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	535023	A. BUILDING _____ B. WING _____	03/05/2020

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WESTON COUNTY HEALTH SERVICES	**1124 WASHINGTON BLVD NEWCASTLE, WY 82701**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 3/2/20 to 3/5/20. The following common abbreviations are used throughout this document. CNA: Certified Nursing Assistant CPR: Cardiopulmonary Resuscitation DNR: Do Not Resuscitate DON: Director of Nursing LPN: Licensed Practical Nurse MAR: Medication Administration Record MDS: Minimum Data Set RN: Registered Nurse SSD: Social Services Director TAR: Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		4/20/20

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

Electronically Signed | 07/30/2020

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F 578	Continued From page 1 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure advanced directives were accurately reflected for 2 of 20 sample residents (#11, #30). The findings were: 1. Review of the "Advance Health Care Directive Form" dated 8/1/19 showed resident #30 chose "not to prolong life" if the resident had an incurable and irreversible condition that would result in death within a relatively short time, became unconscious and, to a reasonable	F 578	1. The facility ensured that advanced directives were accurately reflected for resident #30 on 04/09/20 and resident #11 04/22/20. In addition all resident charts were reviewed for accuracy of advanced directives. 2. All admissions will be screened for advanced directives and completion will be required within 30 days of admission. 3. Educated staff on 03/11/20 and 03/16/20 on the process of advanced	

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F 578	Continued From page 2 degree of medical certainty, would not regain consciousness, or the likely risks and burdens of treatment would outweigh the expected benefits. Review of the "CPR Guidelines for Residents of Weston County Manor" dated 8/28/19 showed the resident wished that cardiopulmonary resuscitation (CPR) "Not Be Done" and that life support machines "Not Be Used" to sustain life. The following concerns were identified: a. Review of a physician's order dated 8/28/19 showed resident status as "Full Code." b. Interview with LPN #1 and LPN #2 on 3/4/20 at 9:40 AM revealed nurses were to follow resident CPR status on the MAR per physician orders. Further interview revealed the facility also recorded the code status in the resident's medical record and on a list at the nurse's station. c. Review of the resident list at the nurse's station on 3/4/20 at 9:42 AM showed the resident was to receive CPR. d. Interview with the DON on 3/4/20 at 9:43 AM revealed the nurses would find the code status in the hard chart and electronic record. Further she confirmed the code status was not accurately reflected for resident #30 and the resident's status should be identified as DNR not full code. 2. Review of the POLST (Provider Orders for Life-Sustaining Treatment) form dated 6/11/17 showed resident #11 chose to have "CPR/ Attempt Resuscitation" if s/he had no pulse and was not breathing. The following concerns were identified: a. Review of the resident's physician orders dated 6/21/2017 showed a code status of "DNR." b. Review of the "Wyoming Advance Health Care Care Directive Form" signed 8/2/18 showed	F 578	directives. 4. Monitoring will be completed monthly by DON or designee for compliance and will report at monthly QA for 3 months.	

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F 578	Continued From page 3 a code status of "DNR." c. Review of the resident care plan last updated on 12/12/2019 showed a code status of "CPR." d. Interview with RN #1 on 3/4/20 at 9:34 AM revealed she would check a resident's physician orders or the physical chart to determine what to do if a resident went into cardiac arrest. Further interview confirmed the resident's advance directive in the front of the chart was inconsistent with what was present in the physician orders. e. Interview with the DON on 3/4/20 at 9:58 AM revealed the physical chart should only contain the most recent advance directives, since a nurse would not have the time to compare advance directives when responding to a resident whose heart had stopped.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		7/31/20

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F 584	Continued From page 4 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview the facility failed to implement measures to ensure a safe environment for 1 of 20 sample resident rooms observed (#19). The findings were: 1. Review of the 12/24/19 annual MDS showed resident #19 had a brief interview for mental status (BIMS) score of 4 out of 15 (severely cognitively impaired) and diagnoses which included non-Alzheimer's dementia, anxiety, and depression. Review of the care plan last revised on 1/13/20 showed the resident had short term memory loss due to dementia, disorganized thinking, and inattention. Further, the care plan	F 584	1. The microwave was removed from resident #19 room 7/28/20. 2. Private microwaves will not be permitted in any resident rooms in the locked special care unit. 3. Staff will be educated by 07/31/20 appropriate private microwave use in locked special care unit. 4. Monitoring will be completed monthly by DON or designee for compliance and will report at monthly QA for 3 months.	

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F 584	Continued From page 5 showed the resident requires/benefits from secured unit placement due to exit seeking and wandering. The following concerns were identified: a. Observation on 3/2/20 at 1:26 PM showed the resident had a small white microwave oven which was plugged in and sitting on a stand at the foot of the resident's bed. b. Interview with CNA #1 on 3/4/20 at 9:56 AM revealed the resident's family came in every day and the microwave was used to make tea. c. Interview with the chief executive officer on 3/4/20 at 2 PM revealed the facility had not done a resident safety evaluation on the resident for the microwave .	F 584		
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 observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure timely repositioning was performed for 1 of 7 sample residents (#50) who required assistance for repositioning and were at risk for skin breakdown. The following concerns were identified: 1. Review of the quarterly MDS assessment	F 684	1. Care plan for resident #50 was updated to more accurately reflect individual resident needs. 2. All resident care plans are reviewed and updated quarterly and PRN to ensure we are meeting all resident□s needs. 3. Staff were educated on 03/11/20 and 03/16/20 on repositioning according to care plans.	3/31/20

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F 684	Continued From page 6 dated 2/11/20 showed resident #50 had diagnoses which included non-Alzheimer's dementia, depression, and psychotic disorder and had short-term memory problems and long-term memory problems. Further review showed the resident was totally dependant on 1 person physical assistance for bed mobility, locomotion on and off the unit, dressing, eating, personal hygiene and bathing and was totally dependant on 2 or more people for toilet use and transfers. Review of the "Skin" care plan last revised on 11/24/19 showed "Assist me to reposition every two hours and prn [as needed]." The following concerns were identified: a. Observation on 3/3/20 beginning at 1:49 PM showed the resident was in bed, on his/her back, with a positioning device to the resident's right side. The resident remained in the same position until 4:47 PM (2 hours and 58 minutes), when CNA #2 and CNA #3 entered the room to provide incontinence care and assist the resident out of bed. Continued observation showed the resident was incontinent of bowel and bladder at that time. b. Review of a "Braden Assessment" dated 2/11/20 showed the resident had a score of 14 (moderate risk for skin breakdown). c. Interview with the DON and compliance educator #1 on 3/05/20 at 8:16 AM revealed staff should follow a resident's care plan and the resident should be positioned at least every 2 hours to prevent skin breakdown. 2. Review of the policy titled "Identification, Treatment, and Prevention of Pressure Ulcers" last revised on 2/2016 showed "I. Determine which residents are at risk for developing pressure ulcers...II. Prevention and early	F 684	4. Monitoring will be completed weekly by DON or designee for compliance and will report at monthly QA for 3 months.	

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F 684	Continued From page 7 treatment...C. Position Changes and pressure reduction..2. Turning schedules D. Incontinence management 1. Toileting/changing schedules..."	F 684		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure safety assessments were performed for 2 of 4 sample residents (#13, #20) with bed rails. The findings were: 1. Observation on 3/2/20 at 1:22 PM showed resident #13 had a bed rail present near the head	F 700	1. Safety assessments and care plans were completed for resident #13 and resident #20 on 03/03/20 and all residents on 03/31/20. 2. Safety assessments and care plans will be completed initially and quarterly. 3. IDT staff were educated on 03/04/20 on the safety assessment completion.	3/31/20

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F 700	Continued From page 8 of his/her bed with the call light cord wrapped around it. The bed rail was designed with four gaps, which measured 5 3/4 inches by 3 7/8 inches, 3 3/4 inches by 3 7/8 inches, 5 7/8 inches by 1 3/4 inches on two L-shaped gaps. The following concerns were identified: a. Review of the medical record showed no evidence a safety assessment was performed and no evidence the care plan identified the use of bed rails or risk of entrapment. b. Interview with compliance educator #2 on 3/3/20 at 3:26 PM revealed the resident was using the bed rail to help with repositioning in bed. She confirmed that monitoring, safety assessments, and a care plan would be expected for use of the bed rail, and none were present in the resident medical record. 2. Observation on 3/2/20 at 1:49 PM showed resident #20 had a bed rail present near the head of his/her bed with the call light cord wrapped around it. The bed rail was designed with four gaps, which measured 5 3/4 inches by 3 7/8 inches, 3 3/4 inches by 3 7/8 inches, 5 7/8 inches by 1 3/4 inches on two L-shaped gaps. The following concerns were identified: a. Review of the medical record showed no evidence a safety assessment was performed and no evidence the care plan identified the use of bed rails or risk of entrapment. b. Interview with RN #1 and compliance educator #1 on 3/4/20 at 9:30 AM revealed the bed rail was necessary for the resident to help prevent falls during transfers. They confirmed that monitoring, safety assessments, and a care plan would be expected for use of the bed rail, and none were present in the resident medical record.	F 700	4. Monitoring will be completed monthly by DON or designee for compliance and will report at monthly QA for 3 months.	

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F 700	Continued From page 9 3. Review of facility policy titled "Restraint Policy, 100.520" last revised 11/2013 showed "...10. Restraints shall only be used after a pre-restraining assessment is completed and the interdisciplinary team has tried other alternatives unsuccessfully. If any factors are identified as unfavorable on the pre-restraining assessment tool, devis appropriate interventions and document accordingly in the progress note and on the care plan...14. The continued use of a resident's restraints will be evaluated quarterly and as needed ..."	F 700		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health 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. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on medical record review, incident review, staff interview, and policy & procedures review, the facility failed to provide behavioral health services for 2 of 4 residents (#28, #51) with identified behaviors. The findings were: 1. Review of a facility-reported incident with a situation-background-assessment-recommendation (SBAR) dated 2/24/20 and	F 740	1. Initiated pain management program and behavior monitoring for resident #28 and all residents. Increased activities with resident #28, #51, and all other residents who exhibit increased behaviors and would benefit from non-pharmacological interventions. 2. Residents will be identified by increased behaviors through staff	3/16/20

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F 740	Continued From page 10 timed 5:51 PM showed residents #28 and #51 had a verbal altercation at a table in a common area, which escalated to physical violence. The following concerns were identified: a. Review of health status notes for resident #51 showed s/he made threats to harm his/her roommate (resident #28) on 2/12/20, 2/19/20, 2/21/20. Review of behavior notes showed an additional threat towards his/her roommate on 2/23/21. Further review showed staff identified the threats were due to resident #28's yelling during two of the events. The progress notes did not show any identification of specific target interventions, and the two residents were not separated to different rooms following any of the four events. Further record review showed there were no care plans related to identified behaviors exhibited by the resident. b. Review of the progress notes for resident #28 from 2/1/20 to 2/29/20 showed s/he had behaviors of yelling out on 2/9/20, 2/10/20, 2/12/20, 2/13/20, 2/14/20, 2/15/20, 2/16/20, 2/17/20, 2/18/20, 2/19/20, 2/21/20, 2/22/20, 2/23/20, and 2/24/20 prior to the altercation. Further review showed the facility staff attempted various interventions to reduce this behavior; however, there were no documented attempts to address the threats the resident received as a result of his/her yelling. 2. Interview with the SSD and social services designee on 3/4/20 at 10:54 AM revealed any behaviors identified by the CNAs and nurses should be documented on the daily census sheets communicated to the DON, which should be discussed in the morning meeting to attempt to identify the cause of the new behaviors and possible solutions. The information would also be	F 740	documentation and will be reviewed at morning meeting. 3. Educated staff on 03/11/20 and 03/19/20 on the process of documenting behaviors, reviewing behaviors, non-pharmacological interventions. 4. Monitoring will be completed weekly by DON or designee for compliance and will report at monthly QA for 3 months.	

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F 740	Continued From page 11	F 740		

emailed to the relevant departments for further review. Further interview revealed social services typically only viewed the CNA documentation of behaviors at the time of the residents' quarterly assessments, and revealed residents #28 and #51 should have received separate rooms following their altercation on 2/24/20.

3. Interview with social services designee on 3/4/20 at 11:44 AM revealed there was no email received regarding the incident between the two residents or the identification of new behaviors. In addition, the SS designee stated they did not have any care plans created or modified following the incident on 2/24/20, and did not identify any new behaviors or non-pharmacological interventions as a result.

4. Interview with the MDS coordinator on 3/4/20 at 2:40 PM revealed resident #51 did not have any care plans created for behaviors, and no documented interventions to address those behaviors.

5. Interview with compliance educator #2 on 3/5/20 at 8:18 AM revealed the nurses complete daily census sheets based on any new behaviors or events that occurred on their shift; the daily census sheets are then discussed in the IDT morning meeting.

a. Review of the February "Daily Census Sheets" completed by the nurses each day showed resident #28 was being reviewed daily for behaviors with an onset date of 2/10/20, and resident #51 was being reviewed daily for behaviors with an onset date of 1/31/20. The census sheets did not document any information on interventions related to those behaviors.

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F 740	Continued From page 12 b. Review of the February "Daily Clinical Meeting Sheets" showed resident #28's behaviors were discussed in the IDT morning meeting on 2/11, 2/12, 2/21, and 2/27, and resident #51's behaviors were discussed on 2/14, 2/18, 2/19, 2/26, and 2/27. Further review showed no evidence of discussion about the nature of the residents' behaviors or the development of non-pharmacological interventions. 6. Review of the facility policy titled "Resident-to-Resident Altercations" last revised 08/2010 showed "If two residents are involved in an altercation, staff will...2.d. Review the events with the Nursing Supervisor and Director of Nursing, including interventions to try to prevent additional incidents...f. Make any necessary changes in the care plan approaches to any or all of the involved individuals ... g. Document in the resident's clinical record all interventions and their effectiveness...	F 740		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		7/31/20

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F 758	Continued From page 13 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents were free from unnecessary psychotropic	F 758	1. Initiated and care planned pain management program and behavior monitoring for resident #28 and all	

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F 758	Continued From page 14 medication for 2 of 6 residents (#28, #51) reviewed for unnecessary medication use. The findings were: 1. Review of the significant change MDS assessment dated 1/14/20 showed resident #28 did not participate in the interviews related to cognition, but was reportedly oriented to location, with impairments in his/her orientation to time and remembering staff names and faces. Further review showed the resident had delusions, "verbal behavioral symptoms," "other behavioral symptoms," and "rejection of care" coded 1 to 3 days of the week and the behavioral symptoms were noted to significantly interfere with the resident's care and significantly disrupt the care or living environment for other residents. The following concerns were identified: a. Review of the resident's care plan last modified on 3/4/20 showed the resident was receiving psychotropic medications with interventions related to administering medications, evaluating the resident for risks/benefits of medication use, and monitoring for adverse reactions to the medications. The care plan did not identify specific target behaviors related to the medication use or non-pharmacological person-centered interventions to be attempted prior to use of psychotropic medications. b. Review of the resident's February 2020 MAR (medication administration record) showed the resident was prescribed Abilify (antipsychotic) 15mg by mouth one time a day on 2/28/20 for agitation and behaviors. Review of the February 2020 treatment administration record (TAR) showed the nurses were to document if the resident had a behavior, attempted to use	F 758	residents. Increased activities with resident #28, #51, and all other residents who exhibit increased behaviors and would benefit from non-pharmacological interventions. 2. Initiate and modify care plans and behavior pain tracking/TAR when behaviors are identified at morning meeting through review of staff documentation. 3. Educated staff on 03/11/20 and 03/16/20 on the process of documenting behaviors, reviewing behaviors, non-pharma logical interventions. 4. Monitoring will be completed weekly by DON or designee for compliance and will report at monthly QA for 3 months.	

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non-pharmacological interventions, the outcome of those interventions, and note specific concerns. Further review of the TAR showed the presence of verbal/physical behaviors for 16 days in February; however, the TAR did not have information noted about interventions.

c. Review of a physician action report dated 3/3/20 showed a request sent to the physician for a diagnosis for the Abilify that was prescribed on 2/28/20. There was no response from the physician present in the chart at that time.

d. Review of the February nursing progress notes showed the resident had verbal behaviors for 19 days in February and the notes did not show any attempts of resident-specific non-pharmacological interventions.

2. Review of the quarterly MDS assessment dated 2/11/20 showed resident #51 had diagnoses of depression, and a BIMS (Brief Interview of Mental Status) score of 9 out of 15 (moderate impairment). Further review showed the resident had a history of delusions, "physical behavioral symptoms," "verbal behavioral symptoms," "other behavioral symptoms," and "rejection of care" coded 1 to 3 days of the week. The following concerns were identified:

a. Review of the resident's care plan showed the resident was to receive Seroquel for behavior management and interventions included monitoring for medication side effects. There were no specific target behaviors or non-pharmacological interventions identified.

b. Review of the resident's February 2020 MAR showed the resident was prescribed Seroquel (antipsychotic) 150 mg by mouth at bedtime on 2/24/20 for "behaviors." Review of the February 2020 TAR showed nurses were to

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document if the resident had a behavior, attempted to use non-pharmacological interventions, the outcome of those interventions, and note specific concerns. Further review of the TAR showed the presence of verbal/physical behaviors for 16 days in February; however, it did not show any information about the interventions used.

c. Review of nursing progress notes showed the resident had verbal behaviors towards others for 17 days in February, but the notes showed no attempts to try any resident-specific non-pharmacological interventions.

3. Interview with RN #1 on 3/4/20 at 9:43 AM revealed the nurses and CNAs were expected to document new behaviors in their charting and the information would be used to create a situation-background-assessment-recommendations (SBAR), and would be used to contact the physician to request psychotropic medications as needed.

4. Interview with the SSD and social services designee on 3/4/20 at 10:54 AM revealed any behaviors identified by the CNAs and nurses were documented on the daily census sheets communicated to the DON, which should be discussed in the morning meeting to attempt to identify the cause of the new behaviors and possible solutions. The information would also be emailed to the relevant departments for further review. Further interview revealed social services typically only viewed the CNA documentation of behaviors at the time of the residents' quarterly assessments, and revealed residents #28 and #51 should have received separate rooms following an altercation on 2/24/20.

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F 758	Continued From page 17 5. Interview with social services designee on 3/4/20 at 11:44 AM revealed there was no email received regarding the incident between the two residents or the identification of new behaviors. In addition, the social services designee stated they did not have any care plans created or modified following the incident on 2/24/20, and did not identify any new behaviors or non-pharmacological interventions as a result.	F 758		
F 880 SS=D	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, 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	F 880		3/16/20

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F 880	Continued From page 18 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. §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.	F 880		

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F 880	Continued From page 19 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, medical record review, staff interview, and policy and procedure review, the facility failed to ensure infection prevention practices were implemented for 1 of 7 sample residents (#50) with perineal care observations. The findings were: 1. Review of the quarterly MDS assessment dated 2/11/20 showed resident #50 had diagnoses which included non-Alzheimer's dementia, depression, and psychotic disorder and had short-term memory problems and long-term memory problems. Further review showed the resident was totally dependant on 1 person physical assistance for bed mobility, locomotion on and off the unit, dressing, eating, personal hygiene and bathing and was totally dependant on 2 or more people for toilet use and transfers. The following concerns were identified: a. Observation on 3/3/20 at 4:47 PM showed CNA #2 and CNA #3 assisted the resident with perineal care. The CNAs donned gloves and unfastened the resident's brief. The CNA performed perineal care on the resident's genitalia by wiping front to back and clean to dirty. The CNAs positioned the resident on his/her left side and CNA #2 removed the resident's brief, which was soiled with urine, and placed a clean brief under the resident. The CNA performed perineal care to the residents buttock and identified the resident had been incontinent with stool. During the perineal care, the clean brief became soiled with feces and the CNA removed it and replaced it with a clean brief. The	F 880	1. C.N.A. #2 and C.N.A. #3 and all staff were educated on handwashing, glove use, and perineal care on 03/11/20 and 03/16/20. 2. Random hand hygiene monitoring of staff will be monitored by Infection Preventionist and/or delegated staff, and are providing immediate education as feedback. 3. All staff were educated on 03/11/20 and 03/16/20 on handwashing, glove use, and perineal care. Annual training is completed for all infection control processes via Healthstream and staff meetings. 4. Monitoring will be completed monthly for compliance by DON or designee and report at monthly QA for 3 months.	

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F 880	Continued From page 20 CNA finished removing the feces from the resident, discarded the soiled wipes, and attached the clean brief. Without removing the soiled gloves, the CNA adjusted the resident's shirt and pulled up his/her pants. The CNA grabbed the resident's sling, placed her hands on the resident's shirt and pants and assisted to the resident to roll so the sling could be placed under him/her. The CNA removed the gloves, obtained the lift, and attached it to the sling. The resident was transferred from the bed to the wheelchair and CNA assisted the resident out of the room. The CNA assisted the resident to the dining room, positioned the resident at the table, and left the dining room. Hand hygiene was not performed until the CNA was leaving the dining room. b. Interview with the DON and compliance educator #1 on 3/5/20 at 8:19 AM revealed staff were expected to remove gloves after providing perineal care and hand hygiene should be performed upon room entry, after removal of gloves, and after care to prevent cross contamination. 2. Review of the policy titled "Hand Hygiene" last revised on 11/2016 showed "...Hand Hygiene is generally considered the most important single procedure for preventing healthcare associated infections...1. Indications for Handwashing and Hand Antisepsis...C. Decontaminate hands before having direct contact with patients...E. Decontaminate hands after contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). F. Decontaminate hands after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings if hands	F 880		

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F 880	Continued From page 21 are not visibly soiled...H. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. I Decontaminate hands after removing gloves...6. Other Aspects of Hand Hygiene...E. Change gloves during patient care if moving from a contaminated-body site to a clean-body site..." 3. Review of the policy titled "Standard Precautions" last revised on 11/2013 showed "...Gloves: To be worn when touching blood, body fluids, secretions, excretions, mucous membranes, non-intact skin and other contaminated items, i.e., equipment. Gloves do NOT take the place of hand hygiene. Hands are to be washed after removing gloves. Gloves should be changed between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms..."	F 880		