Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	11/20/2025

RECEIVED
DEC 11 2025
Healthcare Licensing and Surveys

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE CHEYENNE, WY 82009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020. Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001. A complaint survey was conducted by Healthcare Licensing and Surveys on 11/19/25 through 11/20/25. The survey was prompted by complaint intake LIC-26-011.	S 000		
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;	S5020		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jano J. Lovato

TITLE: Executive Director (Interim)

(X6) DATE: 12/10/2025

The plan of correction was accepted on 12/12/25. A voicemail was left with CSD Hannah. The date of correction was changed From 1/20/25 to 1/20/26. ~~on multiple deficiencies~~.

Jean Yennie 12/12/25

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S5020	Continued From page 1 (III) Sex, race, date of birth, social security number, and former occupation; (IV) Name, home address, and telephone number of relative, friend, Power of Attorney, or guardian; (V) Name, address, and telephone number of resident's personal physician, dentist, ophthalmologist or optometrist; (VI) Medicare number or other medical insurance identifying data; (VII) A written inventory of all personal possessions; however, this inventory need not include personal clothing; (D) All accidents, injuries, incidents, illnesses, and allegations of abuse, neglect or exploitation shall be reported to the resident's family or responsible party and be documented in the individual resident records. All such occurrences shall also be reported to the appropriate entity for follow up and resolution. Reports of all incidents affecting the health, welfare of safety of a resident shall be provided to the Licensing Division immediately (within one business day). Reporting shall be done by telephone or fax. The facility's investigation of the incident shall be reported to the Licensing 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	S5020		

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S5020	Continued From page 2 deposited with and disbursed by the facility; (I) Upon written authorization of a client, the facility must hold, safeguard, manage and account for the personal funds of the client. (1.) The facility must deposit any personal funds in the excess of $100 in an interest bearing account. (2.) The facility must establish and maintain a system that assures a full and complete and separate accounting according to generally accepted accounting principles of each resident's personal funds entrusted to the facility. (3.) Upon the death of a resident with personal funds deposited with the facility, the facility must convey, within 30 days, the resident's funds a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. (4.) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid of Medicare except for applicable deductible and coinsurance amounts. (F) A signed copy of the resident's rights; (G) The resident's assessment and 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	S5020		

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S5020	Continued From page 3 including admission/discharge policies; (J) Copy of all ALF 102's; and (K) Copy of outside contractual responsibilities, if applicable. (ii) The resident shall be assured of confidential treatment of all information in the record, and the resident's written consent (or the consent of the guardian) shall be required for the release of information to persons not otherwise authorized for receive it. (iii) All residents' records shall be retained in a physically secure area for a minimum of six (6) years after the resident has left the facility and may be disposed of, by shredding or burning, after that time. (iv) In the event of dissolution of the facility, the manager shall notify the Licensing Division as to the location of all residents' records. (v) All records shall be protected from damage by fire, water and other hazards. (vi) All entries in each resident's record shall be made in ink, signed and dated. 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,	S5020		

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S5020	Continued From page 4 neglect, or incidents which affected the health, welfare, or safety of a resident was reported to the Licensing Division in a timely manner for 6 of 6 incidents reviewed. The findings were: 1. Review of the "Abuse Prevention, Intervention, Reporting and Investigation" policy showed "...D. Investigation...11. The Registered Nurse...provides a written report of the results of the investigation and action taken to the state licensing agency with the (sic) required time frame..." The following concerns were identified: a. Review of an incident which affected the health, welfare, or safety of resident #1 on 7/27/24 was reported to the state survey agency on 7/30/24; however, the results of the investigation were not reported to the state agency. b. Review of an incident which affected the health, welfare, or safety of resident #2 on 6/11/25 was reported to the state survey agency on 6/18/25; however, the results of the investigation were not reported to the state agency. c. Review of an allegation of neglect which affected resident #3 which occurred on 8/28/25 was reported to the state survey agency on 8/29/25; however, the results of the investigation related to the allegation of neglect were not reported to the survey agency. d. Review of an incident which affected the health, welfare, or safety of resident #4 which occurred on 9/18/25 was reported to the state survey agency on 9/25/25; however, the results of the investigation were not reported to the state agency. e. Review of an incident which affected the health, welfare, or safety of resident #2 on 9/19/25 was reported to the state survey agency on 9/23/25; however, the results of the	S5020		

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S5020	Continued From page 5 investigation were not reported to the state agency. f. Review of an incident which affected the health, welfare, or safety of resident #5 which occurred on 9/20/25 was reported to the state survey agency on 9/23/25; however, the results of the investigation were not reported to the state agency. 2. Interview with the clinical service director on 11/20/25 at 9:21 AM revealed it was the responsibility of the assistant clinical service director or the executive director to complete the investigations and submit the results to the state agency.	S5020		

Facility Name:
Sierra Hills Assisted Living Community, 4606 N. College Dr. Cheyenne, WY 82009
Survey Date:
11/20/2025
Tag Number:
{S5020}

Upon receiving the deficiency finding the following will be completed:

All open investigations will be reviewed, completed, and properly documented.

Corrective actions for each investigation will be finalized and implemented.

The incident/incident's that had not been reported to the State will be reported.

How we will identify other residents potentially affected:

A 90-day retrospective audit will be completed on all incident reports and investigations to identify any additional cases where follow-up, documentation or required reporting may have been missed.

Any identified incidents will be reported and/or completed according to state regulations.

To prevent recurrence

A standardized incident & tracking form will be implemented.

All incidents will require:

Documentation and reporting to the state within 24 hours (except over the weekend)

Investigation initiation within 24-72 hours

Completion within 5 days and reported to the state.

Review and sign-off by ED or CSD

Accepted 12/12/25

QAPI

The committee will review all incidents and follow up actions quarterly as well as verify that all state required reporting has been submitted.

Staff training

All Department heads will receive training on:

Wyoming reporting requirements

Internal investigation procedures

Documentation standards

The QAPI process

Accountability

The CSD will track all incidents and ensure deadlines are met

A weekly review by the ED will verify

- All incidents are logged
- Follow-up is complete
- Any required reports have been sent to the State

The ED will conduct a monthly audit of all incident reports and investigations for 3 months then quarterly thereafter.

Audit results will be reviewed by the QAPI committee and documented in meeting minutes

Completion Date

All corrective measures will be fully implemented by 1/20/2026 JY

David J. Lovato Interim Executive Director 12/10/2025

12/12/25