Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF026	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER TRAIL ASSISTED LIVING	2360 REAGAN AVENUE ROCK SPRINGS, WY 82901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020. Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001. A complaint survey was conducted by Healthcare Licensing and Surveys from 6/9/26 through 6/10/26. The survey was prompted by complaint intakes LIC-25-039, LIC-25-052, LIC-26-051, and LIC-26-058. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant ED: Executive Director RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5047	Ch 12 Sec 8 (a) Services Which Cannot Be Provided By Level 1 (a) The following services cannot be provided: (i) Continuous assistance with transfer and mobility; (ii) Care of the resident who is unable to feed himself independently and/or; monitoring of diet is required; (iii) Total assistance with bathing and dressing;	S5047		

This plan of correction was accepted on 7/1/26. Jeff Smith was notified via telephone on 7/1/26 at 3 PM.

Jean Yennie MT(ASCP) 7/1/26

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(iv) Invasive catheter or ostomy care, such as changing of catheter or irrigation of ostomy;

(v) Care of resident who is on continuous oxygen, if;

(A) Continuous monitoring is required; or

(B) Oxygen is ordered by the physician of physician extender to be titrated based on oxygen saturation levels;

(vi) Care of resident whose wandering jeopardizes the health and safety of the resident;

(vii) Incontinence care by facility staff;

(viii) Wound care requiring sterile dressing changes;

(ix) Stage II skin care and beyond;

(x) Care of the resident with inappropriate social behavior; e.g. frequent aggressive, abusive, or disruptive behavior; and

(xi) Care of resident demonstrating chemical abuse that puts him and/or other at risk;

(xii) Monitoring of acute medical conditions.

This State Rule and Regulation is not met as evidenced by:
Based on observation, resident record review, resident and staff interview, and policy and procedure review, the facility failed to ensure residents which required care beyond the scope of the assisted living rules were discharged to a higher level of care for 1 of 4 sample residents (#1) reviewed. The findings were:

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1. Review of the record for resident #1 showed s/he was admitted to the facility on 2/7/25 and was discharged to the hospital following a 3/24/25 fall which resulted in a pelvis fracture. Following the hospital stay, the resident was admitted to a long-term care facility on 4/4/25 for rehabilitation. Review of the 4/4/25 long-term care admission assessment showed the resident required the extensive assistance of two or more staff members for transfers, bed mobility, and toilet use. The resident had a diagnosis of dementia other than Alzheimer's disease, had a catheter due to urinary retention, was a fall risk, and weighed 111.4 pounds. Review of the 10/31/25 long-term care discharge summary showed the resident refused cares and performed tasks unassisted which was unsafe; refused to get on the toilet for bowel movements; was reluctant to be cleaned up; and required the extensive assistance of two or more staff members for bed mobility, transfers, ambulation, dressing, and bathing. The resident weighed 111.6 pounds on 10/14/25. The resident's diagnoses included chronic pain, chronic kidney disease, iron deficiency anemia, benign prostatic hyperplasia with lower urinary tract symptoms, adult failure to thrive, mild protein-calorie malnutrition, muscle weakness, and unspecified dementia. In addition, the discharge summary stated the resident required home health, physical therapy, occupational therapy (OT), and speech therapy services following discharge. The following concerns were identified:

a. Review of the 10/30/25 resident evaluation showed the resident did not exhibit present or past behavioral issues; required stand-by assist with dressing, grooming, and bathing; had intermittent episodes of incontinence; and required the assistance of one person for

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transferring. The evaluation was signed by the ED.

b. Review of the 10/31/25 service plan, signed by the ED and RN #1, showed the same resident needs as the initial evaluation. Interview with RN #1 on 6/10/26 at 12 PM revealed the ED performed the initial evaluation of residents prior to admission and she prepared the service plan from his evaluation. In addition, RN #1 stated the ED was not a registered nurse. The ED was unavailable for an interview.

c. Review of the 10/28/25 physician admission orders showed the resident was to have weekly weight checks.

d. Review of the 11/24/25 resident evaluation showed the resident was non-compliant and refused care; required physical assistance with dressing and grooming; required two staff members to assist with showers; had intermittent episodes of incontinence with staff assistance required; and required the assistance of one staff member for transfers. The evaluation was signed by the wellness director. Interview with the wellness director on 6/10/26 at 12 PM revealed she initiated the resident evaluations and a RN and the direct care staff assisted with the assessment.

e. Review of 11/4/25 nursing note showed the resident fell out of bed because s/he wanted his/her catheter bag to hang in a lower area on the bed and s/he "tumbled out onto his/her knees." Review of a 12/24/25 nursing note showed the resident refused to have his/her catheter changed by the home health nurse and was physically and verbally aggressive to the home health staff. The resident was sent to the emergency room to have the catheter changed. In addition, the note showed "non compliance with nurse, OT."

f. Review of the 2/3/26 resident evaluation

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showed the resident was non-compliant and refused care; required physical assistance with dressing and grooming; required two staff members to assist with showering; and required the assistance of one staff member for transferring. The evaluation was signed by the ED.

g. Review of the resident's record showed no nursing notes from 1/1/26 through 6/10/26.

h. Review of the refusal of care report from 1/3/26 through 6/10/26 showed the resident refused medications on 1/3, 2/3, 2/8, 2/10, 3/24, 3/24, 3/31, 5/12, 5/17, 5/20, 5/27, 5/29, 5/30, 5/31, 6/2, 6/3, 6/4, 6/5, and 6/6; refused to be weighed on 1/6, 3/3, 3/17, 4/7, 5/26, 6/2, and 6/9; refused bathing on 4/1, 5/17, 5/20, twice on 6/3; and refused to be toileted on 3/5, 5/10, and 5/14. The reason for the refusals were "won't get out of bed to stand on scale", "refused to get out of bed", "resident refused to be changed", "resident does not use the bathroom", and "would not stand."

i Review of the resident's vitals report showed the resident weighed 105.2 pounds on 5/19/26.

j. Review of the resident's record showed the last provider visit was on 2/3/26. There was no evidence the resident's provider had been notified of the resident's refusals and/or weight loss.

k. Interview with CNA #1 on 6/9/26 at 4:17 PM revealed resident #1 was "very difficult, refused everything, and was dependent on staff for transfers." The CNA was concerned about when the resident's right to refuse turned into neglect.

l. Interview with CNA #2 and CNA #3 on 6/10/26 at 8:50 AM revealed resident #1 was not compliant and exhibited verbal and physical behaviors when cares were provided. In addition, the CNAs stated when the resident was transferred s/he would grab onto them because

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s/he was afraid of falling.

m. Review of the 4/21/26 fire drill record showed the resident was unable to evacuate in the required time allowed by the evacuation capability rating of the facility. The section labeled "Comments on the factors that contributed to each individual's inability to evacuate successfully and any corrective actions recommended" was left blank for the resident.

n. Observation of resident #1 on 6/9/26 at 10:20 AM showed the resident's bed was in a semi-upright position with mobility bars on both sides of the bed. The resident was lying on his/her right side in a curved position with his/her head off of the pillow. The resident appeared ungroomed and underweight. A catheter bag was attached to the bed. Interview with the resident, at that time, revealed s/he chose to stay in bed; however, would go out to meals occasionally. An additional observation on 6/10/26 at 8:23 AM showed the resident was in the same position as before and demonstrated how s/he could eat the food on the plate which was located on a table at the right side of the bed. Interview with the resident, at this time, revealed s/he did not like to shower in his/her room because it was "too cold" so the staff would take him/her to the "basement" for showers. In addition, the resident stated s/he did not get out of bed, the CNAs come in and check his/her brief "all the time", and s/he used the rails on the bed to assist with changing positions.

o. Interview with the wellness program director on 6/9/26 at 4:17 PM revealed the resident was "weak" and was a fall risk. An additional interview on 6/10/26 at 10:48 AM revealed the resident was provided a hospital bed with mobility bars by the home health agency. In addition, the wellness program director stated the resident was discharged from therapy services

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due to non-compliance.

p. Interview with the wellness program director and RN #1 on 6/10/26 at 12 PM confirmed the resident required a higher level of care.

2. Review of the Resident Agreement, last revised 12/1/21, showed in Section 3 "PERSONAL ASSISTANCE AND CARE 'RESIDENT SERVICE PLAN OF CARE'...B. In the event you leave the community for any higher care including admission to a hospital or healthcare facility for any reason, or for any period of time, a reassessment will be required prior to your return to the community...Section 7 TRANSFERS FROM APARTMENT A. Transfer for More Appropriate Care: Deer Trail, in which you will reside, is licensed as an Assisted Living Residence by the Wyoming Department of Health and is not designed to provide higher levels of care, such as nursing, or care for serious mental or emotional disorders. You may remain in your Apartment as long as doing so is (1) permitted by applicable licensure laws and fire safety standards, in the judgment of Deer Trail, (2) your care needs and levels of functioning are consistent with those of other residents and with the level of staffing and facilities offered at Deer Trail, and (3) your presence does not create a danger to self or others..."

DEER TRAIL
ASSISTED LIVING
& MEMORY CARE

PLAN OF CORRECTION
Tag S5047 – Services Which Cannot Be Provided by Level 1
Survey Date: June 9–10, 2026
Facility: Deer Trail Assisted Living
Completion Date: July 2, 2026

Corrective Action

Resident #1 will be provided a 30-day notice of discharge to a higher level of care after reassessment on 6/29/2026 confirmed their needs exceeded the Level 1 scope of care. The discharge will include coordination with the receiving facility, transfer of medical information, and documentation of the discharge in the resident record.

Identification of Other Residents with Potential to Be Affected

A review of all residents was completed on 6/29/26. This review included service plans, evaluations, weight records, refusal logs, nursing notes, and mobility/behavioral assessments.

Resident #2 was noted as a resident of concern due to decreased mobility. A dialogue started before the survey visit regarding the ability of Resident #2 to improve after a fall resulted in a fracture to the proximal humerus. Resident #2 moved from Deer Trail to Sage View Care Center for a higher level of care on 6/30/26.

Residents #1 and #2 were the only residents identified as needing higher levels of care.

Systemic Changes to Prevent Recurrence

Admission and Readmission Procedures

- All pre-admission and readmission assessments are now completed wither by an RN or jointly by an RN and Wellness Director.
- A Level-of-Care Screening Tool is in use to ensure residents requiring services prohibited under Ch. 12 Sec. 8(a) are not admitted or readmitted.
- Any resident returning from a hospital stay or skilled care will undergo a reassessment prior to return. A short hospital stay with no change in condition may result in a verbal reassessment with the discharge planners and the nurse on duty.

You're Home

2360 Reagan Ave. Rock Springs, WY 82901
(307)362-0100
deertrailassistedliving.com

This plan of correction was accepted on 7/1/26.
Jean Yanni MT (ASCP) 7/1/26

Service Plan Development

- Service plans are developed from the assessment performed by the RN or jointly by the RN and Wellness Manager and signed by the RN to ensure accuracy.
- Service plans will be updated upon change in condition, including significant weight loss or patterns of refusal of care.

Documentation Standards

- Nursing notes are communicated daily via the Square app for any resident with changes in condition, refusals, or safety concerns. CNAs will continue to chart in Med Right.
- Provider notification will occur for weight loss, repeated refusals, mobility changes, behavioral escalation, or any condition potentially exceeding Level 1 scope.

Staff Training

All direct care staff will be retrained by 7/10/26 on:

- Level 1 scope of care
- Documentation of refusals
- Resident rights vs. neglect thresholds
- Evacuation expectations for residents with mobility limitations

Nurses will be retrained by 7/10/26 on:

- Provider notification requirements
- Transfer criteria for higher level of care

Training will be repeated annually and during new-hire onboarding.

Monitoring to Ensure Ongoing Compliance

A Quality Assurance Monitoring Program has been implemented:

- The RN will review all evaluations and service plans upon move-in, 30-days after move-in, upon change in condition, or annually at least.
- The Wellness Manager and nursing staff will audit refusal logs, weight records, and nursing notes weekly.
- Any resident with three or more refusals in a week, significant weight loss, or increased mobility needs will receive an RN reassessment within 72 hours.
- Monthly QA meetings will review documentation resident needs, and any transfers to higher care.
- Monitoring will continue for three months, then quarterly thereafter.

Completion Date

All corrective actions will be completed by **July 10, 2026**.

Respectfully submitted,

Jeffrey Smith
Executive Director

JS 7/1/26