced by: Based on review of personnel records and staff interview, the facility failed to ensure 1 of 5 sample employees (LPN #1) reviewed received the required 12 hours of continuing education related to the care of persons with dementia on an annual basis for 1 of 2 years reviewed (2024) The census of the memory care unit was 15. The findings were: 1. Review of the direct care staff continuing education credits for 2024 showed the following concerns: a. LPN #1 completed 3.0 hours of continuing education credit. 2. Interview with the ED on 4/22/26 at 9:30 AM revealed no further documentation could be located.	S5054		

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S5060	Continued From page 8	S5060		
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 15. The findings were: 1. Observation of the facility on 4/21/26 at 9:30 AM showed no evidence the state licensure survey results were available for public view. 2. Interview with the ED on 4/22/26 at 11:18 AM revealed she was unaware of the state rule.	S5060		

Cottonwood Creek of Cheyenne
Plan of Correction for Survey 04/22/2026

S5002

a. All employee files will be audited immediately to verify completion of Wyoming DCI fingerprint background checks and DFS Central Registry screenings prior to direct resident contact. The Administrator or Executive Director will maintain a pre-hire checklist requiring DCI fingerprint and Central Registry clearance before orientation or resident contact. HR files will be audited weekly for 8 weeks, then monthly.

b. All potential employees will have Central Background checks done prior to start of employment.

c. All employees have the potential to be affected.

d. Correction Date: 06/22/2026

S5022

a. The facility grievance procedure has been reviewed and posted in a conspicuous public location within the facility. Residents and responsible parties will be informed of the grievance process, and documentation will be placed in resident records showing the policy was reviewed or explained. Posting will be checked weekly during environmental rounds.

b. All Residents and responsible parties have the potential to be affected.

c. Correction Date 06/22/2026

S5026

a. All kitchen staff and any facility staff entering food preparation areas will wear hair restraints, including hair nets while preparing or serving food. Staff were re-educated on food safety and hair restraint expectations. The Dietary Manager/designee will monitor compliance daily for 4 weeks, then weekly.

b. All staff and residents will be affected.

d. Correction Date 06/22/2026

S5041

a. The facility will complete a Facility Self-Assessment Survey of Compliance and updated the Quality Improvement Plan to address identified areas of noncompliance. The QI plan will be reviewed monthly by leadership, with action items tracked to completion. Results will be documented in QI meeting minutes.

b. All potential residents will be affected.

c. Correction Date 06/22/2026

S5054

a. All staff will complete at least 12 hours of annual continuing education related to care of persons with dementia. Training records were reviewed, missing hours were assigned, and a tracking log was created. The Administrator or Executive Director will audit training monthly to ensure staff remain current.

b. All staff and residents have the potential of being affected.

c. Correction Date 06/22/2026

S5060

a. The facility survey results/licensure survey report will be posted in a conspicuous public location accessible to residents, visitors, and the public. The Administrator and Executive Director will verify the posting location and will include survey posting verification during weekly environmental rounds to ensure continued compliance.

b. All Residents and responsible parties have the potential to be affected.

c. Correction Date 06/22/2026