Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF019	A. BUILDING: _____ B. WING _____	10/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNDANCE ASSISTED CARE	108 ABBY LANE SUNDANCE, WY 82729

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Opening Comments Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 12/12/2007 Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001 A COVID-19 focused infection control survey was conducted by Healthcare Licensing and Surveys on 10/21/20 through 10/22/20. The following common abbreviations are used throughout this document; CDC: Centers for Disease Control CNA: Certified Nursing Assistant DON: Director of Nursing Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5007	Ch 12 Sec 6 (d)(i) Personnel And Staffing Requirements (d) Infection Control. Written policies shall be in effect to ensure that newly hired and current employees do not spread a communicable disease that could be transmitted through usual job duties. These shall not be limited to: (i) Ensure a safe and sanitary environment for residents and personnel. This State Rule and Regulation is not met as evidenced by: Based on observation, review of COVID-19 testing worksheets, staff interview, review of	S5007		

This plan of correction was accepted on 11/30/2020 with the director of nursing, Linda Johnson.

Jean Yonnie MT (ASCP)

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S5007	Continued From page 1 policy and procedure, and review of CDC guidelines, the facility failed to ensure appropriate infection control practices were implemented. The census was 14. The findings were: Review of the facility's COVID-19 resident testing worksheet showed a total of 8 residents had tested positive for COVID-19 (#3, #7, #8, #9, #10, #11, #12, #13) as of 10/13/20. Interview with the DON/owner on 10/21/20 at 9:30 AM revealed she suspected an additional resident (#6) was positive and was awaiting test results. The following concerns were identified: 1. Observation on 10/21/20 at 10 AM of the South Wing showed a one blue isolation gown, a container of bleach wipes, and a bottle of hand sanitizer were sitting on a table at the end of the hall. In addition, there was one face shield located on the hand rail near room number 125. There was no PPE (personal protective equipment) visible in the North Wing. Review of the COVID-19 resident testing worksheet showed five confirmed COVID-19 positive residents and one COVID-19 negative resident resided in the South Wing and five confirmed COVID-19 positive residents and one COVID-19 negative resident resided in the South Wing. a. Observation on 10/21/20 at 10:45 AM showed CNA #2, who was wearing a mask, washed her hands, donned gloves, and entered resident #12's room to obtain a body temperature. The CNA did not don an isolation gown or a face shield. b. Observation on 10/21/20 at 11:25 AM showed resident #13 came out of his/her room and asked for coffee. The resident crossed the hall in his/her wheelchair and picked up a box of gloves off of the top shelf of a table and placed them on the bottom shelf. The resident returned	S5007		

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S5007	Continued From page 2	S5007		

to his/her room. Observation at 11:35 AM showed CNA #2 was walking down the hallway and picked up the same box of gloves in her ungloved hand and placed it back on the top shelf. Without performing hand hygiene, the CNA donned a new isolation gown and went to the kitchen for resident #10's food tray. Without performing hand hygiene the CNA donned gloves and a face shield and entered the room. After leaving the room the CNA removed the face shield and put it back on the hand rail and doffed her gown and then gloves. Without performing hand hygiene the CNA took the food tray back to the kitchen, opened the door to the nurse's station to get a box of gloves and then performed hand hygiene. At no time was the face shield disinfected.

c. Observation on 10/21/20 at 11:25 AM showed CNA #1 donned gloves in the kitchen and carried a food tray into resident #13's room. The CNA did not don an isolation gown or a face shield. Without removing the gloves the CNA returned the food tray to kitchen. The CNA then removed the gloves and performed hand hygiene.

d. Interview with CNA #1 at 10 AM revealed she did not wear an isolation gown when going into resident rooms unless she was going to provide care that required direct contact. The CNA was wearing an N95 mask, however she was not wearing eye protection. The CNA stated she had eyeglasses in her car, however did not wear them because the mask caused them to fog up too much. In addition, the CNA stated there were two face shields available for use and were shared between staff.

e. Interview with CNA #2 on 10/21/20 at 10:30 AM revealed she used an N95 mask and gloves when she entered resident rooms and tried not to get "too close". In addition, she stated the gowns were not used for any resident that had not tested positive for COVID-19. Further, she only wore a

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S5007	Continued From page 3	S5007		

face shield in a room if the resident was coughing. In an additional interview at 11:40 AM revealed residents were not required to wear a mask when staff were in their rooms.

f. Interview with the owner/DON on 10/21/20 at 10:40 AM revealed she did not have her staff wear gowns when entering a resident room because she did not know how to implement the procedure. She also stated after staff completed a shift their N95 mask was stored in a paper bag and then reused the next day. The DON was unaware of the proper way to extend the use of N95 masks. In an additional interview on 10/22/20 at 3:14 PM the owner/DON revealed her expectation was for staff to perform hand hygiene before and after resident care and in addition, she did not require the COVID-19 positive residents to wear a mask when staff were in their rooms.

2. Observation on 10/21/20 at 11:10 AM showed resident #3 was seated in the common room and watching television. The resident was wearing a cloth mask, however s/he was observed to be coughing. Resident #14 (COVID-19 negative resident); masked and socially distanced, was seated in the same area. Interview with the DON/owner on 10/22/20 at 3:14 PM revealed resident #3 did not have a television in his/her room and she had allowed the resident to come to the common room because she was concerned about the resident not having anything to do.

3. Interview on 10/22/20 at 3:14 PM with the owner/DON stated resident #13 was admitted to the facility on 10/3/20. The resident had tested negative for COVID-19 on 10/1/20, however the resident had not been quarantined to his/her room following admission.

a. Review of an undated policy titled

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S5007	Continued From page 4 "Sundance Assisted Living COVID-19 Protocol" showed "...7. a. All new admissions will be required to have a negative COVID-19 test before admission to Sundance Assisted Living Facility. " The protocol did not include a 14-day quarantine of the new admission. 4. Review of the September and October 2020 resident "Daily Temps" log showed each resident's body temperature was recorded and a signs or symptoms box was marked as yes or no. The signs and symptoms monitored were noted to be cough, sore throat, and shortness of breath. Interview with the owner/DON on 10/21/20 at 10:40 AM confirmed cough, sore throat, and shortness of breath were the only symptoms they monitored. In addition, she was not aware of the list of symptoms of COVID-19 published by the CDC. 5. Review of CDC guidelines found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html and retrieved on 10/23/20 showed: "Hand Hygiene HCP (Health Care Personnel) should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. HCP should perform hand hygiene by using ABHS with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS. Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location.	S5007		JY

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S5007	Continued From page 5 6. Review of CDC guidelines found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html and retrieved on 10/23/20 showed: "How to Put On (Don) PPE Gear More than one donning method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of donning. Identify and gather the proper PPE to don. Ensure choice of gown size is correct (based on training). Perform hand hygiene using hand sanitizer. Put on isolation gown. Tie all of the ties on the gown. Assistance may be needed by other healthcare personnel. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available). If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or tented. Do not pinch the nosepiece with one hand. Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin or store in scrubs pocket between patients. Respirator: Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.Facemask: Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around your ears. Put on face shield or goggles. When wearing an N95 respirator or half facepiece elastomeric respirator, select the proper eye protection to ensure that the respirator does not interfere with the correct positioning of the eye protection, and the eye protection does not affect the fit or seal of the respirator. Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common. Put on gloves. Gloves should cover the cuff (wrist) of gown. Healthcare personnel	S5007		JY

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S5007	Continued From page 6 may now enter patient room. How to Take Off (Doff) PPE Gear More than one doffing method may be acceptable. Training and practice using your healthcare facility' procedure is critical. Below is one example of doffing. Remove gloves. Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak). Remove gown. Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle. Healthcare personnel may now exit patient room. Perform hand hygiene. Remove face shield or goggles. Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles. Remove and discard respirator (or facemask if used instead of respirator). Do not touch the front of the respirator or facemask. Respirator: Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.Facemask: Carefully untie (or unhook from the ears) and pull away from face without touching the front. Perform hand hygiene after removing the respirator/facemask and before putting it on again if your workplace is practicing reuse." 7. Review of the CDC guidelines found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html and retrieved on 10/23/20 showed: "Screen everyone	S5007		

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S5007	Continued From page 7 (patients, HCP, visitors) entering the healthcare facility for symptoms consistent with COVID-19 or exposure to others with SARS-CoV-2 infection and ensure they are practicing source control. Actively take their temperature and document absence of symptoms consistent with COVID-19. Fever is either measured temperature =100.0°F or subjective fever. Ask them if they have been advised to self-quarantine because of exposure to someone with SARS-CoV-2 infection." 8. Review of CDC guidelines found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html and retrieved on 10/23/20 showed: "Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic SARS-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE."	S5007		JY

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S5007	Continued From page 8 9. Review of CDC guidelines found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html and retrieved on 10/23/20 showed: "...One strategy to reduce the risk of contact transfer of pathogens from the FFR [filtering face piece respirator] to the wearer during FFR reuse is to issue five N95 FFRs to each healthcare staff member who care for patients with suspected or confirmed COVID-19. The healthcare staff member can wear one N95 FFR each day and store it in a breathable paper bag at the end of each shift with a minimum of five days between each N95 FFR use, rotating the use each day between N95 FFRs. This will provide some time for pathogens on it to "die off" during storage [8]. This strategy requires a minimum of five N95 FFRs per staff member, provided that healthcare personnel don, doff, and store them properly each day. As a caution, healthcare personnel should treat reused FFRs as though they are contaminated, while preventing FFR contamination prior to donning by following the precautions outlined in the reuse recommendations found here. Hand hygiene with soap and water or an alcohol-based hand sanitizer with at least 60% alcohol should be performed before donning and after touching or adjusting the FFR while in use (if necessary for comfort or to maintain fit) or after doffing. More information about ways to minimize the risks of FFR reuse can be found here. CDC recommends limiting the number of donnings for an N95 FFR to no more than five per device. It may be possible to don some models of FFRs more than five times [2]. Fit performance during limited reuse should be monitored by the respiratory protection program manager or appropriate safety personnel. Information about how to assess N95 FFR fit during limited reuse can be	S5007		JY

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S5007	Continued From page 9 found below."	S5007		
S5008	Ch 12 Sec 6 (d)(ii)(A-F) Personnel and Staffing Requirements (d) Infection Control. Written policies shall be in effect to ensure that newly hired and current employees do not spread a communicable disease that could be transmitted through usual job duties. These shall not be limited to: (ii) Tuberculin Testing. (A) Tuberculin testing must be accomplished for each employee prior to employment and annually thereafter. (B) Employees having known positive skin tests shall provide a certificate of noninfectiousness, recommendations, if any, for treatment, and evidence they have complied with such recommendations. (C) Individuals provide documentation of negative skin test administered within the last twelve (12) months do not require a follow-up (D) Individuals who have not had a skin test or who do not have written proof of skin test results, shall have an intradermal Mantoux using 5TU PPD. This shall be accomplished via the two (2) step procedure. If the first test is negative and the employee is asymptomatic, the employee may engage in resident contact prior to the results of the second skin test. (I) A negative reaction requires no follow-up.	S5008		JY

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S5008	Continued From page 10 (II) A positive reaction (10mm in duration suing 5TU PPD) requires a referral to a physician for x-ray and certification of noninfectiousness and appropriate treatment if needed. Follow up shall comply with the recommendations of the attending physician. (E) If symptoms occur, a new certificate of noninfectiousness is required. (F) No person with an airborne, contagious or infectious disease shall be employed until a work release is obtained. (I) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents and their food, if direct contact will transmit a disease. (II) The facility shall require staff to follow universal precautions when performing direct resident care. This State Rule and Regulation is not met as evidenced by: Based on observation, staff interview, review of staff and visitor screening logs, review of CDC guidelines, and review of policy and procedure, the facility failed to ensure an effective COVID-19 screening process was implemented for staff and visitors. The census was 14. The findings were: 1. The surveyor was invited into the facility by CNA #2 on 10/21/20 at 9:35 AM and a body temperature was taken and recorded on a log sheet next to the front door. However, no screening questions were asked. The following	S5008		JY

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S5008	Continued From page 11 concerns were identified: a. Review of the October 2020 visitor screening log showed the visitor's name, the recorded body temperature, the date and purpose of the visit, and the time of departure. b. Review of the October 2020 "Staff Daily Temps" log showed each staff member recorded their body temperature and answered yes or no to having a cough, sore throat, or shortness of breath. c. Interview with the owner/DON on 10/21/20 at 10:40 AM revealed she was unaware of the CDC's published list of COVID-19 signs and symptoms. 2. Review of the undated "COVID-19 Protocol" policy showed "1. Employees shall be screened prior to every shift for fever and/or symptoms of COVID-19 or exposure to an individual with COVID-19 within the previous 14 days...2. a 100% screening of all persons entering the facility and all staff at the beginning of each shift: *temperature checks * Ensure all outside persons entering the building have cloth face covering or facemask. * Questionnaire about symptoms and potential exposure * Observation of any signs or symptoms...4. All Visitors will be kept to a maximum of 2 persons per room and will be pre-screened by a staff member for symptoms of COVID-19 prior to their entrance." 3. Review of the CDC guidelines found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html and retrieved on 10/23/20 showed: "Screen everyone (patients, HCP, visitors) entering the healthcare facility for symptoms consistent with COVID-19 or exposure to others with SARS-CoV-2 infection and ensure they are practicing source control. Actively take their temperature and document	S5008		

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S5008	Continued From page 12 absence of symptoms consistent with COVID-19. Fever is either measured temperature =100.0°F or subjective fever. Ask them if they have been advised to self-quarantine because of exposure to someone with SARS-CoV-2 infection."	S5008		

Statement of Deficiencies and Plan of corrections	(x1)Provider/supplier/clia identification number	(x2)Multiple construction	(x3) Date survey completed
	ALF019	A. Building_____ B. Wing _____	10/22/2020

Name of Provider or Supplier	Street Address, City, State, Zip Code
Sundance Assisted Care	**108 Abby Lane/PO Box 944, Sundance, WY. 82729**

(x4) ID PREFIX Tag	Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)	ID PREFIX TAG	Providers Plan of correction (Each corrective action should be cross-referenced to the appropriate deficiency)	(x5) Complete Date

Providers Plan of correction
Corrective Action Plan

The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements o the Wyoming Department of Health Aging Division Rules for Program Administration of Assisted Living Facilities, Chapter 12, for the affected unit identified in the deficiency.

The director of nursing and the administration, shall complete the following:

1. Identify and implement hand hygiene procedures, for staff and residents, consistent with current nursing facility guidelines from the Centers for Disease Control (CDC).
2. Identify and implement use of personal protective equipment (PPE) procedures consistent with current nursing facility guidelines from the Centers for Disease Control (CDC).
3. Identify and implement transmission-based precautions procedures consistent with current nursing facility guidelines from the Centers for Disease Control (CDC).

Identification of Others:

The administration and DON will review current COVID-19 nursing facility guidelines from the CDC. The Administration and DON will evaluate the facility's overall compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance

System Changes:

On or before 11/13/2020 the facility shall complete the following actions:

Related to hand hygiene:

1. The administration and DON will conduct a root-cause analysis to identify and address the reasons for non-compliance related to:
   a. Failure to ensure hand hygiene was performed before and after contact with a resident.
   b. Failure to ensure hand hygiene was performed after contact with objects and surfaces in the residents' environment.
   c. Failure to ensure hand hygiene was performed before donning and after the removal of personal protective equipment (PPE).

Provider/supplier representative's signature Wayne Johnson	Title	Date
	Owner	**11/05/2020**

This plan of correction was accepted on 11/30/2020 with the director of nursing, Linda Johnson.
Jan Jennie MT(ASCP)

Statement of Deficiencies and Plan of corrections	(x1)Provider/supplier/clia identification number	(x2)Multiple construction	(x3) Date survey completed
	ALF019	B. Building_____ B. Wing _____	10/22/2020

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Sundance Assisted Care	**108 Abby Lane/PO Box 944, Sundance, WY. 82729**

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Related to PPE:

1. The administration and DON will conduct a root-cause analysis to identify and address the reasons for non-compliance related to

   a. Failure to ensure an isolation gown was worn for direct resident contact if the resident had uncontained secretions or excretions.
   b. Failure to ensure PPE was appropriately removed and discarded after resident care and hand hygiene performed.
   c. Failure to ensure extended/reused PPE was used according to national guidelines.
   d. Failure to ensure face masks and shields were worn appropriately.

Related to Transmission-Based Precautions:

1. The administration and DON will conduct a root-cause analysis to identify and address the reasons for non-compliance related to

   a. Failure to ensure staff don gloves and isolation gown before contact with resident and/or his/her environment when on contact precautions.
   b. Failure to ensure staff follow standard, contact, and droplet precautions (facemask, gloves, isolation gown, and eye protection) when caring for a resident with an undiagnosed respiratory infection.
   c. Failure to ensure staff wear gloves, isolation gown, eye protection and an N95 or higher-level respirator (if available) or facemask (acceptable alternative if N95 is not available) for a resident with known or suspected COVID-19.
   d. Failure to ensure staff wear the required PPE (gloves, gown, eye protection and respirator or facemask) when caring for residents on the unit (or facility-wide based on location of affected residents).
   e. Failure to ensure signage on the use of specific PPE was posted in appropriate locations in the facility.
   f. Failure to ensure newly admitted residents were isolated for 14 days.

Monitoring:

Monitoring of approaches to ensure infection control and prevention are effective will include:

1. Weekly for no less than 12 weeks, the facility nurse or appropriate delegate will conduct on-going monitoring via observation to ensure staff are complying with the requirements for:
   a. Compliance of staff with hand hygiene during resident care.
   b. Compliance of staff with hand hygiene before and after the use of PPE.
   c. Compliance of staff with appropriate PPE use during resident care.
   d. Compliance of staff with the use of extended/reused PPE
   e. Compliance of staff with the use of facemasks and face shields.
   f. Compliance of staff using the appropriate PPE for all types of transmission-based precautions.
   g. The appropriate use of PPE signage.

After 12 weeks of monitoring, provided that such monitoring demonstrates expectations are met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality improvement program. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring which demonstrates sustained compliance as approved by the quality improvement program.

Date of compliance
11/13/2020

Additionally to S5007:

1. Specific focus as to numbers of isolation gowns and face shields will be addressed.
2. Both wings of the facility will be stocked with the proper PPE and isolation procedures posted.
3. Additional education for residents to wear facemasks when anyone enters the resident room.
4. 14 day quarantine will be reestablished for all new admissions.
5. Hand hygiene procedures will be reviewed to continue to before and after PPE sanitation.
6. Facility staff will be retrained as to the different ways to don the proper PPE.
7. All screenings will include: Temperature checks, Documentation of absence of symptoms consistent with COVID-19 practices and all visitors will be asked if they have been advised to self quarantine because of exposure to someone with SARS-CoV-2 infection.

Additionally to S5008:

1. All screenings will include: Temperature checks, Documentation of absence of symptoms consistent with COVID-19 practices and all visitors will be asked if they have been advised to self quarantine because of exposure to someone with SARS-CoV-2 infection.
2. Awareness to staff of CDC's published list of signs and symptoms of COVID-19.
3. Signs will be posted for visitor maximums.

11/5/20