Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF011	A. BUILDING: _____ B. WING _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE JOURNEY	624 TWIN RIDGE AVENUE EVANSTON, WY 82930

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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 licensure survey was conducted by Healthcare Licensing and Surveys from 3/19/25 to 3/20/25. Also reviewed in the course of the survey was complaint intake LIC-24-060. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant LPN: Licensed Practical Nurse NA: Nursing Assistant RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5001	Ch 12 Sec 6 (b) Personnel and Staffing Requirements (b) Staffing. (i) The staffing level shall be sufficient to meet the needs of all residents of the facility, and insure the appropriate level of care is provided. (ii) There shall be personnel on duty to maintain order, safety, and cleanliness of the premises, to prepare and serve meals, to keep and adequate supply of clean linens, to assist the residents in personal needs and recreational activities, and to meet the other operational	S5001		

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S5001	Continued From page 1 needs of the facility. (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. (iv) There shall be at least one (1) RN, LPN, or CNA on duty every shift. There shall be at least one (1) person on duty and awake at all times. (v) If the assisted living facility does not employ an RN, the facility shall Contract with an RN to provide the initial assessment, periodic reviews, assistance plans, as well as the periodic updates of resident assessment, reviews, assistance plans, and medication management. This State Rule and Regulation is not met as evidenced by: Based on review of personnel files, staffing schedule review, and staff interview, the facility failed to ensure one RN, LPN, or CNA was on duty every shift for 15 out of 19 days reviewed from 3/1/25 through 3/19/25. The census was 13. The findings were: 1. Review of the employee roster supplied by the facility showed the facility employed one LPN, 2 CNAs, 4 nursing assistants, 3 cooks, and a housekeeper to provide resident care. Two RNs had been contracted by the facility. Review of the staff schedule for March 2025 showed the following concerns: a. No licensed nurses or CNAs were scheduled from 7 PM on 3/2 until 7 AM on 3/3. b. No licensed nurses or CNAs were scheduled from 3:30 PM on 3/3 until 7 AM on 3/4. c. No licensed nurses or CNAs were	S5001		

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S5001	Continued From page 2 scheduled from 3:30 PM on 3/4 until 7 AM on 3/5. d. No licensed nurses or CNAs were scheduled from 9 PM on 3/5 until 7 AM on 3/6. e. No licensed nurses or CNAs were scheduled from 7 PM on 3/9 until 7 AM on 3/10. f. No licensed nurses or CNAs were scheduled from 9 PM on 3/10 until 7 AM on 3/11. g. No licensed nurses or CNAs were scheduled from 9 PM on 3/11 until 7 AM on 3/12. h. No licensed nurses or CNAs were scheduled from 9 PM on 3/12 until 7 AM on 3/13. i. No licensed nurses or CNAs were scheduled from 3:30 PM to 9 PM on 3/13 and 3/14. j. No licensed nurses or CNAs were scheduled from 7 AM until 11 AM on 3/15. k. No licensed nurses or CNAs were scheduled on 3/16 from 7 AM until 4 PM and from 9 PM to 7 AM on 3/17. l. No licensed nurses or CNAs were scheduled on 3/17 from 7 AM until 3:30 PM and from 9 PM to 7 AM on 3/18. m. No licensed nurses or CNAs were scheduled from 9 PM on 3/18 until 7 AM on 3/19. n. No licensed nurses or CNAs were scheduled from 9 PM on 3/19 until 7 AM on 3/20. 2. Interview with the facility owner on 3/19/25 at 1:18 PM revealed she had difficulty staffing the facility with licensed nurses and CNAs, and had been diligently working within the community to promote the education of CNAs. In an additional interview on 3/20/25 at 5:15 PM the facility owner confirmed the facility was not staffed as required.	S5001		
S5002	Ch 12 Sec 6 (c) Personnel and Staffing Requirements (c) Background checks. All staff of the assisted	S5002		

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S5002	Continued From page 3 living facility shall successfully complete, at 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 review of personnel records, staff interview, and policy and procedure review, the facility failed to ensure the required background checks were completed prior to direct resident contact for 6 of 6 sample employees (CNA #2, NA #3, NA #4, NA #5, LPN #1, cook #1) reviewed. The findings were: 1. Review of the personnel file for CNA #2 showed she was hired on 2/25/25. There was no evidence a State of Wyoming Division of Criminal Investigation (DCI) fingerprint background check and a Department of Family Services (DFS) Central Registry Screening had been completed. 2. Review of the personnel file for NA #3 showed she was hired on 3/5/25. There was no evidence a State of Wyoming DCI fingerprint background check and a DFS Central Registry Screening had been completed. 3. Review of the personnel file for NA #4 showed she was hired on 3/17/25. There was no evidence a State of Wyoming DCI fingerprint background check and a DFS Central Registry Screening had been completed. 4. Review of the personnel file for NA #5 showed she was hired on 2/6/23. The personnel file showed a DCI criminal background check was completed on 2/27/23; however, there was no	S5002		

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S5002	Continued From page 4 evidence a DFS Central Registry Screening had been completed 5. Review of the personnel file for cook #1 showed he was hired on 4/26/20. There was no evidence a State of Wyoming DCI fingerprint background check and a DFS Central Registry Screening had been completed. 6. Review of the personnel file for LPN #1 showed she was hired on 1/1/20. The personnel file showed a DFS Central Registry Screening was completed on 11/30/20; however, the personnel file did not contain a copy of the State of Wyoming DCI fingerprint background check. 7. Interview with the facility owner on 3/20/25 at 2:05 PM confirmed the background checks had not been completed as required. 8. Review of policy "Background Checks", initiated on 2/06, showed "The owner and manager of a facility, employees who have direct personal contact with the residents of this facility, and any volunteer performing personal services or protective oversight, under the auspices of the facility shall be of good, moral, and responsible character. In making such a determination, the facility obtains, prior to staff or volunteers performing duties, any criminal history record information from a criminal agency, subject to any restrictions imposed by such agency, for any person responsible for the care and welfare or (sic) residents of the facility. The facility ascertains whether prospective staff or volunteers have been convicted of a felony or a misdemeanor that could pose a risk to the health, safety, and welfare of the residents, when making employment decisions."	S5002		

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S5003	Continued From page 5	S5003		
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; (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 personnel file review, policy and procedure review, and staff interview, the facility failed to ensure 2 of 3 newly hired employees (NA #3, NA #4) reviewed were tested for tuberculosis and 3 of 3 current employees (NA #5, cook #1, LPN #1) were tested or screened as appropriate for tuberculosis. The findings were:	S5003		

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S5003	Continued From page 6 1. Review of the personnel file for NA #3 showed she was hired on 3/5/25. There was no evidence the staff member had been tested for tuberculosis prior to resident contact. 2. Review of the personnel file for NA #4 showed she was hired on 3/17/25. There was no evidence the staff member had been tested for tuberculosis prior to resident contact. 3. Review of the personnel file for NA #5 showed no evidence she had been tested for tuberculosis prior to resident contact; however, NA #5 was last screened for tuberculosis on 7/25/23. 4. Review of the personnel file for cook #1 showed no evidence he had been tested for tuberculosis prior to resident contact; however, cook #1 was last screened for tuberculosis on 9/8/22. 5. Review of the personnel file for LPN #1 showed she was last screened for tuberculosis on 9/27/22. 6. Interview with the facility owner on 3/20/25 at 2:05 PM confirmed the newly hired employees had not been tested for tuberculosis prior to resident contact, and there was not a procedure in place for annual screening. 7. Review of the "Personnel/Employee Health" policy, initiated on 1/2020, showed "All employees and volunteers who have direct personal contact with residents must have a tuberculin skin test prior to contact with residents..." 8. Review of the "Tuberculosis Surveillance and Screening Program" policy, initiated on 1/2020, showed "...All personnel will be tested for	S5003		

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S5003	Continued From page 7 tuberculosis according to established guidelines." The policy failed to have a procedure in place for the annual screening or testing of employees.	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. (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,	S5005		

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S5005	Continued From page 8 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 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.	S5005		

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S5005	Continued From page 9 This State Rule and Regulation is not met as evidenced by: Based on resident record review and staff interview, the facility failed to have a system in place for documenting the RN's medication review for 4 of 4 sample residents (#1, #2, #3, #4) reviewed for medications. The findings were: 1. Review of the records for resident #1, #2, #3, and #4 showed no evidence a RN had conducted a medication review every two months. 2. Telephone interview with contract RN #1 on 3/20/25 at 1:51 PM revealed she reviewed the residents' medications on a monthly basis; however, the computer program the facility used did not provide a place to document when the review had taken place.	S5005		
S5006	Ch 12 Sec 7 (b)(i) Assisted Living Facility (ALF) Core Services (b) Resident Assessment and Services, The staff/contract Registered Nurse (RN) shall conduct initial and, at the minimum annually, and 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:	S5006		

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S5006	Continued From page 10 (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 review of resident records and staff interview, the facility failed to conduct an initial assessment of the resident's functional capacity, physical assessment, and medication review (ALF 102) for 1 of 4 (#3) residents reviewed for timely assessments. The findings were: 1. Review of resident #3's record showed s/he was admitted on 1/10/25 and a RN completed a comprehensive assessment on 1/15/25; however, there was no evidence an ALF 102 had been completed. 2. Interview with the facility owner on 3/20/25 at 11:48 AM confirmed the ALF 102 assessment had not been completed as required.	S5006		
S5007	Ch 12 Sec 7 (b)(ii) Assisted Living Facility (ALF) Core Services	S5007		

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S5007	Continued From page 11 (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. (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 and staff interview, the facility failed to have admission orders which included orders for tuberculosis screening, and orders for influenza and pneumococcal immunizations if required, unless contraindicated for 4 of 4 sample residents (#1, #2, #3, #4) reviewed; and failed to have a health care provider history and physical completed	S5007		

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S5007	Continued From page 12 within 90 days prior to admission for 1 of 4 sample residents (#4). In addition, the facility failed to develop a policy and procedure to ensure residents or their legal representatives were educated on the risks and benefits of the immunizations; the immunizations were offered, unless medically contraindicated or the resident was currently immunized; and a process for documenting the resident's immunization status or declination in the resident's record. The census was 13. The findings were: 1. Review of the resident record for resident #1 showed s/he was admitted to the facility on 10/20/23. The resident's admission orders did not include an order for tuberculosis screening, influenza, or pneumococcal immunizations. Further review showed a tuberculosis test was performed on 10/24/23 (4 days after admission); however, there was no record of the resident's immunization status. 2. Review of the resident record for resident #2 showed s/he was admitted to the facility on 7/1/24. The resident's admission orders did not include an order for tuberculosis screening, influenza, or pneumococcal immunizations. Further review showed a tuberculosis test was performed on 7/3/24 (2 days after admission); however, there was no record of the resident's immunization status. 3. Review of the resident record for resident #3 showed s/he was admitted to the facility on 1/10/25. The resident's admission orders did not include an order for tuberculosis screening, influenza, or pneumococcal immunizations. Further review showed no evidence the resident had been screened for tuberculosis prior to admission and there was no record of the	S5007		

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S5007	Continued From page 13 resident's immunization status. 4. Review of the resident record for resident #4 showed s/he was admitted to the facility on 7/26/24. The resident's admission orders did not include an order for tuberculosis screening, influenza, or pneumococcal immunizations. Further review showed a tuberculosis test was performed on 10/4/24 (167 days after admission); however, there was no record of the resident's immunization status. In addition, a history and physical had not been completed until 8/8/24. 5. Interview with the facility owner on 3/20/25 at 11:48 AM revealed residents received vaccinations from public health; however, copies of their vaccination status were not kept in the residents' records. In addition, the facility owner confirmed no further information was available related to tuberculosis screening of residents prior to admission, a history and physical completed prior to admission for resident #4; and was unable to locate a policy on influenza and pneumococcal immunizations.	S5007		
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 must ensure that food prepared in nutritionally adequate in accordance with the Dietary Reference Intakes (DRI) for adults.	S5026		

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S5026	Continued From page 14 This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, policy and procedure review, 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 13. The findings were: Related to temperature monitoring of food storage units: 1. Observation on 3/19/25 at 1:20 PM showed food was stored in a Hotpoint refrigerator/freezer; a Haier refrigerator/freezer; a GE upright freezer; a Crosley side-by-side freezer; and a small Magic Chef refrigerator in the dining area. Interview on 3/19/25 at 1:41 PM revealed the temperatures of the food storage units were not monitored. 2. 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..." Observation on 3/19/25 at 1:20 PM showed the following concerns related to the storage of food: 1. The Hotpoint refrigerator/freezer showed the following concerns: a. An unlabeled resealable plastic bag of a tomato-based food substance with a build-up of frost. b. An unlabeled resealable plastic bag with	S5026		

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S5026	Continued From page 15 an unidentifiable food substance. c. An undated resealable plastic bag of chicken spaghetti. d. An undated resealable plastic bag of a gravy-like substance. e. A resealable plastic bag of ziti dated 11/18/24. f. An unlabeled unidentifiable food substance stored in a plastic resealable bag. g. An unlabeled resealable plastic bag of a brown food substance with a build-up of frost. h. An undated plastic bag of turkey stock. i. The refrigerator showed a bottle of horseradish sauce with a best by date of 12/26/23 and a prepared bottle of horseradish with a best by date of 2/13/23. j. Both the refrigerator and freezer were unclean with a build-up of dried food residue. 2. The Haier refrigerator/freezer showed the following concerns: a. An undated resealable plastic bag of corn chowder. b. A resealable plastic bag of chicken spaghetti dated 9/10/24. c. A resealable plastic bag of kielbasa with sauce dated 8/30/24. d. An unlabeled resealable plastic bag of an unidentifiable food substance. e. The refrigerator showed a container of cottage cheese with a best by date of 3/12/25. f. Both the refrigerator and freezer were unclean with a build-up of dried food residue. 3. The GE upright freezer showed the following concerns: a. An undated plastic resealable bag with 2 cups of sausage and a build-up of frost. b. Deli-style roast beef stored in a resealable plastic storage bag was dated 6/17/24.	S5026		

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S5026	Continued From page 16 c. A plastic resealable bag of hot dogs was dated 9/7/24 with a build-up of frost. d. Seven miscellaneous packages of meat which had been removed from the original packaging were unlabeled. e. The freezer was unclean with a build-up of dried food residue. 4. The Crosley side-by-side refrigerator/freezer showed the following concerns: a. A bottle of Thousand Island dressing had a best by date of 4/13/23. b. The refrigerator/freezer was unclean with a build-up of dried food residue. 5. The Magic Chef refrigerator/freezer located in the dining area of the facility was unclean with a build-up of dried food residue. 6. Observation and interview with cook #2 on 3/19/25 at 1:41 PM confirmed there were expired products in the refrigerator and the food substances in the freezer were not labeled correctly. Cook #2 was unsure how long different food substances could be frozen to ensure the food maintained its quality. Related to the sanitary environment of the kitchen: 1. Observation on 3/19/25 at 4:27 PM showed cook #2 was preparing the evening meal. With ungloved hands cook #2 sliced a cantaloupe in half, wiped her hands and opened the refrigerator to show a resident a bag of lettuce. Without performing hand hygiene the cook continued to cut the cantaloupe into bite-size pieces with her ungloved hands. Observation at 4:35 PM showed the cook retrieved hard boiled eggs from the refrigerator and using her bare hands sliced the	S5026		

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eggs and placed them in a bowl. At 4:37 PM cook #2 retrieved tomatoes from the refrigerator and without washing the tomatoes diced them with her bare hands and placed them in a bowl. Continued observation showed the cook handled cheese, cooked chicken, dinner rolls, and plated salads for the residents using her ungloved hands. Interview with cook #2 on 3/19/25 at 4:31 PM revealed she only used gloves when she was working with raw meat.

2. Observation on 3/20/25 at 11 AM showed cook #1 and cook #3 were preparing the noon meal without wearing hair restraints. Interview with cook #3 on 3/20/25 at 4 PM revealed she did not wear a hair restraint when preparing food.

3. Observation on 3/19/25 at 5:17 PM showed a bucket of water on the bar area between the kitchen and the dining room. Interview with cook #2 and the facility owner revealed dishwashing soap was added to water to clean the counters of the kitchen. There was no evidence the food-contact areas had been sanitized after they had been cleaned.

4. Observation on 3/19/25 at 4:40 PM showed cook #2 removed breaded chicken from the oven. The cook took the temperature of the chicken; however, was unsure at what temperature the chicken was considered safe for consumption. Further, cook #2 stated she took the temperature of food; however, the temperatures were not documented.

5. According to the 2022 FDA Food Code showed "2-301.11 Clean Condition. FOOD EMPLOYEES shall keep their hands and exposed portions of their arms clean. 2-301.12 Cleaning Procedure. (A) Except as specified in (D) of this section,

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S5026	Continued From page 18 FOOD EMPLOYEES shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound in a HANDWASHING SINK that is equipped as specified under § 5-202.12 and Subpart 6-301. (B) FOOD EMPLOYEES shall use the following cleaning procedure in the order stated to clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands and arms: (1) Rinse under clean, running warm water; (2) Apply an amount of cleaning compound recommended by the cleaning compound manufacturer; (3) Rub together vigorously for at least 10 to 15 seconds while: (a) Paying particular attention to removing soil from underneath the fingernails during the cleaning procedure, and (b) Creating friction on the surfaces of the hands and arms or surrogate prosthetic devices for hands and arms, finger tips, and areas between the fingers; (4) Thoroughly rinse under clean, running warm water; and (5) Immediately follow the cleaning procedure with thorough drying using a method as specified under § 6-301.12. (C) TO avoid recontaminating their hands or surrogate prosthetic devices, FOOD EMPLOYEES may use disposable paper towels or similar clean barriers when touching surfaces such as manually operated faucet handles on a HANDWASHING SINK or the handle of a restroom door. (D) If PROVED and capable of removing the types of soils encountered in the FOOD operations involved, an automatic handwashing facility may be used by FOOD EMPLOYEES to clean their hands or surrogate prosthetic devices." 6. According to the 2022 FDA Food Code showed "2-301.14 When to Wash FOOD EMPLOYEES shall clean their hands and exposed portions of	S5026		

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their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using TOBACCO PRODUCTS, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands."

7. According to the 2022 FDA Food code showed "2-301.15 Where to Wash FOOD EMPLOYEES shall clean their hands in a HANDWASHING SINK or APPROVED automatic handwashing facility and may not clean their hands in a sink used for FOOD preparation or WAREWASHING, or in a service sink or a curbed cleaning facility used for the disposal of mop water and similar liquid waste."

8. According to the 2022 FDA Food code showed "4-701.10 Food-Contact Surfaces and Utensils. Effective sanitization procedures destroy organisms of public health importance that may be present on wiping cloths, food equipment,

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or utensils after cleaning, or which have been introduced into the rinse solution. It is important that surfaces be clean before being sanitized to allow the sanitizer to achieve its maximum benefit."

9. 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."

10. According to the 2022 FDA Food code showed "3-401.11 Raw Animal Foods. (A) Except as specified under ¶ (B) and in ¶¶ (C) and (D) of this section, raw animal FOODS such as EGGS, FISH, MEAT, POULTRY, and FOODS containing these raw animal FOODS, shall be cooked to heat all parts of the FOOD to a temperature and for a time that complies with one of the following methods based on the FOOD that is being cooked: (1) 63oC (145oF) or above for 15 seconds for: (a) Raw EGGS that are broken and prepared in response to a CONSUMER'S order and for immediate service, and (b) Except as specified under Subparagraphs (A)(2) and (A)(3) and ¶ (B), and in ¶ (C) of this section, FISH and INTACT MEAT including GAME ANIMALS commercially raised for FOOD as specified under Subparagraph 3-201.17(A)(1) and GAME ANIMALS under a voluntary inspection program as specified under Subparagraph 3-201.17(A)(2); (2) 68oC (155oF) for 17 seconds or the temperature specified in the following chart that

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S5026	Continued From page 21 corresponds to the holding time for RATITES, and nonINTACT MEATS; the following if they are COMMINUTED: FISH and GAME ANIMALS commercially raised for FOOD as specified under Subparagraph 3-201.17(A)(1), and GAME ANIMALS under a voluntary inspection program as specified under Subparagraph 3-201.17(A)(2); and raw EGGS that are not prepared as specified under Subparagraph (A)(1)(a) of this section: (3) 74oC (165oF) or above for < 1 second (instantaneous) for POULTRY, BALUTS, wild GAME ANIMALS as specified under Subparagraphs 3-201.17(A)(3) and (4), stuffed FISH, stuffed MEAT, stuffed pasta, stuffed POULTRY, stuffed RATITES, or stuffing containing FISH, MEAT, POULTRY, or RATITES..." 11. Review of the "Food service and nutrition" policy, initiated 2/06, showed "Food must be prepared, handled and stored in a sanitary manner, so that it is free from spoilage, filth, or other contamination, and will be safe for human consumption...1. Such food handling techniques include preparing, holding, and serving, cooling, and storing food at safe temperatures...food must be maintained at the proper temperature during food preparation and food service...hot food must be maintained and served at 140 degrees, cold food must be maintained and served at 45 degrees or less...gloves, tongs, spoons, or other utensils must be used to minimize the handling of food during both food preparation and food service...working surfaces must be cleaned and sanitized before and after use...all food supplies must be maintained at the proper temperature during food storage..."	S5026		

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S5027	Continued From page 22	S5027		
S5027	Ch 12 Sec 7 (j)(iii) Assisted Living Facility (ALF) Core Services (j) (iii) Food service supervision: (A) Day to day responsibilities for food production and management of the dietary services shall be assigned to a person with nutrition and food service management experience equivalent to that of a Certified Dietary Manager. Based on personnel records and staff interview, the facility failed to employ a food service manager to oversee the day-to-day responsibilities for food production and management of the dietary services with experience equivalent to that of a Certified Dietary Manager. The census was 13. The findings were: 1. Review of the employee list provided by the facility upon entrance showed the position of dietary manager was not listed. 2. Interview with cook #2 on 3/19/25 at 1:41 PM revealed she was currently enrolled in the Certified Dietary Manager class. 3. Interview with the facility owner on 3/20/25 at 12:12 PM confirmed the facility did not employ a dietary manager with experience equivalent to that of a Certified Dietary Manager.	S5027		
S5041	Ch 12 Sec 7 (l) Assisted Living Facility (ALF) Core Services (l) Quality Improvement. (i) The facility shall have an active quality	S5041		

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S5041	Continued From page 23 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 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:	S5041		

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S5041	Continued From page 24 Based on review of facility documentation and staff interview, the facility failed to have an active quality improvement program. The census was 13. The findings were: 1. Review of an undated and unsigned "Quality Improvement" worksheet showed areas listed for review in the categories of "Facility Improvements", "Residents", and "Staffing." There was no system in place to determine how the corrective action was going to be monitored or at what frequency. 2. There was no evidence a facility completed an annual self-assessment survey of compliance with the regulations or a satisfaction survey was provided to the resident, resident's family, or resident's responsible party on an annual basis. 3. The facility owner exited the facility prior to the end of the survey granting permission to cook #2 to complete the interviews. Interview with cook #2 on 3/20/25 at 5:25 PM revealed she was unaware if a self-assessment of compliance had been completed or if satisfaction surveys were issued to residents.	S5041		
S5042	Ch 12 Sec 7 (m) Assisted Living Facility (ALF) Core Services (m) Facility Policies and Procedures. (i) Management shall develop policies and procedures that are available to residents and staff, including but not limited to: (A) Resident rights; (B) Disciplinary procedures surrounding	S5042		

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S5042	Continued From page 25 substantiated cases of resident abuse; (C) Admission, transfer, bed hold days, and discharge of residents; (D) Medication management; (E) Emergency care of residents (including missing resident, blizzard, water outage, etc.); (F) Fire/disaster plan; (G) Departure and return; (H) Smoking; (I) Visiting hours; (J) Activities; (K) Management of resident trust accounts; (L) Personnel policies; (M) Grievance procedure; (N) Per Diem rate/charges/fees, to include a listing of what is included in the established charges; (O) Incident reports; (P) Notification of change in established per diem rate/charges/fees; (Q) Outside contractual responsibilities; and	S5042		

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S5042	Continued From page 26 (R) Identification and notification of change in resident's condition. This State Rule and Regulation is not met as evidenced by: Based on review of policies and procedures and staff interview, the facility failed to develop 1 of 18 required policies and procedures. The findings were: 1. Review of the facility's policies and procedures showed an "Emergency Plans and Procedures" policy was initiated on 1/2020; however, the policy failed to include procedures to follow in the event of a missing resident, a weather emergency, water outage, or any other non-medical adverse event. 2. Interview with the facility owner on 3/20/25 at 1:58 PM confirmed the Emergency Plans and Procedures policy was incomplete and she was unable to locate any additional policies.	S5042		
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:	S5048		

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S5048	Continued From page 27 (A) Who will provide service(s); (B) What service(s) will be provided; (C) When the service(s) will be provided; (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, review of policy and procedures, and staff interview, the facility failed to ensure a service contract was developed which included all required components for 5 of 5 sample residents (#4, #5, #6, #7, #8) who received services from an outside entity. The findings were: 1. Review of the documentation provided by the facility owner upon entrance showed resident #4, #5, #6, #7, and #8 required oxygen therapy. 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 facility owner on 3/20/25 at 12:12 PM confirmed no service contracts were available. 3. Review of the "Personal Care/Resident Care" policy, initiated on 2/06, showed "...This assisted living facility agrees to admit and provide services to those persons whose needs can be met by the programs within the assisted living facility or in conjunction with agencies, individuals, and others with which the assisted living facility has written	S5048		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF011	A. BUILDING: _____ B. WING _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE JOURNEY	624 TWIN RIDGE AVENUE EVANSTON, WY 82930

(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
S5048	Continued From page 28 contracts and/or agreements...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...A contract between the resident, the ALF and all outside service providers in the ALF must be in place prior to the time of service delivery. The contract must identify the clean delineation of services..."	S5048		
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 13. The findings were: 1. Observation of the facility on 3/19/25 at 1:10 PM showed no evidence the state licensure survey results were available for public view. 2. Interview with the facility owner on 3/20/25 at 1:58 PM revealed the survey results were kept in a cupboard in her office.	S5060		

Compassionate Journey Assisted Living
Survey Date: 3/20/2025

Tag Number: S5001

Corrective action: Due to a number of issues with regard to the lack of trained and licensed CNA's being available to hire, there has been an effort put into place that has allowed unlicensed nursing assistant staff to be hired and work while gaining their education and licensing. This is certainly not optimal and does not meet the regulated standard. Recruiting, hiring, and developing appropriately licensed staff is a process that will occur. Upon talking with a potential staff member, a search for licensing will occur. If licensing is in order, the potential employee will move forward in the hiring process. If a person desires to be employed that is not currently licensed, the individual will be referred to the local training program for licensure. Training classes and dates will be available in the facility, as well as options for financial assistance availability. The potential licensed professional will then be tracked for progress.

With regard to the people currently employed at Compassionate Journey, the following action will be taken.

CNA Day Shift - confirmation of enrollment in the CNA program that began in early March. The owner will track successful completion of the class and the clinicals. This is scheduled for May 3 and May 4, 2025. Upon completion of class, testing will be scheduled and temporary licenses will be filed for with the State Board of Nursing. Testing will be completed according to the schedule for the class, with the computer portion scheduled for the 3rd week of May and the hands on for the second week of June. Upon successful completion, she will apply for and obtain her CNA licensing.

CNA Weekend shift - was not enrolled in the current CNA class and did not enroll in the one that begins in August. [redacted] no longer works for our facility.
sy with Jay Bell

CNA Evening shift - confirmed application for permanent licensing in May, 2025.

CNA Night shift - CNA license was filed for and reinstated in April, 2025. License confirmed

CNA Night shift - no issues with licensing - license confirmed

LPN Evening shift - no issues with licensing - license confirmed

Additional corrective action put into place includes having unlicensed employees in training working with a licensed employee. This provides hands-on training and allows new employees to become familiar with the position and the facility.

This plan of correction was accepted with the agreed upon change on 8/14/25. Jay Bell was notified at 8:19 am.

Jean Yennie
8/14/25

Scheduling will be performed weekly. People with either an RN, LPN, or CNA license will be scheduled to provide licensed services for the residents of the facility. The licenses will be confirmed prior to scheduling of individuals for these duties.

Measures to be put in place:

1. Check on licensure with the State Board of Nursing website upon desire to hire. Print and place licensing information in file for employee.
2. Check each employee after each renewal cycle to assure renewal of license was processed. Print licensing information after each renewal.
3. Work with Workforce Services and Western Wyoming Community College to recruit new CNA's to training program. Purchase seat in training when necessary.
4. Create tracking mechanism for new staff members with regard to application, hiring, training, testing, and licensing.

Monitoring of corrective action:

1. Licensure will be tracked on Quality Assurance Plan by providing a copy of licensure for each employee located in both employee file and Quality Assurance binder. The owner/manager will be responsible for ensuring the licensure is in place.
2. Each active employee will be reminded of renewal via an internal memo in October of even numbered licensure years. Licensure will be reviewed, printed, and put into each employee file upon renewal. Renewals will be tracked through the Quality Assurance process to ensure that renewals occur. Non renewal will result in termination until renewed. The owner/manager will be responsible for the corrective action and monitoring of it.
3. A calendar of training programs through Western Wyoming Community College will be kept in the administrative office. It will be reviewed when potential employees need to be trained and licensed and a referral will be presented. Financing options available in the community will be shared. Purchasing a seat in a class will be completed if necessary. The owner/manager will be responsible for this corrective action.
4. The Quality Assurance Plan will include the schedule of employees. The schedule will be reviewed when it is created weekly to ensure that licensed staff is in place. The licensed staffing issue will be reviewed at a monthly time frame.
5. Track possible new employees from application through licensing to ensure that each applicant is meeting the needs of the position and the business. The tracking mechanism will be part of the Quality Assurance Plan and will address all applicants for positions.
6. Schedules produced each week will have appropriately licensed professionals - RN, LPN, or CNA - providing services to residents. The schedules will be kept on file in the Quality Improvement Program binder. Each schedule will be reviewed by the Manager of the facility each week.

Date for completion: April 30, 2025

Tag Number S5002

Corrective action: All persons hired will be subject to the background check dictated by the Background Check rule of the State of Wyoming. Persons not currently showing background checks that are currently employed will have their fingerprints taken and submitted. All new persons hired will provide fingerprints upon commitment to hire for background check purposes. DFS Registry is checked directly by access to that background information via an online system. All existing employees will be audited for this rule and processed in accordance with the rule if results are not found in personnel file.

CNA #2, NA #3, NA #4, NA#5, LPN #1, and Cook #1 will be required to submit fingerprints necessary for the background check process to occur. DFS Registry checks can now be performed via an online process and will be processed for each person.

Measure to be put in place:

1. Upon commitment to hire new employees, fingerprints will be requested and provided by new employee. Fingerprints will then be sent to the State of Wyoming Background Check specialist for processing.
2. DFS Registry background checks will be processed upon hiring of each new employee and will be reviewed.
3. All employee files will be reviewed for background check information and addressed if not currently in compliance.

Monitoring of corrective action:

1. Background check information on new employees will be addressed as soon as an employee is hired. The Quality Assurance Program binder will contain a checklist of new hires that will monitor the date sent to the Background Specialist, the date returned to the facility, and the outcome of the background check. The background check information will be added to the employee file. The owner/manager will be responsible for implementing and monitoring this corrective action.
2. The DFS Registry check will be performed upon hire through the online system currently available. The Quality Assurance Program binder will contain a checklist of new hires that will monitor the date sent to the employee requesting information, the date the DFS Registry processed the request, and the outcome of the request. The background check information will be added to the employee file. The owner/manager will be responsible for this corrective action.
3. All employee files will be audited for compliance. If not compliant, the employee will be subject to the background check process stated above. The background check information will be added to the employee file. The owner/manager will be responsible for the corrective action.

Date of completion: April 30, 2025

Tag number S5003

Corrective action: Proof of tuberculin testing will be required of all newly hired employees. Each employee will be screened for tuberculosis each year as an employee of the facility.

NA #3, NA #4, NA#5, LPN #1, and Cook #1 will be required to submit testing for tuberculosis.

Measure to be put in place:

1. Upon hire, the candidate will provide a recent screening for tuberculosis. If a screen for the disease is not available within the last 12 months, the candidate will be required to obtain the screening through Uinta County Public Health.
2. The facility will provide screening annually through Uinta County Public Health for all employees. All current files will be assessed for screening.

Monitoring of corrective action:

1. Compliance will be monitored through the Quality Assurance Program. A checklist will contain information regarding the date of the TB screening for each individual. A copy of the screening will be kept in the employee file. The owner/manager will be responsible for compliance with this action.
2. Annual screening will be monitored through the Quality Assurance Program. A checklist will be created and contain the information and date of the screening. Each employee is required to complete the screening and present the results for the employee file. The owner/manager will be responsible for compliance with this action.
3. An audit of all personnel files will be conducted by the owner/manager to ensure that all employees have been tested for tuberculosis within the last 12 months and that a copy of the testing is placed in the employee file.

Date of completion: April 30, 2025

Tag number S5005

Corrective action: Medications for each resident will be reviewed and documented each month by the Registered Nurse contracted by the facility.

There was no documentation of a medication review for resident #1, resident #2, resident #3, and resident #4. The medication reviews for each resident will be conducted by the Registered Nurse and placed in each resident's file.

Measures to be put in place:

1. Documentation of reviews of medication will occur each month as medications are received on a monthly basis from the pharmacy.
2. A record of medication for each resident will be printed from the current electronic system.
3. A form will be developed for the Registered Nurse to attach to each medication record to confirm that the medication record has been reviewed and is accurate.

Monitoring of corrective action:

1. The documentation of the review will be monitored for completeness and compliance by the Registered Nurse.
2. The Registered Nurse will print the medication record and attach the form to the record to assure that the review occurred and is accurate.
3. The development of the form is the responsibility of the owner/manager. Completion of the form each month will be tracked through the Quality Assurance Program. The form will be kept in each resident file and compliance will be maintained monthly by the owner/manager of the facility through review and confirming through a checklist.

Date of completion: April 20, 2025

Tag number S5006

Corrective action: An ALF 102 assessment will be performed and documented for all new residents of the facility by a Registered Nurse within 45 days of admission. The ALF 102 will also be completed annually for each resident. It will also be completed upon a change of condition for each resident.

The ALF 102 for resident #3 will be completed by the Registered Nurse and placed in the resident's file.

Measures to be put in place:

1. Upon acceptance of a potential resident, the Registered Nurse will assess the resident using the ALF 102 documentation to assure that the resident meets the criteria for admission to the facility. The ALF 102 will be kept in the resident record.
2. Each resident will be assessed by the Registered Nurse through the ALF 102 annually.
3. If a resident has a change of condition, the Registered Nurse will perform an ALF 102 assessment to determine if the resident meets the requirements of the facility license.
4. An audit of all resident files will be conducted to ensure that all residents have a current ALF 102 in place.

Monitoring of corrective actions:

1. The Registered Nurse will provide the ALF 102 assessment to the owner/manager prior to admission of the resident. The completion of this assessment will be monitored for

each new resident through the Quality Assurance Program checklist that will address all necessary documents needed upon admission to the facility. The owner/manager will be responsible for tracking this information for each resident upon admission.

2. A checklist will be kept for each resident to address timing for annual recertification and assessment. The Registered Nurse is responsible for the assessment completion. The completed form will be retained in the resident record. The checklist will be maintained as part of the Quality Assurance Program for the facility. The owner/manager will be responsible for monitoring the need for the assessment.
3. The Registered Nurse will perform an ALF 102 assessment for each resident that has a change of condition. A form will be created that will provide information on the need for the assessment and the outcome of said assessment. It will also provide notes for changes to plan of care for the resident. The form will become part of the resident record and part of the Quality Assurance Program quarterly review. The owner/manager of the facility will track the information on changes of condition through the Quality Assurance Process by adding the completed form to the Quality Assurance binder.

Date completed: April 30,2025

Tag number S5007

Corrective action: All new residents will have a history and physical that will include an order for tuberculosis screening, and influenza and pneumococcal immunizations. Each new resident, or their legal representative, will be educated on the risks of living in a communal setting. If the resident is not screened or vaccinated, the reason regarding medical contraindication or refusal will be documented.

Resident #1, resident #2, resident #3, and resident #4 did not have an order addressing tuberculosis screening, and influenza and pneumococcal immunization orders as part of the order or the history and physical provided by the physician.

An appointment for Resident #1 will be made with a local physician and the local physician will address the need for tuberculosis screening, and influenza and pneumococcal immunization. The Resident will have the TB screening if required, and will have the option for influenza and pneumococcal immunizations. If the Resident refuses, a declination form will be completed.

An appointment for Resident #2 will be made with a local physician and the local physician will address the need for tuberculosis screening, and influenza and pneumococcal immunization. The Resident will have the TB screening if required, and will have the option for influenza and pneumococcal immunizations. If the Resident refuses, a declination form will be completed.

An appointment for Resident #3 will be made with a local physician and the local physician will address the need for tuberculosis screening, and influenza and pneumococcal immunization. The Resident will have the TB screening if required, and will have the option for influenza and pneumococcal immunizations. If the Resident refuses, a declination form will be completed.

An appointment for Resident #4 will be made with a local physician and the local physician will address the need for tuberculosis screening, and influenza and pneumococcal immunization. The Resident will have the TB screening if required, and will have the option for influenza and pneumococcal immunizations. If the Resident refuses, a declination form will be completed.

All residents not properly screened and/or immunized will have this issue addressed through the Plan of Correction.

Measures to put in place:

1. The history and physical process will be updated with new forms indicating the status of tuberculosis screening and the immunization status of influenza and pneumococcal vaccines.
2. The history and physical examination requirements will be completed within a 90 day period prior to admission.
3. All residents records will be audited to address immunization and screening issues, as well as the completeness of the history and physical information provided by the physician.

Monitoring of corrective actions:

1. Each resident admission packet will be updated with the new documentation needed for admission. A form will be developed and tracked for each resident. The tracking mechanism will be a checklist that addresses everything inclusive in the admission packet. Vaccinations and immunizations will be part of the comprehensive checklist. The status of immunizations will also address documentation for contraindications and declination for each resident. The checklist will be incorporated into the Quality Assurance Plan and placed in the QAP binder. The owner/manager will be responsible for the form, checklist, and tracking of the plan.
2. The history and physical examination will be completed prior to admission and will be monitored through a comprehensive checklist for each resident and through specific monitoring through the Quality Assurance Plan and placed in the QAP binder. The owner/manager will be responsible for monitoring the checklist and timing associated with the history and physical.
3. A new policy and procedure will be developed to ensure that the facility meets the regulated standard with regard to admission of residents. The vaccination and screening orders will be addressed in the policy and a procedure will be developed to address specifically this concern. The owner/manager will create the policy to ensure the facility has a clear path to meeting this standard.

Date completed: April 30, 2025

Tag number S5026

Corrective action:

1. All refrigerators and freezers in the facility will be monitored daily for correct temperatures with regard to safe food handling and storage guidelines.
2. All containers of food that are opened will be labeled with a date of placement and a date of expiration when placed in either a refrigerator or freezer.
3. All bottles, cans, and other containers of food and drink will be checked weekly for expiration dates.
4. All refrigerators and freezers will be cleaned weekly by kitchen staff.
5. Hand hygiene documentation and training will be addressed at the hiring of kitchen staff. Hand hygiene reminder and process will be posted in the kitchen area.
6. Gloves will be worn by kitchen staff when handling all food - including cutting and other tasks performed during preparation of food.
7. A food thermometer will be used to ensure the appropriate temperature of meat products prior to serving to ensure safety for consumption. The temperatures will be recorded daily for each meal.
8. Food contact areas will be cleaned and sanitized with a cleaning solution designed for kitchen surfaces. This will be completed after each meal is prepared.
9. Hair restraints will be worn by the kitchen staff when preparing food. The restraints will be in the form of a hair net or a hat.

Measures to put in place:

1. Temperatures of all refrigerators and freezers will be taken and recorded daily. A daily grid will be posted each month for kitchen staff to document the temperatures of each unit.
2. All food that is stored that has been cooked will have a label that shows when the food was placed in storage and when it will expire. Expiration will be monitored daily through a report from kitchen staff.
3. Expiration dates for purchased food will be monitored daily and will be incorporated into the daily report from the kitchen staff.
4. The refrigerators and freezers will be cleaned weekly and immediately upon a spill or leak. The documentation will be provided by the kitchen staff on a weekly report.
5. Hand hygiene training that meets the safe handling food standards will become part of the orientation of kitchen staff. Hand hygiene fliers and training will be posted in the kitchen as reminders of good hand hygiene. Supervising staff will observe and document use of hand washing daily.
6. Gloves are available and will be worn by kitchen staff in preparation of all food. Supervising staff will observe and document use of gloves daily.
7. A food thermometer will be used to test food products. A poster will be created and posted in the kitchen showing the required temperatures for each type of meat.

Temperatures will be recorded daily through the reporting form that the kitchen staff will be required to submit daily.

8. An appropriate kitchen cleaner will be purchased and used to sanitize the food preparation areas in the kitchen. The documentation of this task will be incorporated into the form the kitchen staff will complete and turn in daily.
9. All kitchen staff will wear either a hat or hair net when performing duties. The supervisor of the kitchen will observe and document for compliance.

Monitoring of corrective actions:

1. A grid report will be created and developed for use with regard to documenting the temperatures of the refrigerators and freezers. The grid will be attached to a refrigerator or freezer as a reminder to check the temperatures and document them daily. At the end of each month, a new grid report will be placed and the previous month's report will be kept in a binder in the kitchen. The Dietary Manager will be responsible for monitoring this task.
2. A kitchen report will be created that will address the following daily tasks:
   - ☐ Daily - checking food labels on all stored food.
   - ☐ Daily - checking expiration dates of all food.
   - ☐ Daily - monitoring food temperatures with the temperatures recorded when required.
   - ☐ Daily - sanitization of food preparation areas after each meal.
   - ☐ Weekly - cleaning of all refrigerators, freezers, and other appliances.

   The Dietary Manager will be responsible for ensuring that the documentation occurs daily and is complete.

3. Documentation will be developed that addresses the supervisory commitment to hand hygiene practices, use of gloves for food preparation, and the wearing of hats or hair nets by the staff preparing food. Each staff member will be monitored weekly. The Dietary Manager will be responsible for monitoring these tasks in the kitchen. The results of the observations will be kept in the report binder in the kitchen.

Date completed: April 25, 2025

Tag number S5027

Corrective action: One staff member will be assigned to become the Dietary Manager for the facility and complete a training program for certification. A different staff member will also be trained and certified in the Dietary Manager program. Approved certification programs have been sent to the facility by the Department of Aging.

Measures to put in place:

1. Two staff members will be enrolled in an approved program by April 18, 2025.
2. The staff members will complete the training program and incorporate their knowledge into the program at the facility.
3. Certification will be attained and documented in the employee files.
4. Name(s) of Dietary Manager(s) will be forwarded to the Department of Aging.

Monitoring of corrective actions:

1. The owner/manager will meet with staff in training weekly to ensure that coursework is being completed.
2. When certification is awarded, documentation will be kept in the employee file. The owner/manager of the facility will maintain this file.
3. When certification is awarded, the name of the Dietary Manager will be posted in the facility. The owner/manager will post this information in the kitchen area.

Date completed: May 19, 2025

Tag number S5041

Corrective action:

1. The Quality Assurance Plan format will be revised to address how the corrective action will be monitored and the frequency in which each will be monitored.
2. An annual self assessment survey will be developed and implemented to address compliance with the regulations. A review of the regulatory requirements will be part of this assessment.
3. A resident satisfaction survey will be developed and implemented that will provide feedback on the quality of services provided and the concerns of the residents and their families. The results of the survey will become part of the Quality Assurance Plan.

Measures to put in place:

1. The Quality Assurance Plan format will be updated and monitored on a quarterly basis. As issues arise in the organization, action items will be added to the plan and monitored at least quarterly, but more often or by occurrence if needed.
2. The annual assessment survey will be completed in April of each year. All documentation from the quarterly reviews will be addressed and the Quality Assurance Plan will be updated accordingly.
3. The resident satisfaction survey will be available at all times. It will be placed on the table at the entrance of the facility. Residents will also be given the survey and opportunity for feedback every 6 months.

Monitoring of corrective actions:

1. The Quality Assurance Plan format and action items will be updated initially in April, 2025, and then on an ongoing basis. A binder will be kept with the Quality Assurance Plan. All documentation for the tasks in the Plan will be kept in the binder. The staff of the facility will be solicited for input regarding the action items in the Plan. The owner/manager of the facility will perform this function.
1. The annual assessment survey will be completed in April of each year. The owner/manager will provide the documentation from each quarterly review for the annual survey. The staff of the facility will be active participants in the survey.
2. The resident satisfaction survey results will be compiled annually. The results will be reviewed by the owner/manager upon receipt of each survey. Any action items needing addressed based on survey results will be incorporated into the Quality Assurance Plan. The owner/manager will be responsible for monitoring the results of the surveys and compiling the annual report.

Date completed: April 30, 2025

Tag S5042

Corrective action: The Emergency Plan and Procedures will be updated to include procedures that address a missing resident, a weather emergency, water outage, and any other non-medical adverse event. The Emergency Plan and Procedures documents will be reviewed in its entirety to assure that it meets the current needs of the facility.

Measures put in place:

1. The Emergency Plan will give specific instructions to address and define procedures for:
    - ☐ A missing resident
    - ☐ Weather emergencies including blizzards, extensive rain, freezing temperatures, and high winds causing damage to the facility.
    - ☐ Water outage or flooding in the facility due to equipment failure.
    - ☐ A general procedure for any non-medical adverse event.
2. The Emergency Plan and Procedures binder will be placed in the Staff office for accessibility by staff and residents.

Monitoring of corrective actions:

1. The Emergency Plan and Procedures will be reviewed and updated according to the needs of the facility and its residents and staff. The updated Plan will be reviewed by the staff of the facility. Review will be documented in the Quality Assurance Plan. The owner/manager is responsible for this task.

Date completed: May 10, 2025

Tag S5048

Corrective action: Residents, at times, need services that are provided by outside professional sources. An outside services contract will be documented and signed by the resident needing outside assistance. The outside service contract will include the company providing the service, the service provided, the time frame in which the service will be provided, where the service will be provided, and how it will be provided. A contract will be developed and implemented that meets the requirements of the state regulation and will be added to each resident file.

Resident #4, resident #5, resident #6, resident #7, and resident #8 all have outside services provided by a professional healthcare company. There is currently no contract for any resident in place to meet this requirement.

Resident #4 is provided an outside service for oxygen use. A contract will be created and executed between the resident, the facility, and the oxygen provider. The contract will be kept in the resident record.

Resident #5 is provided an outside service for oxygen use. A contract will be created and executed between the resident, the facility, and the oxygen provider. The contract will be kept in the resident record.

Resident #6 is provided an outside service for oxygen use. A contract will be created and executed between the resident, the facility, and the oxygen provider. The contract will be kept in the resident record.

Resident #7 is provided an outside service for oxygen use. A contract will be created and executed between the resident, the facility, and the oxygen provider. The contract will be kept in the resident record.

Resident #8 is provided an outside service for oxygen use. A contract will be created and executed between the resident, the facility, and the oxygen provider. The contract will be kept in the resident record.

Measures put in place:

1. When a resident has a need for an outside professional service, facility staff will present the contract to the resident and assist with filling it out.
2. The completed contract will be housed in the resident file.
3. A copy of the completed contract will be forwarded to the outside agency providing services.
4. The implementation and use of the contract will be monitored through the Quality Assurance Plan. A copy of each contract will be kept in the QAP binder.

5. Facility staff will provide updates on outside service provision on a quarterly basis when the Quality Assurance Plan is reviewed. Issues will be addressed, if needed, at that time.
6. All resident files and plans of care will be reviewed and audited to ensure that all outside services being provided in the facility have a contract in place. Contracts will be developed for all services that are found in this process and added to the resident's files.

Monitoring of corrective actions:

1. All outside services will be monitored for the need for contracts. This includes therapy, oxygen, mental health, and all other services that affect the resident's health. The owner/manager will be responsible for monitoring the contracts.
2. The resident record will house the contract for outside services. The owner/manager will be responsible for adding this item to each record and the Quality Assurance Plan binder.
3. The outside service provider contract and services provided will be reviewed for each resident at the quarterly update of the Quality Assurance Plan review.

Date completed: April 30, 2025

Tag number S5060

Corrective action: The survey results will be made available for public view by placing them in the glass enclosed bulletin board located on the wall near the entrance of the facility.

Measures to be put in place:

1. The surveys from State agencies will be placed on the bulletin board upon receipt of acceptance of the Plan of Correction. All completed surveys will be placed there for public view.

Monitoring of corrective actions:

1. The placement of the survey results will place on the Quality Assurance Plan as a reminder of the requirement. The owner/manager is responsible for this placement.

Date completed: April 30, 2025