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Healthcare Licensma and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF024	A. BUILDING _____ B. WING ___ _____	C 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOME OF BUFFALO	1 NORTH KLONDIKE BUFFALO, WY 82834

PS 8/24/17

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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 licensure survey was conducted by Healthcare Licensing and Surveys on 4/10/17 through 4/11/17. Also reviewed in the course of the survey was complaint intake LIC-17-025. The following common abbreviations are used throughout the document: ALF- Assisted Living Facility RN- Registered Nurse CNA- Certified Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5003	Ch 12 Sec 6(b)(iii) Personnel And Staffing Requirements (b) Staffing. (iii) The assisted living facility shall not employ an individual as a nurse assistant who is not currently certified by the Wyoming State Board of Nursing. Certification must be verified by the manager of the assisted living facility.	S5003		

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dennis L. Lawrence	President/Administrator	8/23/17

STATE FORM PE0311 If continuation sheet 1 of 18

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AUG 23 2017
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8/25/17 3:01 pm Spoke with Dennis Lawrence, Adm. POC accepted with agreed changes.
Penny Swanson, WY State Surveyor

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S5003	Continued From page 1 This State Rule and Regulation is not met as evidenced by: Based on employee record review and staff interview, the facility failed to verify certification of current CNA licensure for 2 of 4 employee records reviewed (CNA#2, CNA#4). The findings were: 1. Review of the employee record for CNA#2 showed a date of hire of 2/27/17. Further review showed no evidence of verification of current CNA licensure. 2. Review of the employee record for CNA #4 showed a date of hire of 11/2014. Further review showed no evidence of verification of current CNA licensure. 3. Interview with the manager on 4/11/17 at 1:35 PM confirmed there was no evidence of licensure verification. In addition, she stated "no, they [licenses] were not printed."	S5003	A. All deficiencies in the employee files have been brought into compliance as of 5/12/17 1. All current employee files have current CNA licensure verification. Including verifications on CNA's #2 and #4 2. The manager of Beehive Homes of Buffalo has completed an audit of the remaining employee files and determined that all employee files are complete and up to date. 3. The manager of Beehive of Buffalo will complete an employee checklist on each employee to ensure that all employee files are accurate and complete and will periodically audit all employee files to ensure that all employee files are complete. 4. Corporate administration will form a Q&A committee consisting of a corporate officer and the local manager to internally audit all employee files as part of our Quality and Assurance program to improve the quality of the care provided in our homes. The audit will be conducted on a semi-annual basis and documented in the QA binder.	5/12/17
S5006	Ch 12 Sec 6 (c) Personnel and Staffing Requirements (c) Background checks. All staff of the assisted living facility shall successfully complete, at a 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 employee record review and staff interview, the facility failed to ensure a Central	S5006		

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S5006	Continued From page 2 Registry screening was completed for 1 of 4 employees reviewed (CNA#1). In addition, the facility failed to ensure criminal background checks were completed for 2 of 4 employees reviewed (CNA#2, CNA#3). The findings were: 1 . Review of the employee record for CNA#1 showed a date of hire of June 2011. Further review showed no evidence a Central Registry screening was completed at time of hire. 2 Review of the employee record for CNA#2 showed a date of hire of 2/27/17. Further review showed no evidence a criminal background check was completed at time of hire. 3 Review of the employee record for CNA#3 showed a date of hire of January 2017. Further review showed no evidence a criminal background check was completed at time of hire. 4. Interview with the manager on 4/11/17 at 1:35 PM verified there was no evidence to show the Central Registry screening and criminal background checks had been completed.	S5006	B. It is standard operating procedure for Beehive Homes that all employees are required to complete a criminal background investigation through the state of Wyoming DCI and the Department of Family Services central registry. 1. We have completed the finger print criminal background checks for all current employees as of 5/12/17. Background checks have been completed and placed in employee files for CNA's #1,#2,#3. 2. All current Staff files have been reviewed, updated and documented with DFS screening and as mentioned above the finger printing has been completed on 5/12/17. 3. The manager of Beehive Homes of Buffalo has been educated on standard operating procedures and to periodically review each employee file to ensure that all background checks are completed 4. Our Q&A committee will semi-annually review background checks to make sure that the local manager is in compliance with all policies and procedures as outlined by the company as well as state guidelines regarding background checks.	5/12/17
S5008	Ch 12 Sec 6 (d)(ii)(A-F) Personnel and Staffing Requirements (d) Infection Control. 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. These shall not be limited to: (ii) Tuberculin Testing. (A) Tuberculin testing must be accomplished for each employee prior to	S5008	C. All current staff TB testing has been completed, documented and brought up to date in the employee files, including CNA #4 as of 5/12/17. 1. The manager has reviewed all employee files to ensure that all employees have been tested or retested for TB. 2. The manager of Beehive Homes of Buffalo was educated on policy and procedures on TB and communicable diseases and the necessary testing and retesting, also on proper documentation that will be maintained in all current employee files and will periodically review all TB documentation to ensure continued compliance.	5/12/17

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S5008	Continued From page 3 employment and annually thereafter. (B) Employees having known positive skin tests shall provide a certificate of noninfectiousness, recommendations, if any, for treatment, and evidence they have complied with such recommendations. (C) Individuals providedocumentation of negative skin test administered within the last twelve (12) months do not require a follow-up (D) Individuals who have not had a skin test or who do not have written proof of skin test results, shall have an intradermal Mantoux using 5TU PPD. This shall be accomplished via the two (2) step procedure. If the first test is negative and the employee is asymptomatic, the employee may engage In resident contact prior to the results of the second skin test. (I) A negative reaction requires no follow-up. (II) A positive reaction (10mm in duration suing 5TU PPD) requires a referral to a physician for x-ray and certification of noninfectiousness and appropriate treatment if needed. Follow up shall comply with the recommendations of the attending physician. (E) If symptoms occur, a new certificate of noninfectiousness is required. (F) No person with an airborne, contaglous or Infectious disease shall be employed until a work release is obtained. (I) The facility shall prohibit employees	S5008	3. The manager will hold in-service meetings periodically to educate the staff on TB and communicable diseases and the testing and retesting that needs to be done annually and why it is necessary. 4. The Q&A committee will semi-annually audit all paperwork with regard to TB and the continued education of the staff and the manager on TB and communicable diseases.	

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S5008	Continued From page 4 with a communicable disease or infected skin lesions from direct contact with residents and their food, if direct contact will transmit a disease. (II) The facility shall require staff to follow universal precautions when performing direct resident care. This State Rule and Regulation is not met as evidenced by: Based on employee record review and staff interview, the facility failed to ensure staff members were free from communicable disease, including TB (tuberculosis) for 1 of 5 employee records reviewed (CNA#4). The findings were: Review of the employee record for CNA #4 showed a date of hire of 11/2014. Further review showed no evidence a communicable disease screening or TB test had been completed. Interview with the manager on 4/11/17 at 1:35 PM confirmed there was no evidence a TB test had been completed.	S5008		
S5009	Ch 12 Sec 6 (e)(i) Personnel And Staffing Requirements (e) Personnel Policies and Records. (i) Management shall provide new employee orientation and education regarding resident rights, evacuation, and emergency procedures, as well as training and supervision designed to improve resident care.	S5009	C. Beehive Homes policies require complete staff orientation and education regarding resident rights, evacuation and emergency procedures. 1. A form exists and has been put into place that will be completed and signed by both the manager and employee acknowledging that the employee has completed their orientation regarding resident rights, evacuation and emergency procedures. This form will be maintained in all employee's file and has been completed and placed in CNA's #2,#3,#4 and ALF manager's files. 2. The manager reviewed all current employee	5/12/17

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S5009	Continued From page 5 This State Rule and Regulation is not met as evidenced by: Based on employee record review and staff interview, the facility failed to provide new employee orientation and education regarding resident rights, evacuation, and emergency procedures for 4 of 5 employee records reviewed (CNA#2, CNA#3, CNA#4, ALF manager). The findings were: 1. Review of the employee record for CNA#2 showed a date of hire of 2/27/17. Further review showed no evidence of new employee orientation or education. 2. Review of the employee record for CNA#3 showed a date of hire of January 2017. Further review showed no evidence of new employee orientation or education. 3. Review of the employee record for CNA #4 showed a date of hire of 11/2014. Further review showed no evidence of new employee orientation or education. 4. Review of the employee record for the ALF manager showed a date of hire of January 2017. Further evidence showed no evidence of new employee orientation or education. 5. Interview with the manager on 4/11/17 at 10:45 AM verified the facility did not have a record of new employee education.	S5009	Files to ensure that all employee have completed orientation. 3. The manager will complete a checklist to ensure that orientation has been done and signed off on by the employee and the manager acknowledging that it has been completed. 4. The manager will periodically review employee files to maintain compliance and will periodically provide continued in-service education regarding resident's rights, evacuation and emergency procedures. 5. Our Q&A committee will semi-annually audit all employee files to ensure that orientation and continued education is being completed.	
S5010	Ch 12 Sec 6(e)(ii)(A-L) Personnel And Staffing Requirements (e) Personnel Policies and Records.	S5010		

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S5010	Continued From page 6 (ii) A record for the manager and each employee shall be maintained and contain at a minimum the following information: (A) Name, current address and telephone number; (B) Social Security Number; (C) Education; (D) Work experience, documentation of reference checks; (E) Date of employment (F) Position in the assisted living facility Uob description); (G) Documentation of tuberculin testing; (H) Orientation checklist; (I) 1-9, (Employment Eligibility Verification); (J) W-4 (Employee's Withholding Allowance Certificate); (K) Licensure, Certification, or Credentials; (e.g., RN, LPN, CNA; and (L) Documentation of all completed background and Central Registry background check with no offenses. This State Rule and Regulation is not met as evidenced by: Based on employee record review and staff	S5010	E. Eldercare has an employee file checklist that addresses all items on the detailed list at S5010. The list is to be in each employee's file, properly marked and signed off with all related documentation, and maintained in the employee's file. Annually new w-4's are to be completed, unless there is a change in status I-9's are only to be done every 5 years. 1. All employee files are compete as of 5/12/17 and the manager of Beehive Homes was educated on policies and procedures regarding employee files as to what is supposed to be in them and maintaining completeness of them by updating as needed. This included CNA #1. 2. The manager has reviewed the current employee files to ensure that they are all complete and the employee checklist is complete and up to date. 3. The manager will be given in-service hours for continued education regarding employee files and what needs to be done to properly maintain them. 4. The manager will periodically review employee files and checklists to ensure they are complete and up to date. 5. Our Q&A committee will semi-annually audit all employee files to assure that all components of the file are complete, accurate and up to date.	5/12/17 PS

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S5010	Continued From page 7 interview, the facility failed to ensure employee personnel records contained all of the required components including 1-9 (employment eligibility verification) for 1 of 4 employees reviewed (CNA #1). The findings were: Review of the employee record for CNA #1 showed a date of hire of June 2011. Further review showed no evidence 1-9 verification had been completed. Interview with the manager on 4/11/17 at 1:35 PM confirmed 1-9 verification was not in the employee record.			
S5018	Ch 12 Sec 7 (a)(ix)(A) Assisted Living Facility (ALF) Core Services (a) The assisted living facility core services include the following: (ix) Assessments completed by a Registered Nurse. (A) Registered Nurse medication review every two (2) months or sixty-two (62) days or whenever new medication is prescribed or the resident's medication is changed; This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a Registered Nurse reviewed resident medications every two (2) months, when a new medication was prescribed, or when there was a change in the resident's medications for 2 of 6 (#3, #4) sample residents. The findings were: 1. Medical record review showed resident #3 was admitted on 10/3/16 with a diagnosis of diabetes.		F. Beehive Homes of Buffalo has a contractual agreement with an RN to provide nursing services to comply with any and all nursing core services of an assisted living facility. This includes resident assessments, medication reviews as required by state rules and regulations. 1. We changed our nursing contract to address the deficiencies noted and have brought everything into compliance as of 5/19/17. 2. Medication reviews on all current residents have been completed and properly documented in the resident files on 5/19/17 including everything for residents #3 and #4. 3. The RN reviewed all current resident's medications and was reminded that medications on all residents need to be reviewed every two months and/or when a change is made. 4. RN was educated on Medication reviews, MARS, and notations what is completed and when it is completed. 5. The manager will every two months review all nursing paperwork and notes to ensure that medication reviews are being completed or when a resident's physician makes a change. 6. Our Q&A committee will semi-annually audit resident files, MARS, and nursing notes to ensure	5/19/17 5/19/17

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S5018	Continued From page 8 Review of the April 2017 medication administration record (MAR) showed the resident received medications; however there, was no indication a RN had reviewed those medications. 2. Medical record review showed resident#4 was admitted on 12/7/16 with a diagnosis of paroxysmal dyskinesias (episodic movement disorders in which abnormal movements are present only during attacks). Review of the March and April 2017 MAR showed the resident received medications; however, there was no indication a RN had reviewed those medications. 3. Interview with the manager on 4/11/17 at 12:45 PM confirmed medication reviews had not been completed every 60 days. In addition, she revealed the facility had a nurse on contract and the nurse was only at the facility five hours per week.	S5018	That medication reviews are being completed.	
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 condupt 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 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;	S5020	G. New ALF 102 forms were completed on 5/19/17 on all current residents including residents #s 1,2,4,5,and 6. 1.The RN reviewed all residents ALF 102 forms to ensure that they were complete and up to date. 2. The RN was educated on policy and procedures regarding the ALF waiver and that all residents that were new needed an evaluation and all residents needed an annual re-evaluation on the anniversary date of their move in. 3. The manager will continually review all ALF 102 forms to ensure that they are complete and up to date. 4. Our Q&A committee will semi-annually audit all ALF 102 forms to ensure that we are in compliance.	5/19/17

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S5020	Continued From page 9 (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 ALF 102 assessments were completed upon admission and annually for 5 of 6 sample residents (#1, #2, #4, #5, #6). The findings were: 1. Review of the medical record showed resident #1 was admitted on 9/1 0/13. Further review showed an ALF 102 assessment was completed 11/2015. Continued review showed there was no ALF 102 asesessment with a more recent date. 2. Review of the medical record showed resident #2 was admitted on 2/15/17 . Further review showed no evidence an ALF 102 assessment was completed. 3. Review of the medical record showed resident #4 was admitted on 12/7/16. Further review showed no evidence an ALF 102 assessment was completed.	S5020		

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S5020	Continued From page 10 4. Review of the medical record showed resident #5 was admitted on 2/27/17. Further review showed no evidence an ALF 102 assessment was completed. 5. Review of the medical record showed resident #6 was admitted on 4/7/17. Further review showed no evidence an ALF 102 assessment was completed. 6. Interview with the manager on 4/11/17 at 1:25 PM confirmed the documentation in the medical records was not current. In addition, she revealed the facility has a nurse on contract that only works five hours per week.	S5020		
S5064	Ch 12 Sec 7 (g)(ii) Assisted Living Facility (ALF) Core Services (g) Grievance Procedure. 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: (ii) Documentation of the provider's response to verbal and written resident grievances; This State Rule and Regulation is not met as evidenced by: Based on staff interview, review of grievances, and policy and procedure review, the facility failed to ensure 11 of 11 grievances reviewed (#1, #2, #3, #4 #5, #6, #7, #8, #9, #10, #11) were investigated or resolved. The findings were:	S5064	H. Eldercare has a grievance policy that is in place in our policy and procedures and also in the resident's rights document that is included in our new resident move in packets. 1. All grievances have been reviewed and resolved by the manager and resolution forms have been completed and attached to the grievance forms and filed. Including grievances 1-11. 2. The Buffalo manager is being given in-service time to come to corporate and re-read and review the full resident packet for admissions, forms, and the maintenance of those forms, was completed on 5/12/17. 3. In-service staff mandatory meetings will be held and documented to review the grievance policy, accident/incident reports, policies, house rules and whatever other areas warrant current staff in-service meetings. these meetings for the Buffalo facility were completed on 5/31/17. 3. A formal grievance form is now in place and part of the form is the disposition and resolution of the grievance and requires that it be signed by all parties to the grievance and the facility manager.	5/31/17

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	ALF024	A. BUILDING _____ B. WING _____	C 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOME OF BUFFALO	1 NORTH KLONDIKE BUFFALO, WY 82834

PS 8/24/17

(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)	1xs1 COMPLETE DATE
S5064	Continued From page 11 Review of facility grievances showed 10 grievances dated 2/13/17 to 3/12/17, and 1 grievance #11 that was not dated. These 11 grievances were variously related to resident care issues, staff interactions with residents, and staff responsibilities/duties not being completed. Each form showed the issue was reported to a staff member. The form used included an area for the name of the complainant, date and time the complaint was received, person receiving the complaint, and the nature of the complaint. Further review showed the manager had signed the forms, but there was no evidence the grievances were resolved or that an investigation had been completed. Interview with the manager on 4/11/17 at 1:35 PM confirmed the grievances had not been resolved. Review of the policy titled "Residents' Rights, not dated, showed "...Residents abiding in Bee Hive Homes are entitled to the following:...R. The right to present grievances on his/her own behalf or on behalf to others to the staff...without justifiable fear of reprisal. ...Bee Hive Homes has written procedures for receiving, handling, and informing the resident ...of the outcome of any grievance presented...". Review of the policy titled, "Section 7. Bee Hive Homes/Assisted Living Facilities (ALF) CORE Services," not dated, showed, ...(g) Grievance Procedure. 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: ...(ii) Documentation of the provider's response to verbal and written resident grievances; ...".	S5064	4. The manager will review the grievance file monthly to ensure all grievances have been resolved and that the resolution form is attached and signed. 5. Our Q&A committee will semi-annually audit the grievance file to ensure that all grievances have been resolved and the resolution has been documented.	

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BEEHIVE HOME OF BUFFALO	1 NORTH KLONDIKE BUFFALO, WY 82834

PS 8/29/17

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S5067	Continued From page 12			
S5067	Ch 12 Sec 7 (g) Assisted Living Facility (ALF) Core Services (g) Grievance Procedure. The written grievance procedure shall be posted in a conspicuous place within the facility. This State Rule and Regulation is not met as evidenced by: Based on observation and policy and procedure review, the facility failed to ensure the grievance procedure was posted in a conspicuous place within the facility. The findings were: Observation on 4/10/17 at 6:15 PM showed the facility did not have a written grievance procedure posted within the facility. Review of the policy titled "Grievance Procedure," not dated, showed "(v) The written grievance procedure shall be posted in a conspicuous place within the facility".		1. The grievance procedure is now formally detailed in writing and is posted in a conspicuous spot in the facility for ease in access by all. 1.the manager has educated all staff and current residents on where the grievance procedure is located and where the grievance forms are located. 2. An in-service meeting was conducted on 5/31/17 educating the staff on the grievance policy and forms. 3. The manager monitor that the grievance procedure stays posted and forms are available, and periodically ask residents if they have any grievances that that they have not filled out a form on. 4. Our Q&A committee will semi-annually audit ensuring that the procedure is posted and the forms are readily available.	5/31/17
S5076	Ch 12 Sec 7 U)(v) Assisted Living Facility (ALF) Core Services U) Food Service and Nutrition. (v) Individuals with food preparation responsibilities shall be in good health and shall practice safe food handling techniques in accordance with the current edition of the Food Code published by the U.S. Public Health Service, Food and Drug Administration. This State Rule and Regulation Is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a sanitary environment was maintained in 1 of 1 food preparation areas			

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S5076	Continued From page 13 (kitchen). The findings were: 1. Observation on 4/10/17 at 2:27 PM showed the kitchen had 2 refrigerators for food storage. The following concerns were identified: a. Observation of the refrigerator closest to the dining tables showed a container of purple liquid that did not have a label or date. Further observation showed a package of meat labeled "bologna," a bottle of "apple juice," a bottle of "cranberry juice," a container of "cottage cheese," a container of "sour cream," and a container of "yogurt" that were opened and were not labeled with the opened date or expiration date. b. Observation of the refrigerator that was furthest from the dining tables showed a plastic bag of cooked bacon dated 4/1/17, 2 single containers of "applesauce" that were not in the manufacturer's container, and a bowl of "chocolate pudding" that were undated, a package of "ham" dated 3/27/17, 2 hot dogs stored in an open package dated 3/6, 1 hot dog in an open package dated 3/25, and 3 hot dogs in an opened package dated 4/3/17. Further, the eggs available in the refrigerator were non-pasteurized. c. Interview with the facility manager on 4/11/17 revealed all the items stored in the refrigerator are available for resident consumption and the facility cooked eggs to order, which included styles that have runny yolks. Further, she confirmed that there were items in the refrigerator that were not dated and/or labeled. 2. According to Food Code 2013, U.S. Public Health Service: 3-501.17 "(A)...refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD	S5076	J. We have immediately implemented and put in place written and posted requirements that all consumable foods and liquids that have been opened for resident consumption and placed in refrigerated storage as "left-overs" are properly dated and marked for identification. 1. The manager has inventoried refrigerators and freezers to ensure that all food is dated, identified and disposed of any food item that is out of date or not dated. 2. All staff members are responsible for monitoring the dates of disposition and an in-service staff meeting to discuss the adherence to the policy and procedure and the monitoring of the "left-over" food or consumables was completed and documented on 5/17/17. 3. The manager will weekly inventory the refrigerators and freezers to ensure that all food is dated, identified and that out dated food has been disposed of. 4. Our Q&A committee will semi-annually inventory refrigerators and/or freezers to ensure food is dated, identified and that there is no outdated food.	5/17/17

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S5076	Continued From page 14 ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days." 3. 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 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;" 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.	S5076		

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S5088	Continued From page 15	S5088		
S5088	Ch 12 Sec 7 (I)(I)(A-D) Assisted Living Facility (ALF) Core Services (I) 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; (IV) Frequency of monitoring; (V) A provision requiring the facility to complete annually a self assessment survey of compliance with 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.	S5088		

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S5088	Continued From page 16 (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 staff interview and review of policy and procedures, the facility failed to have an active quality improvement program to ensure effective utilization and delivery of resident care **services.** The findings were: Review of the policy titled, "Quality Improvement", not dated, showed "...(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; (IV) Frequency monitoring;... (D) The quality improvement program shall be re-evaluated at least annually." Interview with the manager on 4/11/17 at 2:33 PM confirmed the facility had not established an active quality improvement program. In addition, she stated, "We are currently not monitoring identified concerns, [we] mostly talk about education needs during meetings."	S5088	K. Eldercare has and adheres to promoting "Quality Improvement" practices to assure effective delivery of resident care services. 1. We will require monthly staff meetings that are fully attended and documented to detail those in attendance, the items of discussion for the meeting, one of which will be a quality assurance item for review and discussion. 2. The manger has reviewed policy and procedures regarding quality improvement and what needs to be done, where we are deficient and has implemented the necessary steps to correct it. 3. The Buffalo manager has been educated on this requirement and has posted a calendar with the scheduled in-service meetings and topics. The manager will designate an employee to take meeting notes and minutes that will be filed in a QA/Meeting book. It is also the manager's responsibility to insure that this occurs and is properly documented. 4. the manager will continually review the QA/Meeting book to make sure that areas that need improvement are improving in a timely manner and identify areas that are not improving and what strategy needs to be changed, modified, or replaced to achieve improvement. 5. Our Q&A committee will semi-annually review the Q&A meeting book to ensure that our quality improvement practices are being met by the manager successfully and to also look for any needed improvement.	05/31/17
S5100	Ch 12 Sec 8 (a)(vi) 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: (vi) Care of resident whose wandering	S5100		

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S5100	Continued From page 17 jeopardizes the health and safety of the resident; This State Rule and Regulation is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure appropriate level of care for an assisted living facility for 1 of 1 sample residents (#1) where wandering and/or elopement potentially jeopardized the health and safety of the resident. The findings were: 1. Review of a "nurses note" for resident #1 dated 1/19/17 and timed 4:30 PM showed "Res. [resident] has been increasingly confused. Has thoughts that, "they are coming to get me. They're gonna shoot me in the head if I don't get out of here." Res. has left the facility multiple times [with] CNA having to go after [him/her] to bring [him/her] back inside..." 2. Review of a "nurses note" for resident #1 dated 1/29/17 and timed 12 PM showed "Res. cont [continues] [with] confusion and behaviors as above." 3. Review of a "nurses note" for resident #1 dated 4/8/17 and timed 10:45 AM showed "Resident sitting in shower room sleeping - very confused, refusing assistance..." 4. Interview with the facility manager on 4/11/17 at 1:25 PM revealed resident #1 had confusion, required total care with medication administration, and had left the building "multiple times." Further, she confirmed the resident was not appropriate for the facility because of the level of care s/he required.	S5100	L. Eldercare has a strict policy and procedure regarding appropriate levels of care as it pertains to its residents to maintain safety, quality of care and quality of life. 1. The manager has reviewed the risks that render a resident "beyond our licensed level of care" and agrees that resident #1 remains appropriate for our level of care. 2. We will also had the RN complete a written assessment concurring with our assessment of the situation, which was completed and filed on 5/1/17. 3. The manager will ensure that any questions about the fitness of a resident to remain in our facility is investigated and confirmed with the RN, the family and anyone necessary to make sure the facility is in compliance. 4. The manager with the help of the RN will continually monitor all residents to make sure that they remain appropriate for our level of care. 5. Our Q&A committee will semi-annually audit all assessments, notes and all documentation pertaining to the residents and question both the manager and RN about the fitness of all residents.	5/17/17