Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	06/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	OPENING COMMENTS	S 000		

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 licensure survey was conducted by Healthcare Licensing and Surveys from 6/3/25 to 6/5/25. Also reviewed in the course of the survey was complaint intake LIC-25-037.

The following common abbreviations are used throughout this document:

CNA: Certified Nursing Assistant
CSD Clinical Services Director
DA: Dietary Aide
DSD: Dining Services Director
ED: Executive Director
LPN: Licensed Practical Nurse

Less commonly used abbreviations will be annotated in each deficiency.

S6003 Ch 12 Sec 6 (d) Personnel and Staffing Requirements — S6003

(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;

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive director 7/2/25

This plan of correction was accepted on 7/2/25. Chasnee Schaefer was notified via email.

Jean Yannis MT(ASCP) 7/2/25

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S5003	Continued From page 1 (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 review of personnel files, policy and procedure review, and staff interview, the facility failed to ensure 2 out of 2 sample employees (LPN #1, CNA #1) reviewed were tested or screened for tuberculosis (TB) as appropriate on an annual basis. The findings were: 1. Review of the personnel file for LPN #1 showed she received a two-step tuberculin test upon hire; however, there was no evidence LPN #1 had been tested or screened for TB since the completion of the test on 8/31/23. 2. Review of the personnel file for CNA #1 showed she received a two-step tuberculin test upon hire; however, there was no evidence CNA #1 had been tested or screened for TB since the completion of the test on 10/29/23. 3. Interview with the ED on 6/5/25 at 11:48 AM revealed the facility did not have a system in place to screen or test employees on an annual	S5003	The ED and CSD will create a binder that has the necessary documentation of each employees 2-step TB screening, to ensure the ability to track when annual screenings are due and when the TB Risk Assessment Worksheet needs to be completed. This binder will be audited monthly by the QI team to ensure that everyone is up to date for TB screenings. All current employee files and TB screenings will be audited by QI to ensure they are updated and documented as needed. On-going, all new hires will be screened upon hire date and will be added to the binder to ensure the ability to track when the annual screenings are due and when the TB Risk Assessment Worksheet needs to be completed.	8/1/2025

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S5003	Continued From page 2 basis for TB. 4. Review of the "TB SCREENING WYOMING - RESIDENT AND EMPLOYEE" policy, last updated April 2025, showed "The community is required to complete a community TB Risk Assessment on an annual basis to determine how often community staff should be screened for TB. All residents and employees should receive a TB risk assessment and symptom evaluation on an annual basis, or as needed."	S5003	LPN #1 and CNA #1 will be screened for TB with a 2-step test and it will be added to their employee file as well as binder for auditing. ED and CSD informed BOD and all clinical staff of new process for TB testing and tracking.	7/15/2025
S5007	Ch 12 Sec 7 (b)(ii) Assisted Living Facility (ALF) Core Services (b) (ii) Admission orders. A resident shall be admitted only if accompanied by a history and physical completed by a physician or physician extender within ninety (90) days prior to admission. The facility shall confirm the resident's medication regimen and special treatment orders at the time of admission. (A) Admission orders shall include an order for TB screening, influenza and pneumococcal immunization status and orders for immunization if required, unless contraindicated. The facility must develop and implement policies and procedures to ensure the following: (I) Residents, or their legal representative are educated regarding the risks and benefits of these immunizations. (II) The immunizations are offered unless medically contraindicated or the resident is currently immunized.	S5007		

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S5007	Continued From page 3	S5007		

(III) If the resident is not vaccinated, the medical record must reflect the reason, such as medical contraindication or refusal.

This State Rule and Regulation is not met as evidenced by:
Based on resident record review, staff interview, and policy and procedure review, the facility failed to implement their influenza and pneumococcal immunization policy for 5 of 5 sample residents (#1, #2, #3, #4, #5) reviewed. In addition, the facility failed to implement their tuberculosis screening policy for employees and resident policy for 2 of 5 sample residents (#1, #2) reviewed. The findings were:

1. Review of the "IMMUNIZATION" policy, last updated April 2025, showed "...As regulations require, the community shall offer or coordinate with an outside provider for resident vaccinations and shall maintain related documentation in the electronic medical health record. The community shall determine resident's vaccination status at time of admission. After admission, the community shall coordinate for residents to receive vaccinations as required or requested. Appropriate consent (and/or refusal if required) must be obtained from resident, resident's representative, or staff member..." Review of the "TB SCREENING WYOMING - RESIDENT AND EMPLOYEE" policy, last updated April 2025, showed "...All residents and employees should have a patient TB risk assessment, symptom evaluation, and TB test performed prior to admission to the community..." The following concerns were identified:

a. Review of the record for resident #1 showed s/he was admitted to the facility on 4/24/24. There was no evidence a tuberculin test

The CSD will ensure that residents receive a 1-step TB screening upon admission.

Each resident will have a TB Risk Assessment Worksheet, documenting any updated symptoms during their annual care plan.

All current residents' files\charts\TB screenings will be audited to ensure they are updated and documented as needed.

The CSD will ensure that correct and appropriate immunizations are entered into resident charts upon admission. 8/1/2025

The CSD will ensure that vaccinations are offered to residents as requested or required.

Resident or Resident Representative signed consent or signed refusal will be uploaded to residents' chart to ensure that required documentation is available for review as needed.

Resident #1, #2, #3, #4 and #5 will all be screened using a 1-step TB and it will be added to their chart as well as binder for annual auditing and review.

JM
~~7/15/2025~~

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S5007	Continued From page 4 had been performed prior to admission and there was no record of the resident's pneumococcal or influenza immunization status. b. Review of the record for resident #2 showed s/he was admitted to the facility on 9/3/24. There was no evidence a tuberculin test had been performed prior to admission and there was no record of the resident's pneumococcal or influenza immunization status. c. Review of the record for resident #3 showed s/he had received the influenza vaccine on 12/20/24; however, there was no record of the resident's pneumococcal immunization status. d. Review of the record for resident #4 showed s/he last received an influenza vaccine in 2021; however, there was no documentation the resident had been educated on, or offered the vaccine in 2022, 2023, or 2024. There was no record of the resident's pneumococcal immunization status. e. Review of the record for resident #5 showed s/he was admitted to the facility on 10/16/23. There was no documentation of the resident's influenza or pneumococcal immunization status. f. Interview with the CSD on 6/5/25 at 2:19 PM confirmed no further documentation was available.	S5007	The ED and CSD informed BOD and all clinical staff of new process for TB screening and tracking. On-going, all new residents will be screened upon admission date and will be added to TB binder to ensure the ability to track and audit monthly and annual by the QI team.	~~6/30/2025~~
S5017	Ch 12 Sec 7 (d)(iii) Assisted Living Facility (ALF) Core Services (d) (iii) Self medication. (A) Residents able to self-medicate may keep prescription medications in their room if deemed safe and appropriate by the RN. (B) Residents may keep and use	S5017		

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S5017	Continued From page 5 over-the-counter medication in their room without a written order by a physician unless deemed inappropriate by the RN. (C) If more than one resident resides in the room, and assessment will be made of each person and his ability to safely have medications in the room. If safety is a factor, the medication shall be kept in a locked container. (D) The facility will work with the resident to develop a means to mutually resolve any problems relating to self-medication. This State Rule and Regulation is not met as evidenced by: Based on observation, resident record review, staff interview, and policy and procedure review, the facility failed to ensure residents were deemed safe to self medicate for 2 of 7 sample residents (#6, #7) reviewed for medication administration. The findings were: 1. Observation on 6/4/25 at 3:57 PM showed LPN #2 was administering medication to resident #6. LPN #2 placed atorvastatin (a medication to treat high cholesterol), metoprolol (a blood pressure medication), mirtazapine (an antidepressant), remelteon (a medication to treat insomnia), and trimethoprim (an antibiotic) into a medication cup, entered the resident's room, acknowledged the resident, left the medication with the resident, and exited the room. Interview with LPN #2, at that time, revealed it was at the nurse's discretion whether medications could be left with the resident to be consumed at a later time. The following concerns were identified: a. Review of the 3/26/24 nursing assessment for resident #6 showed a self-administration of medication assessment was completed which	S5017	The CSD will ensure that all residents have a completed self-administration assessment upon admission. The CSD will review all current resident self-administration assessments and update appropriately based on the residents' ability and provider orders. The CSD will update the self-administration assessments on an as-needed basis or during their annual care plan review. Nurses will be updated on all changes regarding self-administration assessment determinations to ensure they are educated on the residents' that have the ability to self-medicate and the residents that do not have the ability to self-medicate. ~~7/15/2025~~ JY	

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S5017	Continued From page 6 determined the resident was unable to self-administer medication safely. 2. Observation on 6/4/25 at 4:03 PM showed LPN #2 was administering medication to resident #7. LPN #2 placed melatonin (a medication to treat insomnia) and metformin (a medication used to treat diabetes) into a medication cup, entered the resident's room, acknowledged the resident, left the medication with the resident, and exited the room. The following concerns were identified: a. Review of the 2/12/25 nursing assessment for resident #7 showed a self-administration of medication assessment was completed which determined the resident was unable to self-administer medication safely. 3. Interview with the CSD on 6/5/25 at 2:26 PM revealed leaving medications with a resident was only at the nurse's discretion if the resident had passed the self-administration of medication assessment. 4. Review of the "MEDICATION SYSTEM SUMMARY" policy, last updated April 2025, showed "...Resident self-administration of medication is allowed only when resident has successfully demonstrated safe medication techniques per self-medication assessment..."	S5017	Changes noted in self-administration assessments or provider orders will also be noted in all resident MARs to reflect the ability of self-medicating or the non-ability to self-medicate. Resident #6 and #7 will receive a new self-administration assessment to determine individual ability to self-medicate. CSD will complete self-administration assessments during the annual care plans for each resident or on an as-needed basis to ensure all residents are assessed appropriately in the ability or non-ability to self medicate. Going forward, CSD will ensure that care plan with the self-administration assessments are completed annually or on an as-needed basis to remain in regulation. QI will also monitor monthly and annually to ensure that all assessments for self-medicating are current.	8/1/2025
S5026	Ch 12 Sec 7 (j)(ii) Assisted Living Facility (ALF) Core Services (j) (ii) There must be an 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	S5026		

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S5026	Continued From page 7 must ensure that food prepared in nutritionally adequate in accordance with the Dietary Reference Intakes (DRI) for adults. This State Rule and Regulation is not met as evidenced by: Based on observation, review of manufacturer's instructions, staff interview, and review of the FDA 2022 Food Code regulations, the facility failed to ensure food was prepared, stored, and distributed under sanitary conditions in 1 of 1 kitchen. The census was 56. The findings were: Related to temperature monitoring of food storage units: 1. Observation on 6/3/25 at 9:40 AM showed the kitchen used a walk-in refrigerator and freezer for food storage. The following concerns were identified: a. The DSD was unable to locate the "Refrigeration Temperature Log" sheet for March 2025. b. Review of the April 2025 "Refrigeration Temperature Log" sheet showed the temperature of the refrigerator and freezer were not documented on 17 of 30 days (4/6, 4/7, 4/8, 4/9, 4/12, 4/13, 4/14, 4/15, 4/16, 4/17, 4/22, 4/23, 4/24, 4/25, 4/28, 4/19, 4/30). c. Review of the May 2025 "Refrigeration Temperature Log" sheet showed the temperature of the refrigerator and freezer were not documented on 22 of 31 days (5/1, 5/7, 5/8, 5/13, 5/14, 5/15, 5/16, 5/17, 5/18, 5/19, 5/20, 5/21, 5/22, 5/23, 5/24, 5/25, 5/26, 5/27, 5/28, 5/29, 5/30, 5/31). 2. Interview with the DSD on 6/3/25 at 3:29 PM	S5026	The DSD will create binders for the refrigeration and freezer temperature monitoring logs that are divided into monthly tabs with daily sheets in each tab for each month. The DSD will monitor these logbooks daily x14 days, then weekly x4 weeks, with monthly monitoring on-going to ensure that correct documentation of temperature logs is recorded and available for review at any time.	~~6/30/2025~~ JY

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S5026	Continued From page 8 confirmed the temperatures of the food storage units had not been documented as required. Related to the sanitary environment of the kitchen: 1. Observation on 6/3/25 at 9:40 AM showed the facility used a Scotsman ice machine. The following concerns were identifed: a. A maintenance sticker on the side of the ice machine showed the ice machine had last been serviced on 4/11/24. Further observation showed the exterior air vents and the screen filter behind the air vents, were covered with grease and debris and the top ledge underneath the lid had an accumulation of dirt. b. Review of the "Cooks' Cleaning Schedule", the "Dining Aide Cleaning Schedule", and the "Monthly Cleaning" log sheet showed no evidence the cleaning of the ice machine was included. c. Interview with the DSD on 6/3/25 at 3:40 PM confirmed the ice machine had not been cleaned. In addition, the DSD stated she had recently contacted the service company to schedule the ice machine's maintenance; however, a specific date had not been determined. d. Review of the Ice-O-Matic manufacturer's instructions, provided by the facility, showed the following maintenance should be performed every 3 months "1. Clean the ice-making section, if necessary, per instructions on page 10. Local water conditions may require that cleaning be performed more often than 6 month intervals. 2. Check ice bridge thickness...3. Check the water level in the trough...4. Clean the condenser (air cooled machines) to insure (sic) unobstructed air flow. 5. Check for leaks of any kind; water, refrigerant, oil, etc. 6. Check the bin switch or the thermostat for proper adjustment...7. Check the	S5026	The DSD will ensure that the ice machine is cleaned and serviced based on the manufacturers manual or more often on an as-needed basis. The manufacturer manual state the ice machine is to be cleaned every 3 months and serviced every 6 months. The DSD will also add the cleaning and servicing of the ice machine to the cleaning checklist in the kitchen that will require daily inspection, making it aware of additional and extra cleaning or servicing as needed. The ice machine will be cleaned and serviced by CD services.	~~6/30/2025~~ JY 8/1/2025

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S5026	Continued From page 9	S5026		

Cam Switch for proper adjustment...8. Check the water regulating valve (water cooled machines for proper adjustment...9. Check all electrical connections. 10. Oil fan motor if motor has oil fitting (self-contained air cooled)."

2. Observation of the kitchen on 6/3/25 at 9:40 AM showed the automatic dishwasher had a data plate which showed the minimum temperature of the rinse and water should be 120 degrees Fahrenheit and the minimum concentration of the chlorine should be 50 parts per million. The following concerns were identified:

a. The DSD was unable to locate the dishwasher water temperature and sanitizer concentration log sheets for March and May 2025.

b. Review of the April 2025 dishwasher/sanitizer concentration log sheet showed the temperature of the water and sanitizer solution were to be recorded at breakfast, lunch, and dinner. Further review showed the temperature and sanitizer concentration were not documented 20 out of 90 opportunities. Of the 70 recorded temperatures the wash water was documented to be below 120 degrees Fahrenheit 5 times.

c. Interview with the DSD on 6/3/25 at 3:29 PM confirmed the temperature of the water and sanitizer concentration for the dishwasher had not been documented as required.

3. Observation on 6/3/25 at 9:56 AM showed DA #1 was preparing dessert for the noon meal without wearing a hair restraint. Interview with DA #1 at that time confirmed she was not wearing a hair restraint as required. Interview with the DSD on 6/4/25 at 3:48 PM revealed it was her expectation that hair restraints be worn in the kitchen at all times.

The DSD will create a binder for the dishwasher temperature and sanitation logs that are divided into monthly tabs with daily sheets in each month for monitoring.

The DSD will monitor these logbooks daily x14 days, then weekly x4 weeks with monthly on-going after that to ensure that correct documentation of temperature logs are recorded and available for review.

~~6/30/2025~~
JY

The DSD will ensure that all staff are re-trained and educated on Edgewood standards as well as state regulations.

The DSD will ensure daily that all staff are in proper uniform following the expectation and requirements.

~~6/30/2025~~
JY

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S5026	Continued From page 10 4. According to the 2022 FDA Food Code "2-103.11 Person in Charge. The PERSON IN CHARGE shall ensure that...(J) FOOD EMPLOYEES are properly maintaining the temperature of TIME/TEMPERATURE CONTROL FOR SAFETY FOODS during thawing through daily oversight of the FOOD EMPLOYEE'S routine monitoring of FOOD temperatures..." 5. According to the 2022 FDA Food Code showed "4-602.11 Equipment Food-Contact Surfaces and Utensils...Surfaces of utensils and equipment contacting food that is not time/temperature control for safety food such as iced tea dispensers, carbonated beverage dispenser nozzles, beverage dispensing circuits or lines, water vending equipment, coffee bean grinders, ice makers, and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms. Some equipment manufacturers and industry associations, e.g., within the tea industry, develop guidelines for regular cleaning and sanitizing of equipment. If the manufacturer does not provide cleaning specifications for food-contact surfaces of equipment that are not readily visible, the person in charge should develop a cleaning regimen that is based on the soil that may accumulate in those particular items of equipment." 6. According to the 2022 FDA Food Code showed "4-703.11 Hot Water and Chemical. Efficacious sanitization depends on warewashing being conducted within certain parameters. Time is a parameter applicable to both chemical and hot water sanitization. The time hot water or	S5026	DA #1 was re-educated on the necessity of wearing hair restraints in the kitchen and also received a written coaching. The DSD will set up additional training and educational opportunities to staff by having each staff member and any new hires, to obtain the ServSafe Food Handlers Course. The DSD, along with offering the ServSafe, has educated all staff on the importance and necessity in monitoring the temperatures of the food storage units, cleaning of the dishwasher and the ice machine.	~~7/15/2025~~ JY ~~7/1/2025~~ JY

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5026	Continued From page 11 chemicals contact utensils or food-contact surfaces must be sufficient to destroy pathogens that may remain on surfaces after cleaning. Other parameters, such as rinse pressure, temperature, and chemical concentration are used in combination with time to achieve sanitization...The actual temperatures and rinse pressure should be consistent with the machine manufacturer's operating instructions and within limits specified in §§ 4-501.112 and 4-501.113. If either the temperature or pressure of the final rinse spray is higher than the specified upper limit, spray droplets may disperse and begin to vaporize resulting in less heat delivery to utensil surfaces. Temperatures below the specified limit will not convey the needed heat to surfaces. Pressures below the specified limit will result in incomplete coverage of the heat-conveying sanitizing rinse across utensil surfaces." 7. According to the 2022 FDA Food Code showed "2-402 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 SINGLE-SERVICE and SINGLE-USE ARTICLES."	S5026	The ED will conduct weekly checklists with the DSD to include the monitoring and completion of daily cleaning logs, temperature logs, uniform requirements and other noted needs in the kitchen going forward.	~~6/30/2025~~
S5041	Ch 12 Sec 7 (l) Assisted Living Facility (ALF) Core Services (l) Quality Improvement. (i) The facility shall have an active quality improvement program to ensure effective	S5041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	06/05/2025

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S5041	Continued From page 12 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 the 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. (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 review of facility documentation and	S5041	The ED will conduct a self-assessment survey beginning 7/15/2025, auditing all 4 of the required elements and state regulations within chapter 12. ED will conduct this self-assessment survey annually beginning 8/1/2026.	8/1/2025

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S5041	Continued From page 13 staff interview, the facility failed to complete a self-assessment survey of compliance with the regulations on an annual basis. The census was 56. The findings were: 1. Review of the facility's documentation showed no evidence a self-assessment survey of compliance with the regulations had been completed. 2. Interview with the ED on 6/5/25 at 3:33 PM revealed the quality assurance committee met on a monthly basis and discussed various topics; however, the ED was unable to locate documentation a self-assessment survey of compliance with the state rules had been completed.	S5041	The ED will conduct an additional QI meeting, that will join the existing monthly QA\Directors meetings. The QI meeting will be led by the ED and will be noted with services provided to residents with written descriptions, areas of problem with monitoring and the needed frequency. The QI meeting will also note all incidents in the building within the last 30 days. For the QI meeting, there will be a form that will be signed by all attendees and notes from discussions listed above. JY	~~6/30/2025~~
S5048	Ch 12 Sec 9 (a)(i) Contractual Svcs Provided Outside ALF Auth (a) Residents in an assisted living facility may receive services from an outside entity for care beyond that provided for or specified in the Assisted Living Program Administration Rules. These services must be arranged by the appropriate professional and be incorporated into the resident's assistance plan. The resident's choice of providers must be honored. (i) Components of the outside service(s) contract: (A) Who will provide service(s); (B) What service(s) will be provided; (C) When the service(s) will be provided;	S5048		

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S5048	Continued From page 14 (D) Where the service(s) will be provided; (E) How the service(s) will be provided; and This State Rule and Regulation is not met as evidenced by: Based on review of facility documentation, resident record review, staff interview, and policy and procedure review, the facility failed to ensure a service contract was developed which included all required components for 2 of 3 sample residents (#1, #4) reviewed who received services from an outside entity. The findings were: 1. Review of the resident record for resident #4 showed the resident received hospice services. Review of the resident record for resident #1 showed she received physical therapy from an outside care entity. Further review of the residents' records showed no evidence a contract had been developed between the outside care entity and the facility. 2. Interview with the CSD on 6/5/25 at 2:38 PM confirmed no further documentation was available. 3. Review of the "OUTSIDE HEALTH CARE AGENCY" POLICY, last updated April 2025, showed " To meet resident needs, Clinical Services should coordinate with health care agencies outside the Community, including those related to home health (physical therapy, occupational therapy, mental health, speech therapy, etc.) hospice care and private duty attendants...1. Review state regulations to assure that the resident condition to be treated is within	S5048	CSD will audit all current residents that are currently receiving outside services to ensure that there is an Outside Service Acknowledgement form signed and uploaded in their charts. If there is not an Outside Service Acknowledgement form in their chart, the CSD will fax all providers necessary to obtain signed acknowledgement forms as needed. On-going, the CSD will ensure that all Outside Service Acknowledgment forms are completed and signed upon admission of a resident, or an update in services provided from the outside entity. CSD will ensure that all acknowledgement form are uploaded to resident charts appropriately and consistently for new and existing outside services. CSD has reached out to outside entities for Resident #1 and Resident #4, to obtain signed Outside Service Acknowledgement Agreements.	7/15/2025

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S5048	Continued From page 15 the scope of services the Community can provide (with assistance, if needed.)...Before any service begins, complete and secure signatures for the form Outside Service Acknowledgement...According to instruction on the form, the Community representative who signs can be only the Executive Director, Registered Nurse or Nurse Consultant."	S5048	CSD will audit the Outside Service Acknowledgement Agreements monthly to bring documentation to monthly QI meeting for purpose of tracking.	
S5060	Ch 4 Sec 5 (j)(e) Licensure (j) (E) The Assisted Living Facility shall post the survey results in a manner conducive for public view. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to post the state licensure survey results in a manner conducive for public view. The census was 56. The findings were: 1. Observation of the facility during the survey timeframe of 6/3/25 through 6/5/25 showed no evidence the state licensure survey results were available for public view. 2. Interview with the ED on 6/5/25 at 3:20 PM revealed she was unaware of the state rule.	S5060	The ED has created a binder that can be easily accessed by visitors, residents and staff. The binder is located in the main library on the first floor of the building. ED took note from the surveyors suggestions of maintaining the records of 3 years worth of past surveys in the binder. The ED will add new surveys to the binder as any additional surveys are conducted and concluded. The survey binder will be observed to be in its proper location on a monthly basis, beginning 7/31/2025, and at the end of each following month.	JY ~~6/9/2025~~ 7/31/2025