PRINTED: 03/30/2017
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Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF002	A. BUILDING: _____ B. WING _____	C 03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN SQUARE OF CASPER	1950 SOUTH BEVERLY STREET CASPER, WY 82601

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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 12/12/2007 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 3/15/17 through 3/16/17. The survey was prompted by complaint intakes LIC-17-024 and LIC-16-030. The following common abbreviations are used throughout the document: RN: Registered Nurse LPN: Licensed Practical Nurse CNA: Certified Nursing Assistant CSD: Clinical Service Director Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5020	Ch 12 Sec 7 (b)(i)(A) Assisted Living Facility (ALF) Core Services (b) Resident Assessment and Services. The staff/contract Registered Nurse (RN) shall conduct initial and, at a minimum annually, an 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	S5020	S5020 Ch 12 Sec 7 (b)(i)(A) Assisted Living Facility (ALF Core Services *The corrective action(s) that will be accomplished for Residents #11, #20, & #23 who have been identified to be affected by the deficient practice, will be to ensure that new ALF 102 is completed and signed by an RN to accurately reflect the change of condition for these residents. *The corrective action that will be taken to prevent other residents from being affected by the same deficient practice will be to create a form that reflects our Change of Condition policy, which would prompt the completion of a new ALF 102 by the RN. Additionally, an in-service will be held with nursing staff to ensure that they are properly trained on identifying a change of condition. *Measures that will be put into place to ensure that the deficient practice does not recur will be for nursing staff to review Alert Charting and Incident Reports on a daily basis and identify residents who are needing to have a new ALF 102 completed and signed by the RN. *The effectiveness of this practice will be evaluated weekly during the Health Services Review Schedule Audit, which is part of our Quality Assurance program.	~~04.21.17~~ 05.10.17 ~~4.21.17~~ 05.10.17

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jill Tucker — TITLE: Administrator — (X6) DATE: 4/14/17

STATE FORM 6899 MOCZ11 If continuation sheet 1 of 17

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POC accepted. Changes made per JH Tucker, Administrator on 4/25/17 @ 11:35a.m.
Janelle Cox

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S5020	Continued From page 1 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 resident's condition. (II) The ALF 102 must be completed and signed by an RN. (III) The ALF 102 may be completed telephonically; however, it must be verified in person by an RN. (IV) A new ALF 102 shall be completed at least annually, and when there is a change in the resident's condition. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure the Assisted Living Facility (ALF) 102 form was updated and complete after a resident's change of condition for 3 of 9 (#11, #20, #23) sample residents with a change of condition. The findings were: 1. Review of the medical record for resident #11 showed the ALF 102 was last completed on 7/15/16. Further review of the medical record showed the resident had been placed on Hospice care on 12/2/16 and had fallen on 12/27/16, 1/2/17, 2/27/17, and 3/5/17. 2. Review of the medical record for resident #20 showed the ALF 102 was last completed on	S5020		

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S5020	Continued From page 2 8/9/16. Further review of the medical record showed the resident had fallen on 12/22/16, 12/24/16, 1/4/17, 1/15/17, 1/22/17, 2/8/17, and 2/12/17. The fall on 1/22/17 was marked as "serious injury suspected." In addition, the resident was prescribed Keppra (anticonvulsant) 500 milligrams twice daily on 11/23/16 for seizures. 3. Review of the medical record for resident #23 showed the ALF 102 was last completed on 9/2/16. Further review of the medical record showed the resident had fallen on 12/22/16, 1/6/17, 2/15/17, and 2/23/17. The fall on 1/6/17 resulted in an injury which required a hospital evaluation. 4. Interview with the administrator on 3/16/17 at 2:05 PM confirmed new ALF 102 assessments had not been completed after the residents' change of condition.	S5020	S5023 Ch 12 Sec 7. (b)(iv)(A-C) Assisted Living Facility (ALF) Core Services *The corrective action(s) that will be accomplished for Residents #4, #11, #20, & #23 who were identified to be affected by the deficient practice, will be to ensure that a RN assessment will be completed for these residents, which will include the resident's functional capacity, physical assessment, and medication review. *The corrective action that will be taken to prevent other residents from being affected by the same deficient practice will be to create a form that reflects our Change of Condition policy, which would prompt the completion of a new assessment by the RN, as well as update the Service Plan, to ensure that the resident's needs are being met. Additionally, an in-service will be held with nursing staff to ensure that they are properly trained on identifying a change of condition. *Measures that will be put into place to ensure that the deficient practice does not recur will be to do an in-service with nursing staff to properly review Alert Charting and Incident Reports on a daily basis and identify residents who are needing to have a new assessment completed by the RN.	05.01.17 05.10.17 05.01.17
S5023	Ch 12 Sec 7 (b)(iv)(A-C) Assisted Living Facility (ALF) Core Services (b) Resident Assessment and Services. The staff/contract Registered Nurse (RN) shall conduct initial and, at a minimum annually, an accurate, standardized, reproducible assessment of each resident's functional capacity, physical assessment and medication review. (iv) Frequency of assessment. An assessment must be conducted: (A) No earlier than one (1) week prior to admission; (B) Immediately upon any significant	S5023		

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S5023	Continued From page 3 change in the resident's mental or physical condition; or (C) No less than once every twelve (12) months. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure resident assessments were completed to accurately reflect the resident's condition for 4 of 9 sample residents (#4, #11, #20, #23) with a change in condition. The findings were: 1. Review of the ALF 102 assessment completed on 7/15/16 showed the "Significant Medical Conditions" section for resident #11 was left blank. The resident was determined to need "significant assistance or cuing on a regular basis" for dressing and personal grooming, "cannot bathe without total assistance", had "frequent to total incontinence and unable to manage his/her self", was "completely dependent, frequent transfers, frequent position, frequent falls, unable to evacuate building" for mobility and was "acutely ill; able to maintain safely without 24 hour RN assessment, supervision." The following concerns were identified: a. Review of the service plan assessment showed it was last updated on 1/26/16. This assessment determined the resident to be independent with transfers, independent with waking and dressing, independent with all personal care and hygiene, was continent or independent with incontinence care, and required standby assistance with bathing. b. Review of the medical record showed the resident had fallen on 12/27/16, 1/2/17, 2/27/17,	S5023	*The effectiveness of this practice will be evaluated weekly during the Health Services Review Schedule Audit, which is part of our Quality Assurance program.	05.10.17

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S5023	Continued From page 4 and 3/5/17. The last fall risk assessment had been completed on 7/30/15. No evidence the comprehensive assessment was updated to reflect the falls and/or interventions was in the medical record. c. Review of the medical record showed the resident had been admitted into hospice on 12/2/16. No evidence the comprehensive assessment was updated to reflect the change of health status was found in the medical record. d. Review of the 24-hour CNA communication log from 2/15/17 through 2/28/17 (14 days) showed the resident required incontinence care on a daily basis. Further review, showed the resident required assistance with dressing, oral care, and assistance with his/her oxygen. No evidence the comprehensive assessment was updated to reflect the increase in the level of care was found in the medical record. e. Interview on 3/16/17 at 1:45 PM with CNA #1 and CNA #2 revealed the resident was assisted to the toilet every two hours and they provided pericare and assistance with incontinence products. In addition, they revealed the residents had been receiving regular incontinence care since approximately August 2016. f. Interview on 3/16/17 at 2:10 PM with the administrator confirmed the assessments had not been updated after the resident's change of condition. Further, she stated "If it isn't in the chart it wasn't done." 2. Review of the ALF 102 assessment completed on 8/9/16 showed resident #20 was "mobile, but unable to bathe without regular assistance and supervision. Occasional peri-care for hygiene, was "frequent to total incontinence and unable to manage his/her self", was "independently and appropriately able to transfer and/or ambulate	S5023		

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S5023	Continued From page 5 with or without a device", and was "medically stable." The resident's "Assessment and Service Plan" was last updated on 8/9/16. The following concerns were identified: a. Review of the medical record showed the resident had fallen on 12/22/16, 12/24/16, 1/4/17, 1/15/17, 1/22/17, 2/8/17, and 2/12/17. The fall on 1/22/17 was marked as "serious injury suspected." In addition, the resident was prescribed Keppra (anticonvulsant) 500 milligrams twice daily on 11/23/16 for seizures. No evidence the comprehensive assessments were updated to reflect the falls and/or interventions or the change of medical condition was found in the medical record. b. Interview on 3/16/17 at 2:10 PM with the administrator confirmed the assessments had not been updated after the resident's change of condition. Further, she stated "If it isn't in the chart it wasn't done." 3. Review of the ALF 102 assessment completed on 9/2/16 showed resident #23 "cannot bathe without total assistance" and was "able to transfer and/or ambulate with minimal or standby assistance." The following concerns were identified: a. Review of the service plan showed it was last updated on 10/30/15. b. Review of the medical record showed the resident had fallen on 12/22/16, 1/6/17, 2/15/17, and 2/23/17. The fall on 1/6/17 resulted in an injury which required a hospital evaluation. No evidence the comprehensive assessment was updated to reflect the falls and/or interventions were found in the medical record. c. Interview on 3/16/17 at 2:10 PM with the administrator confirmed the assessments had not been updated after the resident's change of condition.	S5023		

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S5023	Continued From page 6 4. Review of the ALF 102 dated 11/17/16 showed resident #4 was "independently and appropriately able to transfer and/or ambulate with or without a device", had "appropriate behavior, well motivated to, and capable of, performing ADLS", and was "medically stable." The following concerns were identified: a. The anticipated admission date on the ALF 102 was 11/30/16, 13 days after the assessment was completed. b. Review of a nurse's note dated 12/3/16 and timed 4:10 PM showed the resident stated s/he was "very depressed." c. Review of a nurse's note dated 12/5/16 and timed 9:50 AM showed the resident was "found" on the bathroom floor. There was no evidence the resident was assessed for a head injury. Further, there was no evidence of follow up assessments to rule out signs or symptoms of a head injury post-fall. d. Review of a nurse's note dated 12/14/16 and timed 12:04 PM showed the resident was "found on the floor" of the bathroom. A neurological assessment was completed at the time of the fall; however, there was no evidence of follow up assessments to rule out signs and symptoms of head injury post-fall. e. Review of a nurse's note dated 2/5/17 and timed 3:22 PM showed the resident was "very aggitated [sic] and anxious" and "threatened to kill [him/herself] multiple times and put [his/her] hands around [his/her] neck trying to strangle [him/herself]." The resident was placed on "suicide precautions" which included 30 minute checks. f. Review of a nurse's note dated 2/9/17 and timed 7:07 PM showed the resident "fell to the floor" because the wheelchair was not locked prior to the transfer.	S5023		

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S5023	Continued From page 7 g. Review of a nurse's note dated 2/20/17 and timed 10:10 AM showed the resident requested assistance to transfer. The CNA assisted the resident to transfer from the wheelchair to the bed and the resident lost his/her footing and "flopped" on the bed. The nurse and CNA lowered the resident to the floor and back onto the bed. h. Review of a nurse's note dated 2/21/17 and timed 1:31 PM showed the resident needed assistance and it took three people to lift him/her and get positioned in the wheelchair. i. Interview with the administrator on 3/16/17 and timed 2:10 PM showed the resident was temporarily discharged to a rehabilitation center related to falls and a need for strengthening. Further, it was revealed that assessments for head injuries should be in the alert charting for residents.	S5023	S5053 Ch 12 Sec 7 (d)(v)(A) Assisted Living Facility (ALF) Core Services (d) Medications *The corrective action(s) that will be accomplished for Resident #31, who was identified to be affected by the deficient practice, will be to ensure that a Medication Variance Error Report is completed to document this error. *The corrective action that will be taken to prevent other residents from being affected by the same deficient practice will be to in-service all nursing staff who will be administering medications to follow prerequisites that are put in place on the MAR, and review the policy for completing Medication Variance Error Report when a med error has been identified.	04.09.17
S5053	Ch 12 Sec 7 (d)(v)(A) Assisted Living Facility (ALF) Core Services (d) Medications. (v) Medication Administration (A) An RN shall be responsible for the supervision and management of all medication administration as required by the Wyoming Nurse Practice Act, and the Wyoming Board of Nursing Rules and Regulations. This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents were free from medication errors for 1 of 2 sample residents (#31) with transdermal	S5053	*Measures that will be put into place to ensure that the deficient practice does not recur, will be for nursing staff to review Alert Charting notes daily to ensure proper documentation of the Medication Error. *The effectiveness of this practice will be evaluated weekly during the Health Services Review Schedule Audit, which is part of our Quality Assurance program.	05.01.17 04.21.17 05.10.17

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S5053	Continued From page 8 medications. The findings were: Review of the nurse charting for resident #31 dated 8/17/16 and timed 1:23 PM showed "Family member was showering res (resident) this am (morning) and found an exelon patch from the 12th and the one from the 16th, stated they were next to eachother [sic], there is a prerequisite in place, so it has to be charted that it was removed prior to putting a new one on." Review of the subsequent nurse charting showed the next 2 notes were dated 8/18/16 and 9/6/16 and no evidence of monitoring for side effects of a medication error were documented. Review of a physician's order dated 11/2/15 showed the resident was to receive an Exelon Patch 9.5 mg (milligrams) per 24 hours. Further, the order showed apply one patch topically once daily and remove the old patch. Interview with the administrator on 3/16/17 at 3:52 PM revealed a medication error report was not completed.	S5053	S5073 Ch 12 Sec 7 (j)(ii) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition *The corrective action(s) that will be accomplished for residents, who were identified to be affected by the deficient practice, is to ensure only pasteurized eggs will be used when preparing eggs with yolks that are not cooked through. *The corrective action that will be taken to prevent other residents from being affected by the same deficient practice will be to in-service all staff who prepare eggs for consumption by our residents on the Food Code 2013, U.S. Public Health Service: 3-401.11 *Measures that will be put into place to ensure that the deficient practice does not recur, will be to request our food vendor to remove the option to purchase eggs that have not been pasteurized. *The effectiveness of this practice will be to review weekly at the time of delivery by our food vendor, that unpasteurized eggs are not being purchased, and verified on our monthly Safety Survey –Dietary, which is completed by our Registered Dietician, and part of our Quality Assurance Program.	03.22.17 05.01.17 04.07.17 05.10.17
S5073	Ch 12 Sec 7 (j)(ii) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (ii) There must be 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 is nutritionally adequate in accordance with the Dietary Reference Intakes (DRI) for adults. This State Rule and Regulation is not met as evidenced by:	S5073		

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S5073	Continued From page 9 Based on observation, staff interview, review of the breakfast menu, and review of the FDA 2013 food code regulations, the facility failed to ensure food was prepared in a manner that was safe for consumption. The census was 46. The following concern was identified: 1. Observation on 3/15/17 at 5:20 PM showed unpasteurized shell eggs were in the refrigerator. 2. Observation on 3/16/17 at 7:40 AM showed non-sample residents #22 and #29 were in the dining room with breakfast plates which contained eggs with yolks that were not cooked through. 3. Review of the breakfast menu located on the dining table of each resident showed eggs could be ordered and prepared as "Scrambled, Scrambled with Cheese, Over Easy, Over Medium, Over Hard." 4. Interview with the dietary manager on 3/16/17 at 1:15 PM confirmed the eggs she used were not pasteurized and the resident's could order eggs cooked as to their preference. 5. Interview with the administrator on 3/16/17 at 2:05 PM revealed she was unaware of the need to use pasteurized eggs when serving eggs with undercooked yolks. 6. According to Food Code 2013, U.S. Public Health Service: 3-401.11 "(D) A raw animal FOOD such as raw EGG, raw FISH, raw-marinated FISH, raw MOLLUSCAN SHELLFISH, or steak tartare; or a partially cooked FOOD such as lightly cooked FISH, soft cooked EGGS, or rare MEAT other than WHOLE-MUSCLE, INTACT BEEF steaks as specified in ¶ (C) of this section, may be served	S5073	S5077 Ch 12 sec 7 (j)(vi) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition *The corrective action(s) that will be accomplished to correct this deficient practice, develop a Cleaning Schedule to be followed by Dining staff. *The corrective action that will be taken to prevent the same deficient practice from occurring will be to in-service all staff responsible for completing the Cleaning Schedule, to ensure that standard established in the current edition of FDA Food Code. *Measures that will be put into place to ensure that the deficient practice does not recur, will be to have the Dietary Manager review the Cleaning Schedules on a weekly basis to ensure compliance. *The effectiveness of this practice will be to reviewed monthly during our Safety Survey –Dietary, which is completed by our Registered Dietician, and part of our Quality Assurance Program. New fingernail brushes will be ordered and each employee will have their own.	04.24.17 05.01.17 05.01.17 05.10.17

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S5073	Continued From page 10 or offered for sale upon CONSUMER request or selection in a READY-TO-EAT form if: (1) As specified under ¶¶ 3-801.11(C)(1) and (2), the FOOD ESTABLISHMENT serves a population that is not a HIGHLY SUSCEPTIBLE POPULATION;" 7. According to Food Code 2013, U.S. Public Health Service definitions: "Highly susceptible population" means PERSONS who are more likely than other people in the general population to experience foodborne disease because they are: (1) Immunocompromised; preschool age children, or older adults; and (2) Obtaining FOOD at a facility that provides services such as custodial care, health care, or assisted living, such as a child or adult day care center, kidney dialysis center, hospital or nursing home, or nutritional or socialization services such as a senior center.	S5073		
S5077	Ch 12 Sec 7 (j)(vi) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (vi) The kitchen and dining area shall be kept clean and sanitary in accordance with standards established in the current edition of FDA Food Code. The dining area shall provide suitable furniture and adequate space to comfortably seat all residents. This State Rule and Regulation is not met as evidenced by:	S5077		

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	ALF002	A. BUILDING: _____ B. WING _____	C 03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S5077	Continued From page 11 Based on observation, staff interview, and review of the FDA 2013 food code regulations, the facility failed to ensure that food was stored, prepared and distributed under sanitary conditions in 2 of 2 kitchens, 1 of 1 food storage areas, and 1 of 1 resident dining areas. The findings were: Observation on 3/15/17 at 5:20 PM and 3/16/17 at 1:07 PM showed the following sanitary issues: 1. Observations related to the main kitchen included: a. The exterior handles of "Freezer #1", "Fridge #2", and "Fridge #4" were soiled with sticky food residue. b. The interior and exterior of the convection oven and the conventional oven were soiled with food build-up. c. The hood walls and vents above the range/griddle were soiled with grease. d. The exterior surface of the "Steam n Hold" was soiled with sticky residue. e. Six cutting boards located on top of the convection oven, 4 cutting boards located on the prep table to the left of the dry storage area, and the cutting board located on the "Steam n Hold" were visibly scored and unable to be effectively cleaned. f. The industrial mixer had a build-up of dried food debris located on the metal plate directly behind the mixing bowl. The mixer was not in use at the time. g. The exterior of the ice machine was visibly soiled and sticky to the touch. h. The exterior surface of the cupboards throughout the kitchen were visibly soiled and greasy to the touch. i. The black Hamilton Beach can opener located on the prep table to the right of the dry storage area was visibly dirty and greasy to the	S5077		

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S5077	Continued From page 12	S5077		

touch.

j. The lids on two large white canisters which contained sugar and flour in the dry storage area were visibly soiled with black debris.

k. One fingernail brush was located to the left of the faucet on the hand-washing sink. The brush was not labeled and appeared to have been used.

2. Concerns related to the storage area near the main kitchen included:

a. A white shelving unit that contained equipment, disposable utensils and plates, and food items was visibly dirty with dust and dried food debris.

b. A toaster on the counter to the left of the shelving unit was visibly soiled with dried food debris.

c. A 3-inch by 5-inch section of laminate between the wall and the sink was eroded and exposed the wood underneath which created a surface that was unable to be effectively cleaned.

3. Concerns related to the resident dining area included:

a. Observation on 3/15/17 at 6 PM and on 3/16/17 at 1:07 PM showed the exterior surface of a Rival slow cooker was visibly soiled with dry food debris.

b. The exterior surfaces of the cupboards below the warming trays were visibly soiled.

4. Concerns related to the kitchenette available for resident use included:

a. The interior and exterior of the oven, microwave, refrigerator/freezer, and dishwasher were visibly soiled with food debris.

b. The small appliances on the countertop which included a red Oster blender, a Sunbeam Mix Master, a red Keurig coffee maker, and a

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S5077	Continued From page 13 yellow Sunbeam handmixer were greasy to the touch and soiled with dried food debris. c. The 3-compartment sink was stained and soiled with food debris. The sink was not in use at the time. d. A thermometer was not present in the GE Profile refrigerator/freezer. e. The refrigerator contained a carton of cherry tomatoes which was undated and appeared spoiled and had an undated container of thawed "frozen sliced strawberries". The refrigerator had a sign on the outside which stated "Residents' Icebox Only !!!". 5. Interview with the dietary manager on 3/16/17 at 1:15 PM revealed the fingernail brush on the sink was shared by the dietary staff and confirmed the kitchen needed to be cleaned "We don't have time to clean because most of the time we only have 2 people working in the kitchen. We try to clean as we go." In addition, she confirmed the kitchenette needed to be cleaned, but it was not her responsibility; in the past the activity director had "taken care of it." 6. Interview with the administrator on 3/16/17 at 2:05 PM revealed the facility was currently without an activity director. Further, she confirmed the temperature of the refrigerator/freezer was not monitored and the dishwasher was not tested for adequate sanitation. 7. According to Food Code 2013, U.S. Public Health Service, Annex 3- Public Health Reasons / Administrative Guidelines: 2-301.12 Cleaning Procedure: "Fingernail brushes, if used properly, have been found to be effective tools in decontaminating this area of the hand. Proper use of single-use fingernail brushes, or designated individual fingernail brushes for each	S5077		

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S5077	Continued From page 14 employee, during the handwashing procedure can achieve up to a 5-log reduction in microorganisms on the hands." 8. According to Food Code 2013, U.S. Public Health Service: 4-501.112 "The temperature of hot water delivered from a warewasher sanitizing rinse manifold must be maintained according to the equipment manufacturer's specifications and temperature limits specified in this section to ensure surfaces of multiuse utensils such as kitchenware and tableware accumulate enough heat to destroy pathogens that may remain on such surfaces after cleaning. The surface temperature must reach at least 71°C (160°F) as measured by an irreversible registering temperature measuring device to affect sanitization. When the sanitizing rinse temperature exceeds 90°C (194°F) at the manifold, the water becomes volatile and begins to vaporize reducing its ability to convey sufficient heat to utensil surfaces. The lower temperature limits of 74°C (165°F) for a stationary rack, single temperature machine, and 82°C (180°F) for other machines are based on the sanitizing rinse contact time required to achieve the 71°C (160°F) utensil surface temperature." 9. According to Food Code 2013, U.S. Public Health Service: "4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch...(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris."	S5077	**S5101 Ch 12 Sec 8 (a)(vii) Services Which Cannot Be Provided By Level 1 Assisted Living Facility Staff** *The corrective action(s) that will be accomplished for Residents #11 & #20, who have been identified to be affected by the deficient practice, will be to ensure that new ALF 102 is completed and signed by an RN for these residents. If it is determined that the residents are requiring care beyond what can be provided by Assisted Living Facility Staff. If outside services are unable to be secured, the resident(s) will be given a 30-day written notice to notify them of the need for them to move to a facility that can appropriately meet their needs. *The corrective action that will be taken to prevent other residents from being affected by the same deficient practice will be to in-service staff as to the services that can be provided by Assisted Living Facility Staff. * Measures that will be put into place to ensure that the deficient practice does not recur will be to do an in-service with nursing staff to properly review CNA progress notes on a weekly basis to identify residents who are receiving services which cannot be provided by Assisted Living Facility Staff to identify residents who have had a change of condition and are in need of a new ALF 102 completed and signed by an RN. If it is determined by	05.01.17 05.01.17

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S5101	Continued From page 16	S5101	the RN that the resident is needing services which cannot be provided by Assisted Living Facility Staff, and outside services are unable to be secured, the resident(s) will be given a 30-day written notice to notify them of the need for them to move to a facility that can appropriately meet their needs.	05.10.17
S5101	Ch 12 Sec 8 (a)(vii) Services Which Cannot Be Provided By Level I Services which cannot be provided by the Level I Assisted Living Facility staff. (a) The following services cannot be provided: (vii) Incontinence care by facility staff; This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents were appropriate for the core services level of care for 2 of 9 sample residents (#11, #20) who required incontinence care by the facility. The findings were: 1. Review of the ALF 102 assessment completed on 7/15/16 showed resident #11 was determined to need "significant assistance or cuing on a regular basis" for dressing and personal grooming, "cannot bathe without total assistance", had "frequent to total incontinence and unable to manage his/her self", was "completely dependent, frequent transfers, frequent position, frequent falls, unable to evacuate building" for mobility and was "acutely ill; able to maintain safely without 24 hour RN assessment, supervision." Review of the 24-hour CNA communication log from 2/15/17 through 2/28/17 (14 days) showed the resident required incontinence care on a daily basis. 2. Review of the ALF 102 assessment completed on 8/9/16 showed resident #20 was "mobile, but unable to bathe without regular assistance and supervision. Occasional peri-care for hygiene", was "frequent to total incontinence and unable to	S5101	* The effectiveness of this practice will be evaluated weekly during the Health Services Review Schedule Audit, which is part of our Quality Assurance program.	05.10.17

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S5101	Continued From page 18 manage his/her self", was "independently and appropriately able to transfer and/or ambulate with or without a device", and was "medically stable." Review of the 24-hour CNA communication log from 3/10/17 through 3/16/17 showed pericare and scheduled toileting was provided on each shift. 3. Interview on 3/16/17 at 1:45 PM with CNA #1 and CNA #2 revealed resident #11 and resident #20 were assisted to the toilet every two hours and they provided pericare and assistance with incontinence products. In addition, they revealed the residents had been receiving regular incontinence care since approximately August 2016. 4. Interview on 3/16/17 at 2:10 PM with the administrator confirmed the residents were receiving incontinence care and needed to be reassessed for proper placement.	S5101		