STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	C 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITION AND WELLNESS	**60 MAGNOLIA CASPER, WY 82604**

(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 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 10/5/20 through 10/12/20. The survey was prompted by complaint intakes WY000003047, WY000003094, WY000003117, WY000003118, WY000003127. In addition, a COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted by healthcare licensing and Surveys from 10/5/20 through 10/12/20. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing Services LPN- Licensed Practical Nurse MA- Medication Aide MDS- Minimum Data Set NHA- Nursing Home Administrator RN- Registered Nurse	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		11/16/20

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

Electronically Signed | 11/04/2020

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure residents were treated with dignity during 1 of 3 dining room (East Dining Room) observations. The findings were: Observation on 10/5/20 at 5:30 PM of the East Unit dining room showed CNA # 7 standing while assisting 5 residents at 3 different tables to eat.	F 550	1)Identified residents who require assistance with meals are assisted in an appropriate and dignified manner. C.N.A. #7 was re-educated on Resident rights and dignity. 2)Audit completed by Dietary Manager to update the list for those residents requiring assistance with meals.	

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F 550	Continued From page 2 Interview on 10/6/20 at 7:15 AM with CNA #7 revealed she was the only aide to assist 16 residents with their meal. She stated she knew that she needed to sit with each resident, but did not have enough time. Interview on 10/12/20 at 11:47 AM with the DON revealed the expectation is for aides to sit and assist the residents with their meals.	F 550	3)Education provided by DNS/Designee to current staff related to dining room assistance for those requiring assistance with meals. Executive Director/Designee will audit dining room service to ensure appropriate and dignified meal assistance is provided for those residents who require assist with meals at each meal three times per week times three months. 4)Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		11/16/20

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F 561	Continued From page 3 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident representative interview, staff interview, and review of the list to get residents up, the facility failed to ensure residents were not being awakened and gotten out of bed in the morning for staff convenience on 2 of 2 units (South Unit, East Unit) observed. The findings were: 1. Observation on 10/6/20 at 5:40 AM of the South Unit common area and television area showed 8 residents dressed and in wheelchairs with their eyes closed. Interview at this time with CNA #3 revealed they got the residents up at 5:00 AM and at 6:00 AM, in order to help the day shift. 2. Observation on 10/6/20 at 6:00 AM of the East Unit dining room showed resident #13 in a wheelchair with his/her head on the table and eyes closed. a. Review of the care plan for resident #13 showed an admission date of 1/18/17 with diagnoses which included cerebral vascular accident, dysphagia, atrial fibrillation, and age related cognitive decline. Further review of the care plan showed no evidence the resident preferred to get out of bed early in the morning. Review of the 9/2/20 quarterly MDS assessment showed a brief interview for mental status (BIMS) score of 3 (indicating severe cognitive	F 561	1)Residents #13 and #14 are offered assistance out of bed at their preferred times. 2)Audit completed by Social Services Director/Designee of current residents preferred get up times. Results of this audit have been entered into the resident's care plans. 3)Education provided by DNS/Designee to Nursing/CNA staff regarding resident rights related to resident preferences regarding get up times. Education provided by DNS/Designee to Nursing/CNA staff related to resident preferences for get up times including where to find this information for future use. 4)Social Service Director/Designee will randomly audit 25 residents per week times three months to ensure residents are assisted out of bed at their preferred time. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	

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F 561	Continued From page 4	F 561		

impairment). The resident required the physical assistance of 2 or more staff persons for transfers.

b. Interview on 10/8/20 at 10:42 AM with the resident's son revealed he was not aware the resident was getting up so early. He further revealed if the resident was awake and wanted to get up that would be fine, but not if staff were waking the resident up deliberately.

3. Observation on 10/6/20 at 6:50 AM in the East Unit common room showed resident #14 in a wheelchair, with his/her arm hanging off the arm rest and with eyes closed.

a. Review of the care plan for resident #14 revealed an admission date of 6/9/19 with diagnoses which included chronic pain syndrome, hemiplegia, cerebral vascular infarction, hypertension, dysphagia, and chronic kidney disease. Further review of the care plan failed to show any evidence the resident preferred to get out of bed early in the morning. Review of the 7/3/20 quarterly MDS assessment showed the resident had a BIMS score of 13 (intact cognitive response), required the extensive physical assistance of 2 or more staff persons for transfers. Further review showed choosing bedtime was coded as being very important to the resident.

b. Review of the care conference notes dated 7/29/20 failed to show any documentation the resident preferred to get up early.

c. Interview on 10/12/20 at 10:51 AM with the resident's spouse revealed the facility did not ask about the resident's preferred time to get up in the morning, and when the resident was at home s/he would sleep until 7:30 AM.

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F 561	Continued From page 5 4. Interview on 10/6/20 at 6:00 AM with CNA #4 and CNA #5 revealed they start getting residents up at 4:00 AM and the expectation was to get residents who require hoyer lift transfer up by change of shift. CNA #5 further stated there was a list of residents they are required to get up every morning. 5. Interview on 10/8/20 at 11:33 AM with CNA #6 revealed they start getting residents up at 4:00 AM, and they had to wake them up. The CNA further stated there was a list of residents to get up every morning prior to start of day shift. 6. Review of the resident list at the East Unit nurse's station showed 16 resident rooms and read "Please get as many of the following residents up in the AM as you can!" 7. Interview on 10/12/20 at 11:47 AM with the DON revealed they got residents up early, and had a list. She stated some residents prefer to get up early and it was in their care plan.	F 561		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 684	1)ADL documentation is provided	11/16/20

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F 684	Continued From page 6 interview, the facility failed to ensure the plan of care was followed for 2 of 5 residents (#4, #14) reviewed. The findings were: 1. Review of the medical record for resident # 4 showed an admission date of 3/18/20 with diagnoses which included atrial fibrillation, congestive heart failure, chronic kidney disease, and clostridium difficile. Review of the 7/31/20 quarterly MDS assessment showed the resident was at high risk of developing a pressure ulcer. Review of the care plan showed a problem area of deep tissue injury to the right heel and the interventions included turn/reposition at least every 2 hours. Further review of the care plan showed a problem area of bladder incontinence. Interventions included monitor and document intake and output as per facility policy. The following concerns were identified: a. Review of the nursing progress note dated 7/21/20 and timed 6:17 PM showed "...apply barrier cream to coccyx, which has a sore on it..." Review of the nursing progress note dated 7/22/20 and timed 1:59 PM showed "...Air mattress has been placed and resident to be re-positioned every couple of hours..." Review of the nursing progress note dated 7/24/20 and timed 10:13 AM showed "...Resident's gluteal fold area has blistering excoriation.." Review of the nursing progress note dated 7/28/20 and timed 1:07 PM showed "...resident's perineal area is excoriated with a few blisters...". b. Review of the CNA documentation survey report for July 2020, showed 2 days where nothing was documented for bed mobility. Further review showed 9 days where bed mobility was documented once for the 24 hour period. Review of the CNA Documentation	F 684	appropriately for residents #4 and #14 and their care plan matches their ADL needs. 2)Audit completed by DNS/Designee to assess for deficiencies in ADL documentation by CNAs to ensure documentation is accurate compared to care plan needs. 3)Education provided to Nursing/CNA staff by Asst. ED, related to required ADL documentation and accuracy of care plan. Medical Records Director will audit ADL documentation for the previous 24-hour period three times per week times three months. 4)Results of initial and ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	

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F 684	Continued From page 7 Survey Report for 8/1/20 - 8/17/20 showed 2 days where nothing was documented for bed mobility and 6 days where bed mobility was documented once in a 24 hour period. c. Review of the CNA documentation survey report for July 2020 failed to show documentation for bladder monitor for 2 days and 9 days where bladder monitor was documented once in a 24 hour period. d. Review of the CNA documentation survey report 8/1/20 - 8/17/20 failed to show documentation for bladder monitoring for 2 days, and 6 days where bladder monitoring was documented once in a 24 hour period. 2. Review of the medical record for resident #14 showed the resident was admitted on 6/9/19 with diagnoses which included hemiplegia, pressure ulcer of right ankle, open wound left ankle, chronic kidney disease, and neuromuscular dysfunction of bladder. Review of the care plan showed a care problem area of skin and interventions included staff to assist for frequent turning/repositioning in bed. Further review of the care plan showed the resident had an indwelling catheter and the interventions included staff to empty the bag per facility protocol and to monitor urinary output every shift. The following concerns were identified: a. Review of the CNA documentation survey report dated 10/1/20 - 10/11/20 showed 6 days where bed mobility was documented only once in a 24 hour period. b. Review of the CNA documentation survey report dated 10/1/20 - 10/11/20 showed 4 days where bladder monitoring was documented only once in a 24 hour period.	F 684		

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F 684	Continued From page 8 3. Interview with the DON on 10/12/20 at 11:47 AM revealed the expectation was that CNAs must document the care provided at least once a shift.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and policy and procedure review the facility failed to provide appropriate supervision for resident smoke breaks for 1 of 1 smoking location. The findings were: Review of the policy and procedure "Resident Smoking Safety", updated August 2019, showed "Policy Statement: The Center completes the Smoking Safety Evaluation for residents desiring to smoke tobacco products (cigarettes, cigars, or pipes, including electronic e-cigarettes)...Residents only smoke with supervision... 9. Residents are supervised when utilizing any smoking device while on center grounds..." The following concerns were identified: 1. Review of the facility's "Weekend of 9/26 - 9/27 smoke break supervisor" form showed there were 3 smoking breaks on 9/26/20 and 3	F 689	1)Current residents who smoke are supervised by a trained staff member. 2)Audit performed by Social Services Director to ensure those staff members who supervise smoking are trained in the process. 3)Education provided to smoking attendants by Activities Director on 10/27/20, related to having a trained staff member supervising those residents who smoke. Executive Director/Designee will audit two of the three smoking times per day three days per week times three months to ensure appropriate smoking supervisor is in place. 4)Results of initial and ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	11/16/20

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F 689	Continued From page 9 smoking breaks on 9/27/20. All six breaks showed resident #16 as the supervisor of the smoking break, not a facility staff member. 2. Interview on 10/5/20 at 4:40 PM with activities staff member #1 revealed the activities department was in charge of the smoke breaks, the resident smoking supplies, and the locked outside door for the smokers. Further, she revealed the whole activities department had been sent home to self isolate on 9/25/20 due to a and activities staff member testing positive for COVID-19. She stated that the transportation staff was handling the activities and the smoke breaks while the activities department was out for the mandatory isolation. 3. Interview on 10/6/20 at 11 AM with the director of activities and activities staff member #1 revealed resident #16 would help out with different things for the activity department.	F 689		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced	F 773		11/16/20

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F 773	Continued From page 10 by: Based on medical record review, review of laboratory test result reports, and staff interview, the facilty failed to act on laboratory test results in a timely manner for 1 of 16 residents (#11) reviewed. The findings were: Medical record review for resident #11 showed s/he was admitted on 10/2/20 with diagnoses which included dementia, hypothyroidism, hypoxemia, thrombocytopenia and gastroesophageal reflux disease. The resident was tested for COVID-19 upon admission. Interview with the DON on 10/5/20 at 12:43 PM revealed they just learned at 11:00 AM that day the resident was positive for COVID-19. The following concerns were identified: 1. Review of the COVID-19 Test Result Summary showed the report was sent via facsimile (fax) on 10/4/20 at 7:12 AM. Interview with the DON & the administrator on 10/8/20 at 9:05 AM verified the correct fax number. The DON stated on the weekends the unit nurse checked the fax machine a couple times a day, and the faxes also go to the administrator. She revealed the fax with the positive test results was missed until 10/5/20 at 11:00 AM.	F 773	1)Resident #11 faxed COVID 19 lab result was not received within 24 hours of being faxed. Current faxed COVID 19 labs are received and addressed timely. AED changed all phone numbers at National Jewish lab, listed for facility, to AED's cell phone so all calls regarding positive results are called to AED only. AED ensures facility is aware of positive results directly following phone call from National Jewish, and resident is moved to COVID Unit. 2)Audit performed by Executive Director related to receiving and addressing faxes. 3)Education provided by DNS/Designee to nursing staff related to the regular checking of current fax machines on each shift. Assigned nursing administration will check current fax machines twice daily times two months to ensure received faxes are addressed timely. 4)Results of initial and ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced	F 800		11/16/20

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F 800	Continued From page 11 by: Based on staff interview and record review the facility failed to provide special dietary needs of 1 of 13 sample residents (#2). The finding were: Review of the 9/24/20 physician orders showed resident #2 had diagnoses included mild dementia, acute kidney failure, urinary tract infection, Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia, dysphagia, and oropharyngeal phaser. Further review showed the diet ordered for the resident was regular, mechanical soft, ground meat, nectar-thickened liquids. The resident was to eat upright always, was an aspiration risk, and was to drink small single sips of liquid. On 9/24/20 the physician communicated the resident diet as mechanical ground (very soft) with extra moisturizing and no bread. Review of the 9/26/20 admission MDS assessment showed the resident had memory problems, and required supervision during meals due to holding food in mouth/cheeks or residual food in mouth after meals, and coughing or choking during meals or when swallowing medications. The following concerns were identified: 1. Review of the facility investigation reports showed the resident's diet was changed on the night of 9/24/20. The speech therapist had made changes to the diet to include "no bread" and gave the order to an RN. The RN was unable to find a dietary person and placed the order on the "out" board for medical records to give to the dietary manager. Further, the investigation notes showed the medical records staff were off duty the following two days, and the diet order was not received in a timely manner by the dietary staff.	F 800	1)Resident #2 no longer resides in center. 2)Audit performed by DNS shows appropriate diet orders for each resident in facility and meal tickets match the diet order in the system. Residents are served their doctor order diet that is listed on the meal ticket. 3)Education was provided to nursing and dietary departments by Dietary Manager on 9/27/20 to include process of change in diet orders. 4)Audit done on every altered diet order for every meal for 7 days. Audits of meals being served done randomly for 3 months. Results of initial and ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	

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	535042	A. BUILDING _____ B. WING _____	C 10/12/2020

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SHEPHERD OF THE VALLEY REHABILITION AND WELLNESS	**60 MAGNOLIA CASPER, WY 82604**

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F 800	Continued From page 12 a. Review of the resident's diet card showed "Diet Order: Reg/Ground Meats, Thick Fluids-Nectar, Notes Mechanical very soft, ground meats, sit upright always, aspiration risk, drink small single sips of liquids in between bites only. Standing Orders: 2 [by] 8 fluid ounce Beverage of Choice NECTAR THICK." Also written on the order was "Scoop Plate." The resident meal ticket was not changed to include 'no bread' for the Thursday 9/24/20 dinner, Friday 9/25/20 all three meals, and Saturday 9/26/20 all three meals. b. Review of the picture the facility provided of the resident's 9/26/20 evening meal showed a cup of soup and half of a sandwich torn apart, as well as what appeared to be cookies torn apart. 2. Interview with the DON on 10/12/20 at 11:45 AM confirmed the resident diet order change was not done in a timely manner.	F 800		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing,	F 880		11/16/20

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F 880	Continued From page 13 identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 14 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to ensure facility staff were using the appropriate personal protective equipment (PPE) during 2 of 4 observations of residents (#12, #15) who were on transmission-based precautions.The findings were: Observation on 10/5/20 at 12:43 PM of the Rapid Recovery Unit showed isolation carts and a Droplet Precaution sign outside of each resident room. Interview with the DON at that time revealed the Rapid Recovery Unit was used for new admissions and each newly admitted resident was placed in quarantine isolation with droplet precautions for 14 days. The DON further revealed the facility had just learned at 11:00 AM a resident who was admitted on 10/2/20 was positive for COVID-19. She stated the resident was in the 200 Hall of the Rapid Recovery unit and they were in the process of moving the residents who were not positive for COVID-19 to another unit (Ellbogen Unit). She stated dedicated staff would be assigned to care for the	F 880	1)Staff educated on PPE and policy of expectations with PPE specifically related to residents #12 and #15. 2)Audit initiated by nurse management on 9/26 as facility opened a performance improvement plan. 3)Education done with Nurse Management by Asst. ED on 9/27/20 as facility opened a performance improvement plan at that time. Education indicated that nurse management will audit their isolation carts daily and to check off on their check list to ensure needed items are on the isolations carts. 4)Audit done weekly for three months, by DNS or designee to ensure audits are done daily by Nurse Management. Results of initial and ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	

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F 880	Continued From page 15	F 880		

resident, and the unit had a separate entrance. The following concerns were identified:

a. Observation on 10/5/20 at 2:27 PM showed resident #12 had an isolation cart and a Droplet Precautions sign posted outside of the room. Continued observation showed CNA #1 providing care to the resident. The CNA was not wearing an isolation gown, or gloves, and safety glasses were hanging off the pocket of the CNA's scrub pants.

b. Observation on 10/6/20 at 9:45 AM of resident #12 showed an isolation cart and a Droplet Precautions sign posted outside of the room. Continued observation showed CNA #2 was providing care to the resident and was not wearing gloves or an isolation gown.

c. Interview on 10/5/20 at 4:35 PM with CNA #1 and CNA #2 revealed they have received education for isolation precautions and what type of PPE to wear.

d. Interview on 10/8/20 at 11:18 AM with the infection prevention nurse revealed the expectation was for staff to wear either safety glasses or safety goggles and to wear the proper PPE for the type of transmission-based precautions. He stated he was not aware staff were not wearing PPE when in isolation rooms. He further stated he conducted audits daily and chose 2 people per day to follow and provided education for improvement in the moment.

e. Review of the Infection Prevention and Control Recommendations for patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 policy, with a revision date 2/27/20 showed, "...c. Apply contact precautions: Droplet and contact precautions prevent direct or indirect transmission.... Use PPE (medical mask, eye

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F 880	Continued From page 16 protection, gloves and gown) when entering room and remove PPE when leaving...".	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure supplies were available for use in 2 of 4 emergency carts. The findings were: 1. Observation on 10/5/20 at 3:10 PM showed the West/Elbogen emergency crash cart nightly check-list for September and October. The following concerns were identified: a. Review of the "September Crash Cart Nightly Check-List" showed on a note dated "9/28/20 Nearly every item with expiration date has expired..." Review of the "October Crash Cart Nightly Check-List" showed for 10/1/20 through 10/3/20 only the first page of four pages was initialed as been checked. b. Observation of the top door of the emergency crash cart showed 2 packages of [intravenous] IV start kits that had expired 2017/08, and 2 Yankauer suction tubes that expired on 2016/10 and 2015/09. c. Review of the "Crash Carts- Audit checklist on crash cart to ensure it was done every day of the week..." showed on 9/27/20 and 10/3/20 the crash cart was not checked and stocked if items were missing. 2. Observation on 10/5/20 at 3:25 PM showed	F 908	1)Current crash carts are stocked with needed equipment and are checked by Nursing Administration against a checklist daily and equipment is functional. 2)Audit performed on 9/26/20 by Assistant Executive Director/Designee verifying the current crash carts equipment was functional at that time. 3)Education provided by Asst. ED on 9/27/20, to Nursing Administration related to the daily checking of crash cart supplies as well as functionality of equipment. Nursing Administration will provide daily checks of crash cart supplies as well as assess functionality of crash cart equipment. 4)Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	11/16/20

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F 908	Continued From page 17 the South emergency crash cart nightly check-list for October had no entries on any of the 4 pages, indicating it had not been checked. a. Review of the "Crash Carts- Audit checklist on crash cart to ensure it was done every day of the week..." showed on 9/27/20 and 10/3/20 the crash cart was not checked and stocked if items were missing. 3. Review of the "Crash Cart Education" provided by the facility showed no date of when the education was provided. Further, the documents showed ..."Crash carts will be checked by a nurse manager at least once per day." 4. Interview with staff related to checking the crash carts revealed the following concerns: a. Interview on 10/5/20 at 3:25 PM with MA #1 revealed the infection control guy checks the South Unit emergency code cart. b. Interview on 10/5/20 at 3:35 PM with the staff development coordinator revealed the night shift nurses checked the emergency code carts. c. Interview on 10/5/20 at 3:55 PM with the DON revealed the code carts were checked daily by the unit managers and weekends by the supervisor on duty.	F 908		