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

PRINTED: 04/02/2015
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
	535049	A. BUILDING _____ B. WING _____	Pr 02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	4041 SOUTH POPLAR STREET CASPER, WY 82601

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADL- Activities of Daily Living ADON - Assistant Director of Nursing CAA- Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set PPE - Personal Protective Equipment RNA - Restorative Nurse Assistant RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in an accordance with the Sate Operations Manual.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the	F 164	F 164 A. Privacy has been provided with resident # 76 by closing the blinds during each Peri-care. CNAs # 1 and # 2 were educated on or before 3/5/15 regarding the importance of providing privacy during Peri-care for all residents B. The DON or her designee will conduct random audits to ensure privacy is being provided for all residents identified to require Peri-	3/6/15

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

Executive Director 4-7-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

WY Dept of Health

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: BEXN11 Facility ID: WY0013 If continuation sheet Page 1 of 24

APR 07 2015
Healthcare Licensing and Surveys

4/10/15 @ 8:15am This POC accepted between Matthew Guettman, Executive Director, and Pat Prine Surveyor with POC of 3/6/15.

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F 164	Continued From page 1 resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure privacy was maintained for 1 non-sample resident (#76) during 1 of 9 observations of personal care. The findings were: Review of the 1/27/15 annual MDS assessment showed resident #76 had diagnoses that included dementia and needed extensive assistance with bed mobility, dressing, and toileting. The following concerns were noted: a. Observation on 2/10/15 at 4:50 PM showed CNA #1 and CNA #2 provided personal care to the resident, including removing his/her brief and replacing it, but did not close the window blinds in the resident's room. Outside of the window was a parking lot. b. Interview at the time with CNA #1 revealed she was "nervous" and didn't remember to close the blinds. c. Interview on 2/10/15 at 6 PM with the Staff Development Coordinator revealed the expectation is for the CNA to pull the blinds when providing personal care. Review of the undated facility policy titled "Personal Hygiene Care..." showed "...provide for privacy..."	F 164	C. The DON or her designee will conduct in-service education on or before 3/06/15 with all direct care staff regarding the importance of providing privacy during Peri-care D. A performance Improvement tool will be utilized to randomly audit the provision of privacy during Peri-care. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the DON or designee. E. The DON or designee will report the results of the audits at the monthly Performance Improvement meeting monthly X 90 days or until substantial compliance has been achieved. The report will include any problems and/or trends noted. The P. I. Committee is the quality assurance group within the facility that is composed of the Executive Director, Director of Nursing, Medical Director and other department managers. The group meets monthly to review clinical audits, customer service issues and other regulatory compliance issues. If a problematic trend(s) is identified the committee develops, or causes the development, of an action plan designed to mitigate the chance of recurrence. The results of the action plan are reviewed in	

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F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure shower rooms were clean and well maintained for 2 of 3 shower rooms (Secure Unit, Nursing Unit I). The findings were: 1. The following concerns were identified with shower room surfaces: a. Observation on 2/11/15 at 8:05 AM showed the Nursing Unit I shower room had missing ceramic tiles on the right wall by the floor at 6 feet past the door that measured 6.5 inches long by 2 inches in height. The left wall by the floor at 6 feet past the door had ceramic tiles missing that measured 9 inches across by 9 inches in height. These missing tiles created an uncleanable surface which was darkened and had collected dirt and debris. b. Observation on 2/11/15 at 8:30 AM showed the Secure Unit shower room had cracks in the tiles by the floor of the back wall from the toilet to the shower that measured 55 inches across. Also, 2 tiles were missing by the right side of the shower door, and 7 tiles were cracked by the shower door floor. These damaged and missing tiles created an uncleanable surface which was darkened and collected dirt and debris. c. Interview with the acting maintenance director on 2/11/15 at 9:40 AM revealed he was aware of the tile damage in the shower rooms. However, he confirmed the facility failed to have a	F 253	subsequent months for effectiveness and modified as necessary. F253 A. Tiles in Nursing Unit 1 shower room and secure unit shower room were repaired on 3/5/15. B. The E.D. or designee inspected shower rooms on each unit to ensure a sanitary, orderly and comfortable space on 3/5/15. Any repairs needed were fixed upon discovery C. E.D educated Maintenance person on ensuring that broken tiles are fixed upon discovery. E.D. or designee will inspect shower rooms randomly to ensure a sanitary, orderly and comfortable space weekly for the next month and monthly for the following 2 months. Any repairs needed will be fixed upon discovery. D. The results of the inspections and any repairs will be summarized, reported and reviewed at P.I. meetings on a monthly basis for the next three months.	3/6/15

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F 283	Continued From page 3 plan with a timeframe to address this issue.	F 283	F 280	3/6/15
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure care plans were revised to reflect the current status and needs for 4 of 22 sample residents (#30, #40, #81, #87). The findings were: 1. Medical record review showed resident #87 was admitted to the facility on 1/15/15 for rehabilitation for lumbago (back ache) related to deteriorating lumbar vertebral discs. Review of a	F 280	A. Resident #87 was discharged home on 2/18/15. Resident #30 care plan was updated to reflect the anti-embolism compression stockings. Resident #81 no longer has a PICC line. Resident #40 care plan was updated to reflect the resident's oral care. RN # 1 was educated regarding the importance of updating the care plan regarding anti-embolism stockings. C.N.A.s #3 and #4 were educated regarding following dental orders while providing oral hygiene. B. The DON or her designee will conduct random audits to ensure that all residents care plans were updated with the following care needs: bed placement against the wall, corset placement, anti-embolism compression stockings, PICC line placement removed, and dentist ordered resident oral care needs. C. The DON or her designee will conduct in-service education on or before 3/06/15 with all nursing staff regarding the importance of updating resident care plans regarding the following care needs: bed placement against the wall, corset placement, anti-embolism stockings, PICC line removed, and appropriate Dentist ordered resident oral care needs. D. A performance Improvement tool will be utilized to randomly audit to determine that appropriate residents care plans have been updated regarding the following: bed placement against the wall, corset placement, anti-embolism stockings,	

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F 280	Continued From page 4 1/16/15 Rehabilitation Services Post-Fall Screening Tool revealed the resident fell out of bed. The findings/recommendations were to place the bed against the wall, and the documentation showed staff placed the bed against the wall. Observation during the survey showed the bed was placed against the wall. Observation on 2/9/15 at 9 AM revealed LPN #1 assisted the resident with applying a therapeutic corset that supported his/her lumbar spine. Interview with the LPN at that time showed the resident had been using either of 2 corsets as needed for relief of lumbar discomfort. The following concerns were identified: a. Review showed the facility failed to add use of either corset to the care plan. b. Review showed the facility failed to add bed placement against the wall to the care plan. c. Interview on 2/10/15 at 2:50 PM with MDS coordinator #1 showed the staff nurses were required to update care plans as needed before care conferences. She confirmed the facility failed to update the resident's care plan to include placing the bed against the wall, and adding the corset for comfort. 2. Review of the 1/8/15 admission MDS assessment for resident #30 showed diagnoses included dementia, hip fracture and edema (swelling). Review of the 1/2/15 Elderly Mobility Scale Score (a mobility assessment) showed the resident was dependent on staff for all mobility maneuvers and required help with basic ADLs "such as transfers, toileting and dressing." Review of the physician orders showed an order, dated 2/2/15, for staff to apply anti-embolism compression stockings to reduce the edema in the resident's legs. Periodic observations on	F 280	PICC line removal, and appropriate Dentist ordered resident oral care needs. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the DON or designee. E. The DON will report the results of the audits at the monthly Performance Improvement meeting monthly X 90 days or until substantial compliance has been achieved. The report will include any problems and/or trends noted.	

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F 280	Continued From page 5 2/10/15 and 2/11/15 revealed the anti-embolism compression stockings had not been applied to the resident's legs and the observed bilateral lower extremity edema remained unchanged. Interview with RN #1 on 2/11/15 at 10 AM revealed the anti-embolism compression stockings should be applied every morning and removed at bedtime. At that time the RN acknowledged the lower extremity edema and confirmed the anti-embolism compression stockings had not been applied that morning as prescribed by the physician. Review of the 1/12/15 care plan showed information regarding the anti-embolism compression stockings had not been added to the care plan. 3. Review of the 12/23/14 admission MDS assessment showed resident #81 had diagnoses that included cellulitis and bacterial wound infection, and needed extensive assistance with dressing and personal hygiene. Review of the care plan dated 12/26/14 showed the resident had a peripherally inserted central catheter (PICC) line and was receiving antibiotics through this line. Observation on 2/8/15 at 3:30 PM showed the resident lying in bed with a wound vacuum attached to his/her lower extremity, and no evidence of a PICC line. Interview on 2/11/15 at 7 AM with the unit 1 nurse manager verified the care plan should have been updated when the PICC line was discontinued on 1/8/15. 4. Review of the 12/2/14 admission MDS assessment showed resident #40 had moderate cognitive impairment and required extensive assistance with personal hygiene. Review of the medical record showed the dentist provided care for the resident on 1/21/15 and prescribed "brush and floss" two times a day and return for "fillings."	F 280		

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F 280	Continued From page 6 Interview with CNA #3 and CNA #4 on 2/11/15 at 9:50 AM revealed staff did not floss the resident's teeth because the facility did not have dental floss. Interview with the unit 2 nurse manager on 2/11/15 at 9:58 AM revealed she was not aware of the 1/21/15 order and staff had not flossed the residents teeth because the facility did not have dental floss. Review of the 12/3/14 care plan showed staff had not updated the care plan to reflect the resident's oral care needs. Observation on 2/9/15 at 11:05 AM and on 2/10/15 at 10 AM revealed small particles of food were visible between the resident's teeth.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure staff followed care plan interventions for 1 of 19 sample residents (#86). The findings were: Review of admissions face sheet for resident #86 showed admitting diagnoses included Alzheimer's disease and cognitive impairment. Review of the care plan for behavior, with an onset date of 1/26/15, showed the resident was known to steal other residents' food while they were trying to eat. The care plan further stated the resident ate his/her meal outside of the dining room. Approaches included: "Anticipate care needs and	F 282	F 282 A. During meals, as appropriate based on behaviors and the need to protect the rights and safety of others, resident # 86 is placed outside of the dining room partition to eat. B. The DON or her designee will conduct random audits to ensure any resident who requires placement outside of the dining room for meals to protect the rights and safety of others are properly placed according to those needs. C. The DON or her designee will conduct in-service education on or before 3/06/15 with all nursing staff regarding the importance of ensuring residents who should be placed outside the dining room for the protection of the rights and safety of others have been properly placed. D. A performance Improvement tool will be utilized to randomly audit that residents requiring placement outside the dining room for the protection of the rights and safety of others are properly placed. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the DON or designee. E. The DON will report the results of the audits at the monthly Performance Improvement meeting monthly X 90 days or until substantial compliance has been	3/6/15

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F 282	Continued From page 7 provide them before resident becomes overly stressed ; "..." intervene as needed to protect the rights and safety of others. Approach in a calm manner, divert attention, remove from situation and take to another location." The following concerns were noted: a. Observation on 2/10/15 at 11:35 AM showed the resident was sitting in the dining room at a table with two other residents. The resident reached across the table, took another resident's glass of juice, and drank the juice. b. Interview with LPN #2 on 2/10/15 at 4:30 PM revealed the resident should be placed outside of the dining room glass partition to eat as stated in the care plan.	F 282	achieved. The report will include any problems and/or trends noted.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview the facility failed to provide necessary care and services for 1 of 19 sample residents (#30). The findings were: Review of the 1/8/15 admission MDS assessment for resident #30 showed diagnoses included dementia, hip fracture and edema (swelling). Review of the 1/2/15 Elderly Mobility Scale Score	F 309	F 309 A. The Anti-embolism compression stockings for resident #30 are applied according to physician orders. The identified RN was educated on or before 3/6/15 regarding the importance of applying resident's anti-embolism compression stockings according to physician's orders. B. The DON or her designee will conduct random audits to ensure that anti-embolism stockings are applied for all residents according to physician orders. C. The DON or her designee will conduct in-service education on or before 3/06/15 with all nursing staff regarding the importance of applying anti-embolism compression stockings according to physician orders. D. A performance Improvement tool will be utilized to randomly audit that anti-embolism compression stockings are	3/6/15

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F 309	Continued From page 6 (a mobility assessment) showed the resident was dependent on staff for all mobility maneuvers and required help with basic ADLs "such as transfers, toileting and dressing." Review of the physician orders showed an order, dated 2/2/15, for staff to apply anti-embolism compression stockings to reduce the edema in the resident's legs. Review of the 2/10/15 nursing monthly summary showed the swelling in the resident's legs was "1+" (a system for measuring the degree of swelling). Periodic observations on 2/10/15 and 2/11/15 revealed the anti-embolism compression stockings had not been applied to the resident's legs and the observed bilateral lower extremity edema remained unchanged. Interview with RN #1 on 2/11/15 at 10 AM revealed the anti-embolism compression stockings should be applied every morning and removed at bedtime. At that time the RN acknowledged the lower extremity edema and confirmed the anti-embolism compression stockings had not been applied that morning as prescribed by the physician.	F 309	applied according to physician's orders. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the DON or designee. E. The DON will report the results of the audits at the monthly Performance Improvement meeting monthly X 90 days or until substantial compliance has been achieved. The report will include any problems and/or trends noted.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview the facility failed to ensure 1 of 19 sample residents (#40) who required	F 312	F 312 A. Resident #40 has received appropriate oral hygiene since 2-12-2015. In accordance with dentist orders. B. The DON or her designee will conduct random audits to ensure proper oral hygiene is provided in accordance with dental orders. C. The DON or her designee will conduct in-service education on or before 3/06/15 with all nursing staff regarding the	3/6/15

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F 312	Continued From page 9 assistance performing ADLs received assistance with oral hygiene. The findings were: Review of the 12/2/14 admission MDS assessment showed resident #40 had moderate cognitive impairment and required extensive assistance with personal hygiene. Review of the medical record showed the dentist provided care for the resident on 1/21/15 and prescribed "brush and floss" two times a day and return for "fillings." Interview with CNA #3 and CNA #4 on 2/11/15 at 9:50 AM revealed staff did not floss the resident's teeth because the facility did not have dental floss. Interview with the unit 2 nurse manager on 2/11/15 at 9:56 AM revealed she was not aware of the 1/21/15 order and staff had not flossed the residents teeth because the facility did not have dental floss. Review of the 12/3/14 care plan showed staff had not updated the care plan to reflect the resident's oral care needs. Observation on 2/9/15 at 11:05 AM and on 2/10/15 at 10 AM revealed small particles of food were visible between the resident's teeth.	F 312	importance of providing oral hygiene needs in accordance with Dentist orders. D. A performance Improvement tool will be utilized to randomly audit to ensure that all resident dentist ordered oral hygiene needs are met. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the DON or designee. E. The DON will report the results of the audits at the monthly Performance Improvement meeting monthly X 90 days or until substantial compliance has been achieved. . The report will include any problems and/or trends noted.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	F 315 A. Resident #26 has been toileted according to identified toileting needs. B. The DON or her designee will conduct random audits to ensure that all resident identified toileting needs are met. C. The DON or her designee will conduct in-service education on or before 3/06/15 with all nursing staff regarding the importance of ensuring that all identified toileting needs are met.	3/6/15

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F 315	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide services to maintain normal bladder function for 1 of 10 sample residents (#26) with toileting plans. The findings were: Review of the 12/15/14 quarterly MDS assessment showed resident #26 required the extensive assistance of 1 person for toileting, was frequently incontinent of bladder, and had a urinary toileting program. Review of the resident's care plan for incontinence, most recently updated on 12/17/14, showed approaches that included "toilet on rising, within 1 hour after meals, after napping, and before bedtime. Look for behavior clues that indicate that toileting may be needed at other times." The following concerns were identified: a. Continuous observation on 2/10/15 beginning at 4:17 PM showed the resident was seated in a wheelchair in his/her room. At 4:38 PM the resident activated the call light. LPN #6 responded at 4:39 PM, and asked the resident if s/he was hungry and would like to go to the dining room. The LPN took the resident to the dining room without asking if s/he needed to use the toilet or offering toileting. b. At 5:32 PM, LPN #5 asked the resident if s/he was finished with dinner, and if s/he wanted to go to his/her room. The LPN took the resident to his/her room, and instructed the resident not to get up by him/herself. The LPN did not ask the resident if s/he needed to use the toilet or offer toileting. c. At 7:40 PM, LPN #2 entered the resident's room and re-directed another resident who was wandering out of the room. Resident	F 315	D. A performance Improvement tool will be utilized to randomly audit that all resident identified toileting needs are met. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the DON or designee. E. The DON will report the results of the audits at the monthly Performance Improvement meeting monthly X 90 days or until substantial compliance has been achieved. The report will include any problems and/or trends noted.	

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F 315	Continued From page 11 #26 was observed to be attempting to stand. The LPN then assisted the resident with a transfer from wheelchair to recliner; but did not ask the resident if s/he needed to use the toilet, or offer toileting. d. At 8:28 PM (two hours after the completion of the evening meal) RNA #1 asked the resident if s/he would like to use the toilet and get ready for bed. The RNA helped the resident to the bathroom, and onto the toilet. The resident was observed to urinate in the toilet. Interview with the RNA at that time confirmed the resident's incontinence brief was wet, and further revealed the resident could "go in the toilet sometimes, but it's hard to get [him/her] in there."	F 315		
F 441 SS=K	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	F 441	F 441 CORRECTIVE ACTION TAKEN: As of 3/3/15, there are no residents exhibiting signs or symptoms of Influenza, no residents who are receiving treatment for Influenza and no residents who are on isolation due to Influenza. As noted in the 2567, the facility provided a corrective action plan which included: 100% of family members of residents positive for Influenza were notified between 2/2-2/8 Signs noting influenza was present in the facility were posted on 2/9/15 Training of staff re: Influenza precautions, droplet precautions and isolation practices were completed on 2/9/15 and training continued prior to any staff member working another shift	3/6/15

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F 441	Continued From page 12 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. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of policy and procedure, and resident and staff interview, the facility failed to implement effective measures to control the spread of a known outbreak of infectious respiratory disease. This failure resulted in an immediate jeopardy situation. The census was 107. In addition the facility failed to ensure staff practices minimize the potential for cross contamination and the spread of disease during one random observations of staff and visitors handling ice, 1 of 6 observations of lack of hand hygiene between glove changes (resident #37), and 1 of 6 observations of inappropriate perineal care (resident #76). The findings were: Regarding the facility's failure to implement effective measures to control the spread of a known outbreak of infectious respiratory disease:	F 441	Auditing of proper use of isolation practices was conducted until 2/16/15, which was the last day a resident exhibited a sign or symptom of Influenza. Residents who exhibited signs and symptoms, received antiviral treatment and were considered infectious for 24 hours after initiation of treatment and afebrile. The facility's cowboy dining room was no longer utilized for symptomatic residents as of 2/9/15, rather residents were served meals in their rooms. As of 2/16/15 the following residents are no longer experiencing signs or symptoms of Influenza: 35, 37, 85, 109, 93, 41, 17, 10, 5, 24, 54, 79, 4, 80, 81, 83, 98, 82, 110, 45, 111, and 62. Residents #51 and #108 expired on 2/18/15. Residents #79 and #52 expired on 2/11/15 As of 2/18/15 no staff are experiencing signs or symptoms of Influenza. On 3/4/15 both ice chests are now stored out of reach of visitors. On or before 3/6/15 the DON or designee educated CNA's #1,2, and 3 on the facility's hand hygiene protocol, as detailed below. As of 3/6/15 CNA's 1, 2 and 3 have been utilizing proper hand hygiene practices when providing personal cares to residents. IDENTIFICATION OF OTHERS TO PREVENT THE ALLEGED DEFICIENT PRACTICE FROM EFFECTING OTHERS	

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F 441	Continued From page 13 1. Observation on 2/8/15 from 2 PM through 2:35 PM revealed no PPE by any resident rooms, or signs on any resident doors during a tour of the entire facility, which would alert staff and visitors of an influenza outbreak. Interview on 2/8/15 at 2:25 PM with MDS coordinator #1 revealed she advised the state survey agency staff to consider wearing a mask in the facility due to an influenza outbreak. Random observations at that time showed no staff or visitors, which included the MDS coordinator, wore PPE at any time. 2. Observation on 2/8/15 at 2:45 PM revealed the front door to the facility lobby had two signs posted that requested if any visitor showed signs or symptoms of illness they should not enter the facility. No signage was present at that time which would alert visitors to avoid the facility due to an influenza outbreak. 3. Interview with the facility administrator, staff development coordinator and DON on 2/8/15 beginning at 3:45 PM revealed the following: a. The facility identified 4 residents with influenza on 2/2/15. These residents included resident #110, who was hospitalized on 2/2/15 and tested positive for influenza; resident #46, who was hospitalized on 2/2/15 and tested positive for influenza; resident #80, who tested positive for influenza in the facility; and resident #111, who tested negative for influenza at the facility, but was subsequently hospitalized and tested positive for influenza. Additionally, resident #62 was symptomatic, but tested negative for influenza at the facility. b. On 2/3/15, the facility identified an additional resident, resident #93, who tested positive for influenza, as well as employee #1 who also tested positive for influenza.	F 441	From 2/8/15 through 2/16/15, residents were assessed by the nursing admin team to determine if any residents had signs or symptoms of Influenza, i.e. non-productive cough, fever of 100.5 or greater or general feelings of malaise. No other residents were identified during this audit. On 3/4/15 the ADON conducted an audit of all ice chests in the facility to determine if they were clean and free of contamination. Upon discovery, the ADON noted areas identified as needing cleaning and corrected it at the time of discovery. The ice chests were cleaned and then stored in an area that is not accessible to visitors On or before 3/6/15 the ADON/designee conducted a one-time random observation of 15 CNAs performing personal cares, observing for proper hand hygiene practices. Any areas of concern noted were addressed at the time of discovery. SYSTEMIC MEASURES The facility as an infection control program that includes the following: Investigation of infections, Controls to prevent the spread of an infection, and preventative measures such as education, surveillance and trending of infections. The program requires documentation of the above listed requirements and has identified a clinical nurse to oversee the program. Prevention of the spread of infections includes identifying what types of precautions are required for resident(s)	

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F 441	Continued From page 14 c. The DON stated the facility's actions in response to the influenza outbreak included "following the protocol and testing anyone with symptoms," putting a sign on the facility's front door discouraging people with signs and symptoms of illness from visiting the facility, increasing handwashing and cleaning, and having symptomatic residents go to "Cowboy Dining" (the dining room on unit 2) or remain in their rooms for meals. The DON further stated employees had "the option to wear a mask." The masks were kept at the nurses' station. d. On 2/3/15, the facility administrator attempted to contact the Wyoming Department of Health, Infectious Disease Epidemiology Unit to report the influenza outbreak, and left a message. On 2/4/15, the Epidemiology Unit returned the call and spoke to the staff development coordinator. The Epidemiology Unit also provided the facility with guidance from the Centers for Disease Control (CDC) on management of influenza outbreaks in long term care facilities. e. The DON stated that, after reviewing the CDC guidelines, she spoke to the facility's medical director. According to the DON, the medical director said the facility was "doing everything they needed to," and as a result the facility did not institute droplet precautions as outlined in the facility's own policy and procedure. The DON further stated "we thought we had it [the outbreak] under control." f. On 2/5/15 an environmental services worker #1, and LPN #2 tested positive for influenza. g. On 2/6/15 resident #82 tested positive for influenza. Additionally, resident #98 was symptomatic, but tested negative for influenza at the facility. h. On 2/8/15 resident #51, resident #81 and	F 441	including outbreak protocols. The program also includes monitoring and surveillance of associates to reduce the risk of spreading infections to residents. Associates newly hired by the facility will receive education and training on infections and infectious outbreaks. Current associates will receive education quarterly and as needed (i.e. during influenza season). If a resident exhibits a change in condition i.e. fever, non-productive cough, malaise etc... the nurse will note this on the 24 hour report, which serves as a communication tool for staff on each shift. The interdisciplinary team will review the 24 hour reports during grand rounds and will determine if a potential infection or infectious outbreak is a concern. If so, the following practices will be initiated: Specifically, the ADON is the clinical nurse who oversees the facility's infection control program. The facility's infections disease policy includes a detailed checklist of how to response in an infectious outbreak to minimize the potential for cross contamination. Included in that checklist are: -Alert all facility staff to the influenza outbreak; - Determine type of precautions appropriate for the outbreak (i.e. droplet) -Isolate the identified residents to their rooms, including meals, activities and therapy immediately	

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F 441	Continued From page 16 resident #54 all tested positive for influenza at the facility. 4. Review of the facility's policy and procedure entitled, "Protocol to Manage a Flu Outbreak" showed interventions to be implemented in the event of an influenza outbreak included the following: a. "Provide notification to families to discourage visitation until flu has cleared up in the facility or in the community." b. "Initiate droplet precautions for care of the symptomatic residents." c. "Stop group activities and group dining during the outbreak." 5. Review of the facility's policy and procedure for "Droplet Precautions" revealed droplet precautions were to be instituted for influenza, and included the following: a. "Stop" sign on door. b. "Visitors are instructed to wear a mask and wash hands when entering and leaving room." c. "Gloves." d. "Mask." e. "Resident Transport - Limit transport of resident to essential purposes only. During transport, resident must wear a mask." 6. CDC recommendations, found in "Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities" include implementing standard and droplet precautions for residents with suspected or confirmed influenza. 7. On 2/6/15 at 5:01 PM the administrator and DON were informed of an immediate jeopardy situation in the area of infection control.	F 441	-Place Isolation supplies outside the affected/isolated resident(s) room(s) -Reinforce hand hygiene with all staff, ensure they know how to put on Personal Protective Equipment -Implement droplet precaution measures for all residents with suspected or confirmed influenza. - Implement respiratory hygiene/cough etiquette measures. -Contact the Medical Director and inform them of the outbreak and your outbreak plan and obtain any additional guidance -Culture/test residents with symptoms to determine if there is a positive case, once there is a confirmed case of positive Influenza, staff will assume that any additional residents presenting with like symptoms are most likely positive as well and will treat, isolate and manage as if positive. -Nursing on all units will initiate a Surveillance Log that will be kept in the MAR to document residents who are on isolation and residents who are actively symptomatic -Conduct laboratory testing to determine specific strain of influenza virus, bacteria and antiviral susceptibility. - Implement daily active surveillance of all residents and staff for illness (refer to signs and symptoms tool). -Institute antiviral chemoprophylaxis for residents and staff, as indicated. q Keep residents with confirmed and suspected influenza together and away from other residents.	

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F 441	Continued From page 16 The facility's action plan included the following immediate changes: a. 100% of Family members of residents positive for influenza were notified between 2/3-8/15. All residents who test positive in the future were to have family member(s) notified immediately. b. Signs illustrating influenza is present were to be posted on all facility entrance doors on 2/09/15. c. Training of all facility staff re: Flu precautions, droplet precautions related to PPE were scheduled for 1:30 - 2:30 & 9:30 PM on 2/9/15 and training was to continue prior to each shift until all staff have been trained. Staff were not to be eligible to work until they had been trained. d. The DON was designated as the individual responsible for facilitating all Flu-related education, surveillance and monitoring. e. Every shift auditing of appropriate use of PPE was to be conducted until influenza has been mitigated in the facility. Audits have begun on all applicable units. f. The criteria for determining whether residents are still infectious will be according to CDC Guidelines, i.e. asymptomatic 7 days after onset of symptoms or 24 hrs [hours] after afebrile for those treated. g. "No terminal outcomes are reported for all residents positive for flu." 8. The action plan was accepted on 2/9/15 at 6:07 PM. 9. Interview with the infection preventionist and the ADON on 2/11/15 beginning at 10:45 AM confirmed droplet precautions were not put in place at the facility on 2/2/15 when the first cases	F 441	-Restrict staff and resident movements among units and floors. -Educate residents on hand hygiene and cough etiquette. -Notify state and county department of health within 24 hours of outbreak recognition -Notify family members and receiving facilities of the outbreak -Ensure that resident rooms and common areas are cleaned more frequently. -Ensure that adequate supplies of masks, gloves, and gowns are available. Associates have been educated on the above listed policy by the Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator March 2nd through 3/6/15. On 3/2/15, the Regional Director of Clinical Services Educated the DON on the above listed policy. The facility has a policy for the use of ice chests. Specifically, ice chests are stored in associate only areas. Associates send the ice chest to the kitchen nightly for cleaning. Cleaning consists of placing the ice chest in the dish area for proper cleaning and sanitizing. The DON educated the SDC on the above listed policy on 3/4/15. The SDC educated staff who access and utilize the ice chests, on the proper cleaning protocol and the importance of keeping the ice chests out of reach of visitors. This education was provided from 3/4/15 through 3/6/15.	

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F 441	Continued From page 17 of influenza were identified, or thereafter until the immediate jeopardy was declared on 2/8/15. 10. Review of nursing notes for resident #81 dated 2/8/15, timed 12:46 PM, revealed the resident was febrile, had a cough and had tested positive for influenza. Observation on 2/9/15 at 3:30 PM showed the resident was lying in bed with a wound vacuum attached to his/her lower extremity. There were no precautions posted anywhere in the room, nor any notice on the door into the room advising of the resident's infectious status. Interview at that time with CNA #7 revealed she was unaware of the resident's positive influenza status. 11. Observation on 2/9/15 at 6 PM showed the unit 2 nurse manager assisted resident #83 (positive for influenza on 2/3/15) to the bathroom. Neither the resident nor the manager wore a mask. Immediately after the observation, the manager stated the resident no longer had signs or symptoms of the flu. However, the manager posted a sign on the resident's door at that time which stated, "Please ask the nurse before entering this room." Observation on 2/9/15 at 6:15 PM showed CNA #6 entered the resident's room without donning a mask. Interview with the aide at that time showed she believed the sign was for the resident's roommate. Interview with the resident on 2/9/15 at 6:25 PM showed the resident felt better. However, the resident stated, "I still have somewhat of a cough. They said I have Influenza A." After the interview, the resident transported him/herself via wheelchair in the hallway without donning a mask. 12. Observation on 2/9/15 at 8:05 AM in the main dining room showed resident #83 and roommate	F 441	The facility has a policy regarding hand hygiene. Specifically, hand washing will occur: When hands are visibly dirty or contaminated or are visibly soiled with blood or other body fluids, before donning gloves and after removing gloves, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water. 1. Turn on water to a comfortably warm temperature. 2. Moisten hands with soap and water and make a heavy lather. 3. Wash well under running water for a minimum of 20 seconds, using a rotary motion and friction. 4. Rinse hands well under running water. 5. Dry thoroughly with a disposable towel. 6. Use a towel to turn off the faucet then discard. The DON/designee provided education to care givers on the above listed hand hygiene protocol from 3/4/15 through 3/6/15. MONITORING	

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F 441	Continued From page 18 resident #4 eating breakfast and not donning a mask. 13. Observation on 2/9/15 at 8:15 AM showed resident #46 in the Cowboy dining room without a mask. The dining room was open to the hallway near Nursing Station II, and staff and residents were present. 14. Observation on 2/9/15 at 9:15 AM showed CNA #6 transporting resident #60 from the Cowboy dining room in his/her wheelchair. The resident was coughing frequently at that time; however, neither the resident nor the aide donned a mask. Interview with the aide at that time outside of the resident's room revealed the resident did not like to wear a mask. 15. Review of the 2/10/15 hospital progress note for resident #61 revealed the resident was admitted to the hospital on 2/6/15 with "acute-on-chronic hypoxemic respiratory failure likely secondary to influenza A." Interview with the ADON on 2/20/15 at 11:05 AM revealed the resident returned briefly to the facility on 2/14/15 before transferring to hospice, where s/he died on 2/18/15. 16. Review of nursing notes dated 2/6/15, timed 4:09 PM, revealed resident #103 began antibiotic treatment for an upper respiratory infection. Nursing notes dated 2/7/15, timed 2:29 PM, revealed the resident had a loose non-productive cough. Nursing notes dated 2/8/15, timed 1:24 PM, showed charting for the 2/7/15 night shift and revealed the resident was suffering an exacerbation of chronic obstructive pulmonary disease with acute bronchitis, and continued antibiotic treatment. Nursing notes dated 2/9/15,	F 441	Daily, the ADON/designee, will review the facilities 24 hour report for changes in residents' clinical condition and will also review the physician orders to determine if any resident(s) are being treated for signs or symptoms of an infection. The results of review of the clinical information will be documented by the ADON/designee and will be discussed with the DON and Executive Director following Grand Rounds. This clinical audit will be completed for the next 30 days, then monthly for the next 60 days. The results of these audits will be provided to the Performance Improvement Committee for input and review. The ADON/designee will conduct observations of staff providing personal cares to residents to ensure proper hand hygiene and hand washing in between donning and taking off gloves occurs as appropriate. A total of 10 random observations a week, will be completed by the ADON/designee and will continue until all staff have been observed and have proven proficient in hand hygiene. The results of the observations will be submitted to the Performance Improvement Committee for input and review. The ADON/designee will conduct 5 observations weekly for 30 days to ensure the proper storage and use of the ice chest by associates and cleaning practices is	

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	535049	A. BUILDING _____ B. WING _____	02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 19 timed 1:45 PM, showed charting for the 2/8/15 evening shift, and revealed the resident was "in cowboy dining due to behaviors..." Nursing notes dated 2/9/15, timed 10:02 AM, revealed the resident was started on Tamiflu 75 mg once daily for 2 weeks. Nursing notes dated 2/10/15, timed 10:35 AM, revealed the resident's Tamiflu had been increased to 75 mg twice daily for 5 days, and the resident had been put on droplet precautions. Interview with the ADON on 2/20/15 at 11:05 AM revealed the resident died on 2/18/15. 17. Review of nursing notes dated 2/6/15, timed 11:58 PM, revealed resident #64 tested positive for influenza on 2/6/15 (not 2/8/15 as was stated in interview). Nursing notes dated 2/9/15, timed 1:54 PM, revealed an intravenous line was started in the resident's right wrist to administer fluids. 18. Review of nursing notes dated 2/6/15, timed 6:31 PM, showed resident #79 had a non-productive cough and complained of not feeling well. The resident was treated for an upper respiratory infection. Nursing notes dated 2/7/15, timed 6:50 PM, revealed the resident continued to have a non-productive cough, but was "feeling well enough to go to dining room for meals." Review of the nursing notes dated 2/8/15, timed 7:37 PM, revealed the resident continued to complain of not feeling well, had a non-productive cough, and further revealed the resident was "going to dining room for meals, but requests that [s/he] be assisted to and from meals." Interview with the medical director on 2/9/15 beginning at 11:07 AM revealed the resident had tested negative for influenza at the facility, and was treated for an upper respiratory infection. There	F 441	occurring. The results of these observations will be submitted to the Performance Improvement Committee for input and review.	

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F 441	Continued From page 20 was no laboratory confirmation of the negative result. The resident's condition declined, and s/he was sent to the hospital on 2/9/15 where a test for influenza was positive. Review of the hospital progress note dated 2/10/15 revealed the resident was suffering "Acute-on-chronic hypoxemic and hypercarbic respiratory failure probably secondary to influenza A on top of a mixed obstructive and restrictive lung disease with chronic respiratory failure." Interview with the ADON on 2/11/15 at 12:25 PM revealed the resident had died that day. 19. Review of nursing notes dated 2/9/15, timed 8:34 PM, revealed resident #24 had a fever of 101.8 degrees Fahrenheit, and was started on Tamiflu (an antiviral medication used to treat flu symptoms caused by influenza). Nursing notes dated 2/10/15, timed 8:36 PM, revealed the resident had upper respiratory symptoms, oxygen saturations in the 60's (below 90% is considered abnormal) on room air, a non-productive cough, and shortness of breath. 20. Based on implementation of the facility's plan, the immediate jeopardy was removed on 2/10/15 at 8:52 AM. However, deficient practice remained at a scope and severity of H (actual harm that is not immediate jeopardy). 21. Interview with the infection preventionist on 2/10/15 at 11:50 AM revealed resident #52 had been put on droplet precautions. Interview with the ADON on 2/20/15 at 11:05 AM revealed the resident was treated with Tamiflu and died at the facility on 2/11/15. 22. Interview with LPN #3 on 2/10/15 at 2:45 PM revealed resident #5 had been put on droplet.	F 441		

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F 441	Continued From page 21 precautions due to symptoms. 23. Interview with LPN #4 on 2/10/16 at 2:02 PM revealed the following residents were on droplet precautions due to symptoms of influenza: resident #52, resident #10, resident #17, resident #41, resident #93, resident #109, resident #85, and resident #37. The LPN further revealed resident #85 had experienced respiratory distress that morning and had been transported to the hospital where s/he tested positive for influenza. 24. Interview with a Surveillance epidemiologist at the Wyoming Department of Health, Infectious Disease Epidemiology Unit on 2/18/15 at 1:15 PM revealed he contacted the facility on 2/4/16 and spoke with the facility SDC. He provided the CDC's "Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities" to the facility and urged the facility to take the influenza outbreak very seriously; due to the currently circulating strain of influenza A being "very detrimental" to persons greater than 65 years of age. Additional findings regarding the facility's failure to minimize the potential for cross contamination and spread of disease were noted during the following observations: 1. Observation on 2/8/16 at 6:06 PM showed a visitor used an ice scoop to fill a resident's mug; while holding the mug over the filled ice chest located at the nurses' station, dirty water ran into the ice chest. The visitor returned to the resident's room. Interview at that time revealed the visitor performed this action "every night" for the resident, and staff had not provided any education about filling the resident's mug with ice	F 441		

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F 441	Continued From page 22 and water. Interview on 2/6/15 at 6:15 PM with the rehabilitation director revealed staff members should be filling the resident's mug with ice water, and she would ask a staff member to clean the ice chest. Interview on 2/6/15 at 6:30 PM with the admission coordinator revealed she rinsed the ice chest and filled it with ice, then returned it to the nursing station to be used. Additionally, she was not educated on how to clean and sanitize the ice chest when contaminated. Interview at that time with the DON revealed she was unaware of how the CNAs clean the ice chest when contaminated. Interview on 2/6/15 at 7:10 PM with the staff development coordinator revealed staff should clean the contaminated ice chests with a 10 percent (%) bleach solution. 2. Review of the 1/27/15 annual MDS assessment showed resident #76 had diagnoses that included dementia, needed extensive assistance with bed mobility, dressing, and toileting. Observation on 2/10/15 at 4:50 PM showed CNA #1 and CNA #2 provided care to the resident. During the observation CNA #2 removed the resident's wet brief and completed the following tasks without performing hand hygiene: wiped the resident's abdomen and perineum, removed her soiled gloves, donned clean gloves, wiped the resident's buttocks, reused the same visibly soiled wipe to clean the resident's perineum, removed soiled gloves, donned clean gloves, pulled up the resident's clean brief and pants, then positioned the resident in his/her wheelchair. Interview on 2/10/15 at 6 PM with the Staff Development Coordinator revealed the expectation is to perform perineal care with a clean wipe and throw away the visibly soiled wipe.	F 441		

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F 441	Continued From page 23 3. Review of the 1/17/15 quarterly MDS showed resident #37 had severe cognitive impairment and required extensive assistance with ADLs. On 2/9/15 from 12:06 PM to 12:20 PM CNA #4 and CNA #8 were observed providing toileting assistance and personal hygiene care for resident #37. During the observation CNA #4 changed gloves 4 times before completing the task of cleaning the resident's perineal and rectal areas. Further observation revealed the CNA did not perform hand hygiene between the glove changes. Interview with the staff educator on 2/11/15 at 10:35 AM revealed the education and in-services provided for the staff did not included hand hygiene between glove changes. According to the CDC "Guidelines for Hand Hygiene in Health-Care Settings", published 2002, ..."hands should be decontaminated or washed after removing gloves..."	F 441		