DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535032	A. BUILDING ______ B. WING ______	C 05/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	1330 PRAIRIE AVENUE 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) COMPLETION DATE
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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

6/12/14 - The POC was accepted between the ADON (Ashley) and [illegible] Maddox with a DOC of 6/28/14. 6/12/14

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F 441	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interview, review of facility policy, and current recommendations for standards of practice, the facility failed to ensure infection control measures were implemented for 1 of 2 resident's (#91) who required contact precautions. The findings were: Review of the medical record showed resident #91 was re-admitted to the facility on 4/21/14 with diagnoses including gangrene and an open wound. Further review showed the resident was placed on intravenous antibiotics on 4/26/14 for the treatment of methicillin-resistant Staphylococcus aureus (MRSA). In addition, the resident was also identified as having an extended-spectrum beta-lactamase (ESBL) infection in his/her urine on 5/10/14. The following concerns were identified: a. Observation on initial tour of the facility on 5/14/14 at 2:15 PM revealed resident #91 had a cart outside the door that contained personal protective equipment (PPE) including gowns, gloves, and masks. There was no signage posted on the resident's door indicating visitors or staff should see nursing staff prior to entering the resident's room. Observation again the same day at 5:15 PM showed no contact precaution sign had been posted on or near the resident's door; additionally visitors were observed entering and exiting the resident's room and no hand hygiene was performed. Interview with the resident's family member at the time of the observation revealed family visited the resident regularly and there had never been a contact precaution sign posted on or near the resident's door informing visitors to see the nurse before entering the resident's room. However, staff had applied	F 441	June 28, 2014 A) Resident #91 was discharged from the facility. B) Random audits of the residents that require contact precautions will be audited to ensure families have been educated on hand hygiene and wearing gowns when appropriate. Staff will be randomly audited for proper bagging of infectious waste. Contact precaution rooms will be randomly audited to ensure the stop sign is posted on the door. C) The ADON/SDC will provide an in-service to nursing staff on educating family members about proper hand hygiene and use of PPE when appropriate, proper bagging of infectious waste, and placement of stop sign on the door of contact precaution rooms by 06/13/2014. D) The facility will utilize a Performance Improvement Audit Tool to perform random audits of educating family members about proper hand hygiene and use of PPE when appropriate, proper disposal of infectious waste, and placement of stop sign on the door of contact precaution rooms E) The Director of Nursing or designee will report results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or	

6/20/14

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F 441	Continued From page 2 gowns and gloves prior to entering the resident's room. The interview further revealed staff had not instructed the family about the importance of handwashing or wearing gowns when visiting the resident or exiting the resident's room. b. Observation on 5/14/14 at 5:25 PM revealed CNA #1 entered the resident's room without donning a gown or gloves. The CNA proceeded to tie up a full red biohazard bag of trash with bare hands, then she applied gloves and placed a new red biohazard trash bag into the receptacle. Interview with CNA #1 at the time showed she should have put on a gown and gloves prior to entering the resident's room, however, she, "forgot." RN #1 was outside the resident's open door during the observation and verified the CNA should have put on a gown and gloves prior to entering the resident's room bagging and removing biohazard trash. The interview verified the resident did not have a contact precaution sign posted on or near the door but should have had one posted. c. Review of the facility's policy last revised on 7/18/11 and entitled, "Standard and Transmission-based Precautions; Isolation Procedure A guide to Infection Control", the following was listed, "Contact Precautions for MRSA and ESBL's" and included, "Stop sign on door...Visitors are instructed to wash hands when entering and leaving room...Gowns/protective apparel-if contact with infectious material." d. According to the Centers for Disease Control (CDC) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, "Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental	F 441	trends noted. This will occur for a period of at least three months or until ongoing compliance has been achieved.	

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F 441	Continued From page 3 contamination. IV.B.3.a. Wear a gown, that is appropriate to the task, to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated [739, 780, 896]. Category IB/ICV.B.3.b.ii. After gown removal, ensure that clothing and skin do not contact potentially contaminated environmental surfaces that could result in possible transfer of microorganism to other patients or environmental surfaces [72, 73]. Category IIClothing, uniforms, laboratory coats,or isolation gowns used as personal protective equipment(PPE), may become contaminated with potential pathogens after care of a patient colonized or infected with an infectious agent, (e.g.,MRSA88,VRE 89,and C. difficile 90... the potential exists for soiled garments to transfer infectious agents to successive patients."	F 441		