Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9044	A. BUILDING: _____ B. WING _____	C 04/24/2023

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

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S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020. Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001. A complaint survey was conducted by Healthcare Licensing and Surveys from 4/20/23 to 4/24/23. The survey was prompted by complaint intakes LIC-23-018, LIC-23-019, LIC-23-020, LIC-23-023, and LIC-23-027. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living CNA: Certified Nursing Assistant GNA: Graduate Nurse Assistant LPN: Licensed Practical Nurse RA: Resident Assistant Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5003	Ch 12 Sec 6 (d) Personnel and Staffing Requirements (d) Infection Control. Written policies must 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 written polices must, at a minimum: (i) Ensure a safe and sanitary environment for residents and personnel;	S5003		

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S5003	Continued From page 1	S5003		

(ii) Require tuberculin testing, or screening as appropriate; and

(iii) Prohibit any person with an airborne, contagious, or infectious disease from being employed until a work release is obtained.

(A) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents and their food, if direct contact will transmit a disease.

(B) 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 observation, staff interview, and policy and procedure review, the facility failed to ensure appropriate infection control practices were implemented during 14 random observations. The census was 13. The findings were:

1. Observation on 4/20/23 at 2:10 PM showed RA #1 placed a blood pressure cuff on the bare left arm of resident #3 who was sitting on the couch; stood up and gave a visitor a hug; removed the blood pressure cuff; entered resident #6's room, and proceeded to obtain a blood pressure. At no time was hand hygiene performed or the shared equipment sanitized between residents.

2. Observation on 4/20/23 at 3:58 PM showed GNA #1 assisted resident #3 to the couch in the common area, took off the resident's nasal cannula and placed the cannula on the floor. GNA #1 moved the resident's oxygen concentrator nearer to the resident, plugged it in, and replaced

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S5003	Continued From page 2 the nasal cannula that had been sitting on the floor back into the resident's nose. 3. Observation on 4/20/23 at 4:06 PM showed RA 1# was assisting resident #6 in the bathroom. The surveyor was in the resident's room and within hearing distance of the care being provided in the bathroom. At no time during this observation was water heard running in the sink. Upon completion of the toileting task RA #1 returned the resident via his/her wheelchair to the common room and then immediately assisted resident #7 to a standing position by grabbing both of the resident's hands in hers. Interview with RA #1 at that time revealed she did not like to wash her hands in the resident's bathroom and preferred to use the staff bathroom. RA #1 then went to the staff bathroom to wash her hands. 4. Observation on 4/20/23 at 2:43 PM showed resident #3 was seated on the couch in the common area with his/her nasal cannula resting directly on the floor. RA #1 assisted the resident to a standing position and walked with him/her to the resident's room. RA #1 returned to the common room and retrieved the resident's oxygen concentrator and went back to the resident's room and placed the nasal cannula back into the resident's nose. Interview with RA #1 at 2:55 PM revealed she had forgotten to wipe it off before placing the nasal cannula back into the resident's nose. In addition, she stated did not know if new nasal cannulas were available. 5. Observation on 4/20/23 at 2:50 PM showed cook #1 was in the kitchen preparing beverages for residents and organizing the placement of the beverage glasses on the counter by placing her ungloved fingertips on the outside surface of the glasses near the rim. Continued observation	S5003		

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S5003	Continued From page 3 shoed the cook touched cookies, wiped her nose, and opened the kitchen trash with her bare hands. The cook then proceeded to open a food storage unit, reenter the kitchen and touch the kitchen cabinets. At no time did the cook wash her hands. At 2:55 PM the cook donned gloves; opened the trash can to throw away some trash and then continued, with the same gloved hands, to open a tortilla package and directly touch the fresh tortillas. 6. Observation on 4/20/23 at 3:05 PM showed GNA #1 was bathing resident #10 including under the breast, hair, buttocks, feet and between the resident's legs using the resident's sponge and soap. Continued observation showed LPN #1 entered the resident's bathroom to assist with body mechanics and remove old bandages from the resident's clavicle while GNA #1 washed the resident's hair. GNA #1 and LPN #1 did not wear gloves during the bathing task. Interview on 4/20/23 at 3:25 PM with LPN #1 revealed she usually did not wear gloves while assisting with showers. Interview on 4/20/23 at 3:50 PM with GNA #1 revealed he usually showered residents without wearing gloves unless the resident was really soiled. 7. Observation on 4/20/23 at 3:35 PM showed RA #1 entered the laundry room with a bag of trash retrieved from resident #7's room. RA #1 placed the bag of trash into a garbage can; pushed the bag down with her bare hands; and with no hand hygiene proceeded to walk down the hall and enter resident #1's room. 8. Observation on 4/20/23 at 3:45 PM showed GNA #1 removed dirty linens from resident #2's bed and exited the resident's room holding the unbagged dirty linens against his chest. Interview	S5003		

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S5003	Continued From page 4 with GNA #1, at that time, revealed he was aware he should have put the bedding in a bag and did not usually transport soiled linens next to his clothing. 9. Observation on 4/20/23 at 4:05 PM showed GNA #1 assisted resident #8 to the bathroom, removed the resident's soiled brief; doffed his gloves; washed his hands at the resident's sink; partially dried his hands on the resident's personal towel; and continued to dry his hands on his pants to complete the drying process. 10. Observation on 4/20/23 at 4:40 PM showed RA #1 was sitting next to resident #7 at the dinner table. RA #1 was observed eating potato chips with an ungloved hand. The then picked up resident #7's water glass by the outside upper lip, and handed the glass to the resident. Continued observation showed RA #1 placed food on the resident's fork and handed the resident the fork while at the same time feeding herself. At no time was hand hygiene performed. 11. Observation on 4/20/23 at 5 PM showed LPN #1 handed resident #2 a glass of water. The LPN held the glass by the outside upper lip, using her ungloved hand. 12. Observation on 4/20/23 at 5:35 PM showed RA #1 assisted resident #5 to the bathroom; donned gloves upon entering the resident's bathroom; removed the resident's soiled brief; and sat on the bathroom floor to remove the resident's socks. Continued observation showed RA #1 applied a clean brief, provided incontinence care to the resident, pulled up the resident's clean pants and then doffed her gloves. RA #1 failed to doff the contaminated gloves, perform hand hygiene; don clean gloves after	S5003		

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S5003	Continued From page 5 providing incontinence care, and before assisting with a clean brief and clean clothing. Interview at that time with RA #1 revealed she did not like to wash her hands in the resident's bathroom because she felt it was not very sanitary and preferred to walk down the hall to the employee bathroom to wash her hands. Further, RA #1 stated if there was a very contagious infection going around then she knew to wash her hands in the resident's bathroom. 13. Observation on 4/20/23 at 5:48 PM showed GNA #1 was assisting resident #8 in the bathroom. After completing care GNA #1 washed his hands; however, he dried them using a cloth towel that belonged to the resident. 14. Observation on 4/20/23 at 6:16 PM showed resident #9 was wandering throughout the facility and stopped at a dining table where a plate of dessert and fork had been left by resident #1. Resident #9 took several bites of the dessert and then continued to wander. At 6:24 PM resident #9 returned to the dining room and finished the dessert that was left on the plate. There was no staff in the vicinity of the dining room at the time of either observation. 15. Interview with the DON on 4/21/23 at 1:46 PM revealed it was her expectation hand hygiene be performed before providing care and between residents; reusable equipment be sanitized between residents; gloves be worn while giving showers; and nasal cannulas should not be placed into a resident's nose after being on the floor. She further stated paper towels were available in a bathroom cabinet for staff to use. The DON confirmed the staff needed more education on infection control.	S5003		

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S5003	Continued From page 6 16. Review of an unsigned and undated policy titled "Handwashing (sic)/Hand Hygiene" provided by the facility showed "...2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors...9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections." 17. Review of an unsigned and undated policy titled "Standard Precautions" provided by the facility showed "1. Standard Precautions apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious disease"...b. Hand hygiene is performed with ABHR (alcohol based hand rub) or soap and water: (1) before and after contact with the resident;...after contact with items in the resident's room...g. Personnel assist the residents with hand hygiene before meals, after toileting and when indicated...5. Resident-Care Equipment b. Reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed	S5003		
S5005	Ch 12 Sec 7 (a) Assisted Living Facility (ALF) Core Services (a) The assisted living facility core services include the following: (i) Meals, housekeeping, personal and other laundry services; (A) Provision of mechanically altered diets and dietary supplements, if required.	S5005		

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S5005	Continued From page 7 (ii) A safe and clean environment; (iii) Assistance with local transportation; (iv) Assistance with obtaining medical, dental, and optometric care, in addition to social services; (v) Assistance in adjusting to group living activities; (vi) Maintenance of a personal fund account, if requested by the resident or resident's responsible party, showing any and all deposits, withdrawals, and transactions of the account; (vii) Provision of appropriate recreational activities in/out of the assisted living facility; (viii) Care of individuals who require any or all of the following services: (A) Partial assistance with personal care, e.g. bathing, shampoos; (B) Limited assistance with dressing; (C) Minor non-sterile dressing changes; (D) Stage I skin care - skin integrity intact; (E) Infrequent assistance with mobility. The resident may use an assistive device; e.g., wheel chair, walker, cane; (F) Cuing guidance with ADLs for the visually impaired resident, or the intermittently	S5005		

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S5005	Continued From page 8 confused and/or agitated resident requiring occasional reminders to time, place and person; (G) Care of the resident who can independently manage his own catheter or ostomy, e.g., resident who can change his own catheter bags, able to clean and care for his ostomy; (H) Care of the resident incontinent of bowel or bladder if the condition can be managed independently; (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 residents' medication is changed; (x) Twenty-four (24) hour monitoring of each resident. This State Rule and Regulation is not met as evidenced by: Based on observation and staff and resident representative interview, the facility failed to ensure a safe environment for residents who wandered during 4 random observations. The census was 13. The findings were: 1. Observation on 4/20/23 at 1:45 PM showed a box containing an antifungal cream was located in resident #2's room. At 2:35 PM resident #7 was observed carrying the box of antifungal cream in the hallway. At that time LPN #1 intercepted the box and noted the box did not have a name on it and she did not know where it came from.	S5005		

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S5005	Continued From page 9 Interview with LPN #1 on 4/20/23 at 3:05 PM revealed resident #7 would wander in and out of resident rooms and pick up items that belonged to other residents. LPN #1 stated the resident had a collection of items in his/her room so if anything went missing they would look in the resident's room and "most of the time" the resident would give the item back. 2. Observation on 4/20/23 at 1:48 PM showed resident #4 entered resident #2's room. Interview with resident #2's representative at that time revealed resident #4 was always entering other resident's rooms. 3. Observation on 4/20/23 at 5:34 PM showed contract caregiver #1 was assisting resident #4 in the common room. The resident ran into a small table by the couch near the television and a screw came loose and fell on the floor. The caregiver picked up the screw and placed it on top of the small table at the back of the couch. Observation at 6:42 PM showed resident #7 was wandering the hallways with the screw in his/her hand and at that time approached RA #2 in the hallway and the screw was retrieved from the resident. 4. Observation on 4/20/23 at 2:40 PM showed 2 sets of dining room chairs were stacked on top of each other in the hallway. Resident #9 was observed approaching the chairs and when s/he attempted to sit in the chair it was observed to rock back and forth. GNA #1 redirected the resident to a chair in the dining room; however, the stacked chairs remained in place. 5. Interview with the DON on 4/21/23 at 1:46 PM revealed the antifungal cream was brought into the facility by a family member and left in resident	S5005		

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S5005	Continued From page 10 #2's room. The DON had educated the family and instigated a new system for items brought in to the facility by family. Further, the DON stated resident #7 had a history of putting items in his/her mouth and having the screw lying around was not safe. In an additional interview on 4/24/23 at 11:30 AM the DON stated the facility was currently shorthanded due to the loss of a CNA; however, all staff members were expected to provide assistance and supervision to the residents.	S5005		
S5011	Ch 12 Sec 7 (b)(vi) Assisted Living Facility (ALF) Core Services (b) (vi) Resident assistance plan. (A) An RN shall develop an assistance plan for each resident. (B) Each facility shall construct its own forms for such plans, which at a minimum shall contain documentation of the following: (I) Who will provide the care/services; (II) What care/services will be provided; (III) When will care/services be provided; (IV) How the care/services will be provided; (V) The expected outcome; (VI) Resident participation in	S5011		

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S5011	Continued From page 11 development of the assistance plan to the extent of his ability to do so. A relative or other interested part may also participate; and (VII) Dated signature of the RN, the facility manager, and the resident or the resident's responsible party. This State Rule and Regulation is not met as evidenced by: Based on observation, review of resident records, and staff, resident, and resident representative interview, the facility failed to develop and/or implement person-centered assistance plans for 3 of 4 sample residents (#4, #5, #6) who required assistance with transfers. The findings were: 1. Observation on 4/20/23 at 1:30 PM showed CNA #1 was transferring resident #5 from a recliner to his/her wheelchair by using a sit-to-stand lift. Interview with the CNA at that time revealed she always transferred the resident with the sit-to-stand lift. Observation on 4/23/23 at 2:37 PM showed RA #1 transferred the resident using a sit-to-stand lift. Interview with RA #1 at that time revealed the resident always required assistance with transfers and staff had been using the lift for a few months. Observation on 4/21/23 at 3:31 PM showed CNA #2 was using a sit-to-stand lift to transfer the resident out of his/her wheelchair and take him/her to the bathroom. At 3:37 PM CNA #2 brought the resident out of the bathroom on the sit-to-stand lift and transferred him/her to a recliner. Interview with CNA #2 at that time revealed she always used the sit-to-stand lift. In addition, she stated if the lift was not available the resident required the assistance of two staff members to transfer. Review of an incident report showed the resident fell on 1/2/23 which resulted in the resident being	S5011		

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S5011	Continued From page 12 transferred to the emergency room. Review of a 2/2/23 nursing evaluation worksheet showed the resident was readmitted to the facility after a stay at a long-term care center following surgery for a left hip fracture. Review of the 2/3/23 ALF 102 form showed the resident was completely dependent on the facility for mobility. Interview with the resident and the resident's representative on 4/21/23 at 10:45 AM revealed staff at the facility used the lift for all his/her transfers since the resident had broken his/her hip. The following concerns were identified: a. Review of the "Resident Needs Assessment Form" dated 2/2/23 showed the resident required the limited assistance (needs some physical help in maneuvering, minimal support) to "transfer to and from the bed, chair, wheelchair from laying, sitting, to standing." b. Review of the resident's 12/13/22 assistance plan showed "assist as needed to help with transfers in and out of bed, changing position, etc. Document any changes and update nursing, Use gait belt with all transfers" There was no evidence the assistance plan had been updated to include the current needs of the resident. 2. Review of resident #4's "Resident Needs Assessment Form" dated 2/21/23 showed the resident was totally dependent on staff to "transfer to and from bed, chair, wheelchair from laying, sitting, to standing". Review of the 2/3/23 ALF 102 form showed the resident was completely dependent for transfers and unable to evacuate the building. Review of the 3/24/23 contract agency care plan showed a full-body mechanical lift was to be used for transfers. Review of the resident's "Mobility Assistance" assistance plan dated 3/31/23 showed "Resident to receive mobility assistance with [contract	S5011		

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S5011	Continued From page 13 agency] per contractual agreement. (sic) every am and pm and prn (as needed), when transferring in and out of bed and wheelchair via Hoyer (full-body mechanical transfer device) lift." The following concerns were identified: a. Observation on 4/20/23 at 6:30 PM showed the DON and GNA #1 transferred resident #4 from the wheelchair to the bed by positioning themselves at the resident's sides, with each placing an arm beneath the resident's arm and lifting (arm and arm). The contractual staff member was present but did not assist in the transfer. A full-body mechanical lift was observed in the bathroom at that time, however it was not used. b. Review of contract agency care notes from 4/13/23 to 4/21/23 (morning and evening visits) showed the contractual staff transferred the resident by gait belt, arm and arm, full-body mechanical lift and used the wheelchair for mobility. 3. Observation on 4/20/23 at 4:06 AM showed RA #1 used a gait belt and transferred resident #6 using a pivot method to transfer the resident from a recliner to a wheelchair. Review of the 2/20/23 ALF 102 form showed the resident was completely dependent on staff for mobility. The following concerns were identified: a. Review of the 12/30/21 care plan showed assistance instructions of "implement fall risk protocol, and mobility changes, monitor for changes in mobility, cognition, behaviors." There was no evidence an assistance plan had been developed to reflect the resident's needs. 4. Interview with the DON on 4/24/23 at 1:46 PM confirmed the resident's assistance plans had not been updated to reflect the current needs of the residents.	S5011		

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	WY9044	A. BUILDING: _____ B. WING _____	C 04/24/2023

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S5014	Ch 12 Sec 7 (c) Assisted Living Facility (ALF) Core Services (c) Resident Rights. The facility shall adopt and follow a written policy of resident rights. The policy shall be posted in a conspicuous place, and there shall be documentation in the resident's record that the resident read, or management explained, the policy. This policy shall not exclude, take precedence over, or in any way abrogate the legal and constitutional rights enjoyed by all adult citizens and shall include, but is not limited to the following: (i) Be treated with respect and dignity; (ii) Privacy; (iii) Free from physical or chemical restraints not required to treat the resident's medical symptoms. No chemical or physical restraints will be used except by order of a physician; (iv) Not to be isolated or kept apart from other resident's (v) Not to be physically, psychologically, sexually, or verbally abused, humiliated, intimidated, or punished. (vi) Live free from involuntary confinement or financial exploitation; (vii) Full use of the facility's common areas; (viii) Voice grievances and recommend changes in policies and services; (ix) Communicate privately, including, but not limited to, communicating by mail or telephone	S5014		

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S5014	Continued From page 15 with anyone; (x) Reasonable use of the telephone, which includes access to operator assistance for placing collect telephone calls; (xi) Have visitors, including the right to privacy during such visits; (xii) Make visits outside the facility. The facility manager and the resident shall share responsibility for communicating with respect to scheduling such visits; (xiii) Make decisions and choices in the management of personal affairs, assistance plans, funds, or property; (A) Including choice of home health agencies, pharmacies, personal care providers and any other private pay provider. (xiv) Except the cooperation of the provider in achieving the maximum degree of benefit from those services which are made available by the facility; (xv) Exercise choice in attending and participating in religious activities; (xvi) Reimbursed at an appropriate rate for work performed on the premises for the benefit of the operator, staff, or other residents, in accordance with the resident's assistance plan; (xvii) Informed by the facility thirty (30) days in advance of changes in services or charges;	S5014		

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S5014	Continued From page 16 (xviii) Have advocates visit, including members of community organizations whose purpose include rendering assistance to the residents; (xix) Wear clothing of choice unless otherwise indicated in the resident's plan, and in accordance with reasonable dress code; (xx) Participate in social activities, in accordance with the assistance plan; and (xxi) Examine survey results. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, resident record review, and resident rights and policy and procedure review, the facility failed to ensure residents were free from physical restraints, not required to treat the resident's medical symptoms, for 1 of 6 sample residents (#4). The findings were: 1. Review of resident #4's "Resident Needs Assessment Form," dated 2/21/23, "Section IV---ADL Functional Performance" showed the resident was able to wheel self. Observation on 4/20/23 at 1:30 PM showed the resident was sitting in his/her wheelchair in resident #6's room. Observation at 1:52 PM showed the resident self-propelled his/her wheelchair in and out of resident rooms. Observation on 4/20/23 at 2 PM showed the resident exited room #1 (not this resident's room), then propelled down the hall in his/her wheelchair and entered room #7 (not this resident's room) without staff intervention. Observation at 2:25 PM showed RA #1 removed the resident from room #10 (not resident's room),	S5014		

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S5014	Continued From page 17	S5014		

took the resident to the dining room; placed the resident in front of a table; and applied both brakes to the wheelchair. The following concerns were identified:

a. Continuous observation on 4/20/23 from 2:25 PM to 5:45 PM showed the resident remained in the dining room with the brakes of the wheelchair locked. The resident made multiple unsuccessful attempts to move the wheelchair and unlock the brakes.

b. Interview with CNA #3 on 4/20/23 at 4 PM revealed the facility locked the resident's wheelchair brakes to keep the resident from leaving the table.

c. Interview with LPN #1 on 4/20/23 at 6:14 PM confirmed the resident was capable of using his/her feet to propel his/her wheelchair; however, the resident "liked" to run over people's feet so staff would lock the wheelchair brakes while the resident was in the dining room.

d. Interview with the DON on 4/21/23 at 9:45 AM confirmed the resident should be allowed to move about the common area freely.

2. Review of the facility's residents rights policy showed "Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:...be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms..."

3. Review of the facility's restraints policy showed... 2. The use of antipsychotic or any other medication that may alter the mental status of a resident may only be used if the resident poses a threat to himself or others and is non-directable by any other means and is deemed necessary by the physician. 3. The Executive and Wellness Director must direct staff on the appropriate

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S5014	Continued From page 18 ordered interventions. 4. The facility encourages re-direction when at all possible." The policy failed to address the physical restraint of residents.	S5014		
S5025	Ch 12 Sec 7 (j)(i) Assisted Living Facility (ALF) Core Services (j) Food Service and Nutrition. (i) Assisted Living Facilities that choose to admit residents who need therapeutic or mechanically modified diets must employ or contract with a Registered Dietitian who shall approve written menus and dietary modifications, approve special diet needs, plan individual diets, and provide guidance to dietary staff in areas of preparation, service, and monitoring. The frequency of visits is determined by the residents' needs and the competency of the dietary staff but must include at least a monthly onsite review of dietary services. This State Rule and Regulation is not met as evidenced by: Based on observation, resident record review, and staff interview, the facility failed to employ or contract with a Registered Dietitian (RD) to approve special diet needs, plan individual diets, and provide guidance to dietary staff in areas of preparation, service, and monitoring which affected resident #3 who required a mechanically modified diet. The findings were: 1. Review of the 4/5/23 physician order report for resident #3 showed an order dated 2/9/23 for "food cut to small bites and nectar thick liquids." The following concerns were identified: a. Observation on 4/20/23 at 4:42 PM showed the resident was served a pureed meal.	S5025		

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S5025	Continued From page 19 Interview with the DON at that time confirmed the resident had also been served nectar-thick water and nectar-thick apple juice. b. Interview on 4/21/23 at 11:18 AM with cook #2 revealed she thought the resident's diet had changed to a pureed diet sometime in mid-March. Further, cook #2 stated she was not given any training on preparing a pureed diet and just put what was on the menu in the food processor. c. Observation on 4/21/23 at 12 PM showed cook #2 placed an egg roll and rice into a food processor with some orange juice and then served the processed food to the resident. 2. Interview with the DON on 4/21/23 at 9:50 AM revealed the facility contracted with an RD to review and approve the menus; however, the RD did not make onsite visits to the facility. During an additional interview at 1:36 PM the DON confirmed the resident did not have a physician order for a pureed diet and thought it was perhaps a communication error.	S5025		
S5029	Ch 12 Sec 7 (j)(v) Assisted Living Facility (ALF) Core Services (j) (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 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, staff interview, and review of the 2017 U.S. Public Health Service Food Code, the facility failed to ensure individuals with	S5029		

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S5029	Continued From page 20 food preparations responsibilities were adequately trained. The census was 13. The findings were: 1. Observation on 4/20/23 at 2:50 PM showed cook #1 was in the kitchen preparing beverages for residents and organizing the placement of the beverage glasses on the counter by placing her ungloved fingertips on the outside surface of the glasses near the rim. The cook then touched cookies, wiped her nose, and opened the kitchen trash with her bare hands. Continued observation showed the cook proceeded to open a food storage unit, reenter the kitchen and touch the kitchen cabinets. At no time did the cook wash her hands. At 2:55 PM the cook donned gloves; opened the trash can to throw away some trash and then continued, with the same gloved hands, to open a tortilla package and directly touch the fresh tortillas. In addition, the cook did not wear a hair restraint during the preparation of the 4/20/23 evening meal. 2. Observation on 4/21/22 at 10:22 AM showed cook #2 was preparing the noon meal without wearing a hair restraint. Interview with the cook on 4/21/23 at 11:18 AM revealed she worked part-time and had been employed by the facility for approximately a year. Further the cook stated she was not required to wear a hairnet while preparing food and had not received any formal training. 3. Interview with the DON on 4/20/23 at 7:10 PM revealed the facility employed 3 cooks and a certified dietary manager. In addition, the DON stated cook #1 had requested a ServSafe training course; however, the facility's Relias (an online educational source) account was inactive and cook #1 had not received the training.	S5029		

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S5029	Continued From page 21 4. Review of the 2017 FDA Food Code showed "Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in ¶ (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLESERVICE and SINGLE-USE ARTICLES."	S5029		

Cottonwood Creek Assisted Living
Plan of Correction for Survey 4/24/2023
Ref: LH-2023-0513

1. **S5003:**
   a. RA1 GNA1 COOK1 and LPN1 will all be re-educated on following universal precautions and handwashing per facility policy.
   b. All caregiving staff will be educated on sanitizing equipment between each resident, educated on not using contaminated items that are placed on the ground (nasal cannula).
   c. All residents in the facility have the potential to be affected.
   d. All facility staff will receive additional training on universal precautions and handwashing per our facility policy for such precautions.
   e. Wellness Director or designee will monitor compliance through periodic 1:1 return demonstration of adherence to universal precautions and handwashing according to the facility policy for such precautions. Additionally, staff will receive in-service training for universal precautions and handwashing as a part of their annual training plan.
   f. Executive Director will ensure compliance through review of facility audits as a Quality Assurance Measure and be monitored until resolution.
   g. Correction will be complete on or before 6/08/2023.

2. **S5005:**
   a. R2's family has been educated that any OTC medications that family may bring in must be kept by nursing staff to ensure all resident's safety. Contract caregiver has been educated on resident safety in the environment and was instructed any item considered a safety risk to residents is to be taken to the office and given to the staff. Stacked chairs have been removed and placed in storage.
   b. All Caregivers will be educated on any OTC medications, safety risks, and be kept by nursing to ensure safety for all Residents.
   c. All residents with wandering behaviors have the potential to be affected.
   d. R4, R7, and all Residents with wandering behaviors will be monitored every 30 minutes and documented by CNA/RA staff.
   e. Wellness Director has been educated on storage of OTC medications and they will be kept in the locked medication room for safety. All families will be notified of this requirement. Wellness Director will require all contract caregivers to receive resident environment safety training prior to providing services in our facility. Periodic facility rounds will be completed to identify potential safety risks for residents.
   f. Executive Director will ensure compliance through review of facility rounds reports and reporting documentation as a Quality Assurance Measure and be monitored until resolution.

Accepted POC 7/6/23 @ 8:28 AM.
Sundae notified @ that time Doc 6/8/23
Doreen Berg RN

g. Correction will be complete on or before 6/08/2023.

3. **S5011:**
   a. R5, R4, and R6's service plans have been updated to the current needs of the residents
   b. All residents have the potential to be affected.
   c. Wellness Director has been educated on formulating person centered interventions for residents and updating the service plan to reflect the needs of the resident upon admission, significant change, and annually. All residents service plans will be reviewed to ensure they address the individualized needs of each resident.
   d. Executive Director will ensure compliance through periodic reviews of service plans as a Quality Assurance Measure and be monitored until resolution.
   e. Correction will be complete on or before 6/08/2023.

4. **S5014:**
   a. CNA3 and LPN 1 have been educated on physical restraints and instructed that R4 is not to have his wheelchair locked except for resident safety.
   b. Residents in wheelchairs with wandering behaviors have the potential to be affected.
   c. All residents will have an initial review of restraints that hinders movement.
   d. All care staff will receive education on any restraint that hinders movement.
   e. R4's service plan will be updated to ensure staff will not utilize the wheelchair brakes to hinder resident movement and only for resident safety. Wellness Director has implemented a program for residents that need cuing and have difficulty remaining at the table for meals that includes grouping of residents with such needs and providing staff supervision for redirection and cuing at meals.
   f. Executive Director will ensure compliance through review of residents at risk of being restrained as a Quality Assurance Measure and be monitored until resolution.
   g. Correction will be complete on or before 6/08/2023.

5. **S5025:**
   a. R3's diet orders have been verified and updated. Registered Dietician has educated staff on preparation of pureed diets.
   b. All residents with special diets have the potential to be affected.
   c. Wellness Director has been educated on the requirements related to assessment and ongoing review of residents on special diets by a Registered Dietician. RD has completed assessment and intervention related to the special diet of R3. RD will review resident monthly and on site as needed. Wellness Director has implemented communication forms for outside therapy providers to communicate

recommendations that require physician orders. Wellness Director will provide CDM written dietary orders for each resident so Dietary staff have correct diets. Wellness Director or designee will audit all residents diet orders to ensure all residents with special orders are receiving RD assessment and intervention and that Dietary is preparing the correct diet for each resident. RD will provide training on preparation of special diets to all dietary staff.

d. Executive Director will ensure compliance through review of resident diet orders, reports, and reporting documentation Quality Assurance Measure and be monitored until resolution.
e. Correction will be complete on or before 6/08/2023.

6. **S5029:**
   a. Cook1 and Cook2 have been re-educated in safe handling techniques per the 2017 Food Code.
   b. All residents have the potential to be affected.
   c. Registered Dietician will be training all dietary staff on safe food handling practices per the food code. All staff will complete ServSafe training at facility cost. All dietary staff will be enrolled in ServSafe by 5/30/23. Dietary staff will be required to wear hair restraints
   d. Executive Director or designee will ensure compliance through periodic ongoing observation of food handling techniques of dietary staff as a Quality Assurance Measure and will be monitored until resolution.
   e. Correction will be complete on or before 6/08/2023.

7/6/23
S Clay RN