FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF27	A. BUILDING: _____ B. WING _____	R 10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONDELL HEIGHTS RETIREMENT COMMUNIT	106 E MAIN STREET NEWCASTLE, WY 82701

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(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 revisit survey was conducted on 10/20/20 for all previous deficiencies cited on 7/29/20. A COVID-19 focused infection control survey was conducted by Healthcare Licensing and Surveys on 10/20/20 through 10/27/20. 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.	(S5007)		

Plan of Correction accepted 11/18/20. The facility director was notified 11/18/20. Alleged date of compliance: 11/20/20.

BSW

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{S5007}	Continued From page 1 This State Rule and Regulation is not met as evidenced by: Based on observation, review of facility disinfectant log sheets, review of the USDA Food Code 2017, staff interview, review of policy and procedure, and review of CDC guidelines, the facility failed to ensure disinfectant solution was monitored for concentration for 5 of 5 solutions observed. Further, the facility failed to ensure staff wore appropriate personal protective equipment (PPE) during 1 random observation. The census was 19. The findings were: Regarding disinfectant solution: 1. Observation on 10/20/20 at 12:15 PM showed 5 unlabeled and undated buckets of a clear solution were sitting outside various resident rooms. Interview with the DON at that time revealed the solution was a quaternary ammonium solution the facility used for wiping up spills and disinfecting the hand rails in the hallway. Interview with the administrator on 10/20/20 at 12:45 PM revealed the quaternary product was used for disinfecting tables, desks, and trays in the resident's rooms. In addition, she stated the product was good for 24 hours after being dispensed into the buckets, and the cook was responsible for changing the buckets on a daily basis. The following concerns were identified: a. Interview with the cook on 10/20/20 at 12:55 PM revealed the housekeeping department was responsible for changing the disinfecting solution in the buckets. In an additional interview at 1:50 PM revealed the cook was unsure who was responsible for ensuring the concentration of the sanitizer in both the dishwasher and the quaternary buckets was within the required limits. b. Review of the "quaternary test readings"	{S5007}		

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{S5007}	Continued From page 2 and the "dishwasher sanitizer test readings" log sheets showed the concentration of the disinfectants was last tested on 5/9/2020. c. Observation on 10/20/20 at 1 PM of the QT 10 Hydrion testing strips showed an expiration date of 9/15/2017 and the QAC QR test strips showed an expiration date of November 2019. Interview with the DON on 10/20/20 at 1:50 PM confirmed the testing strips had expired. d. Interview with the administrator on 10/23/20 at 11:05 AM revealed there had been some confusion as to who was responsible for testing the concentration levels of the disinfectant. Regarding personal protective equipment: 2. Observation on 10/20/21 at 12:20 PM showed CNA #1 was wearing a cloth facemask and a face shield. Interview with the CNA at that time revealed the facility had provided her with surgical masks, however she used her own personal cloth masks instead; only using the facility's facemasks when hers were dirty. Interview with the DON and administrator at 12:45 PM revealed they were unaware cloth face masks were not appropriate for health care providers. 3. Review of the facility's policy and procedure entitled "Covid-19 Focused Infection Control Addendum" last updated 8/19/20 showed " ...ENVIRONMENTAL CLEANING AND DISINFECTION Beyond the routine cleaning that is identified in the normal operating policies, there will be additional disinfecting of handrails, light switches, walls, floors, entries, and any other areas which may require additional attention by a combination of Housekeeping or Maintenance. Infection Control Stations are located in hallways throughout the building with a supply of gloves,	{S5007}		

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{S5007}	Continued From page 3 sanitary aprons, quaternary buckets or hand sanitizer, and trash bags ...OPERATIONAL INFORMATION ...All staff are to be masked at all times while on duty and in proximity to residents, food and medications. Gloving is required for all direct care with residents. Staff are to disinfect between caring for each resident. Infection Control Stations provide the disinfectant to be used between resident cares." 4. Review of CDC guidelines found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html and retrieved on 10/27/20 showed "HCP (Health Care Provider) should wear a facemask at all times while they are in the facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Guidance on extended use and reuse of facemasks is available. Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required." 5. According to Food Code 2017, U.S. Public Health Service: 4-501.116 "Concentration of the SANITIZING solution shall be accurately determined by using a test kit or other device."	{S5007}		
S5054	Ch 12 Sec 7 (e)(i)(A-K) Assisted Living Facility (ALF) Core Services (e) Resident Records and Reports. Each resident's records shall be current, organized and maintained in individual folders which shall be made available to the resident, the Licensing Division, or designated representative upon request.	S5054		

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S5054	Continued From page 4 (i) Each folder shall include the following: (A) Information from the referring agent, if applicable; (B) History and physical performed by a physician or physician extender; (C) Individual admission form. The form shall, at a minimum, contain the following information: (I) Full name of resident and former address; (II) Date of admission; (III) Sex, race, date of birth, social security number, and former occupation; (IV) Name, home address, and telephone number of relative, friend, Power of Attorney, or guardian; (V) Name, address, and telephone number of resident's personal physician, dentist, ophthalmologist or optometrist; (VI) Medicare number of other medical insurance identifying data; (VII) A written inventory of all personal possessions; however, this inventory need not include personal clothing. (D) All accidents, injuries, incidents, illnesses, and allegations of abuse, neglect or exploitation shall be reported to the resident's	S5054		

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S5054	Continued From page 5	S5054		

family or responsible party and be documented in the individual resident records. All such occurrences shall also be reported to the appropriate entity for follow up and resolution. Reports of all incidents affecting the health, welfare or safety of a resident shall be provided to the Licensing Division immediately (within one business day). Reporting shall be done by telephone or fax. The facility's investigation of the incident shall be reported to the Licensing Division and the Long Term Care Ombudsman within five (5) working days. Documentation to support the facility reporting the situation and follow up must also be present in the resident records;

(E) An accounting of all personal funds deposited with and disbursed by the facility;

(I) Upon written authorization of a client, the facility must hold, safeguard, manage and account for the personal funds of the client.

(1.) The facility must deposit any personal funds in excess of $100 in an interest bearing account.

(2.) The facility must establish and maintain a system that assures a full and complete and separate accounting according to generally accepted accounting principles of each resident's personal funds entrusted to the facility.

(3.) Upon the death of a resident with a personal fund deposited with the facility, the facility must convey, within 30 days, the resident ' s funds a final accounting of those funds, to the individual or probate jurisdiction administering the resident ' s estate.

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S5054	Continued From page 6 (4.) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare except for applicable deductible and coinsurance amounts. (F) A signed copy of the resident's rights; (G) The resident's assessment and individualized assistance plan; (H) Copies of all applicable resident assistance contracts, signed by both parties; (I) Written acknowledgment of the receipt and explanation of all facility policies including admission/discharge policies; (J) Copy of all ALF 102's; and (K) Copy of outside contractual responsibilities, if applicable. This State Rule and Regulation is not met as evidenced by: Based on review of resident laboratory test reports, staff interview, and review of the State Licensing Division incident reporting log, the facility failed to report 1 of 1 residents (#25) confirmed positive for COVID-19 to the Licensing Division. The findings were: Review of the laboratory test result form for resident #25 showed a COVID-19 test was collected on 10/14/20 and was resulted as "SARS-CoV2 Detected" on 10/17/20. The	S5054		

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S5054	Continued From page 7 following concerns were identified: Review of the Licensing Division incident reporting log showed no evidence the incident had been reported. Interview with the administrator on 10/20/20 at 12 PM revealed the resident was tested upon admission on 10/14/20 and was discharged on 10/17/20 following the receipt of the positive COVID-19 test. The administrator confirmed she had not reported the incident to the Licensing Division.	S5054		

Mondell Heights Retirement Community
106 E. Main Street, Newcastle, WY 82701

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Plan of Correction for October 27, 2020 Survey - 11/14/20

S5007 Chapter 12 Section 6 (d)(i) Personnel and Staffing Requirements

The facility will provide for an enhanced level of infection control to ensure a safe and sanitary environment by:

Disinfection Solution

1. To resolve the immediate issue regarding preparation, testing and use of disinfecting solutions
    a. new testing logs were prepared on 10/23/20,
    b. new test strips were ordered on 10/23/20 and received on 10/26/20.
    c. The solutions are distributed by an automatic system which is calibrated by the chemical provider. The solutions were tested on 10/23 using the outdated test strips. Upon receipt of the new test strips the solutions were tested again. Both tests resulted in the solution being in the correct range to function as a disinfectant.
2. Measures to ensure that deficient practices do no recur
    a. The Director of Maintenance will be responsible for the disinfecting solutions system and created and for maintaining a supply of disinfection supplies and testing materials by reviewing the logs monthly and initialling the log beginning 11/20/20;
    b. The kitchen staff will be retrained to be responsible for preparing, testing, and using disinfecting solutions for disinfecting surfaces by the Director or her designee no later than 11/20/20.
    c. The kitchen staff will be retrained to be responsible for preparing, testing, and using disinfecting solution used for the dish sanitizer by the Director or her designee no later than 11/20/20
    d. All staff will be trained in the testing of disinfecting solutions for times when they may be called upon to disinfect surfaces in the building by the Director or her designee no later than 11/20/20.
3. To monitor the corrective action and evaluate for its effectiveness the Quality Enhancement Team will review the logs quarterly and determine if additional action is required.

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Plan of Correction for October 27, 2020 Survey - 11/14/20

Mask Use by Staff

1. To resolve the immediate issue regarding mask use by staff, the one individual who used a cloth mask in care of a resident was instructed to cease such use and begin using only a surgical mask provided by the facility.
2. Measures to ensure that deficient practices do no recur
    a. The Director of Nursing will be responsible for seeing that all staff providing care to residents wear only surgical masks;
    b. All staff will be trained in the appropriate use of surgical masks by the Director of Nursing no later than 11/20/20.
3. To monitor the corrective action and evaluate for its effectiveness the Quality Enhancement Team will review the status quarterly and determine if additional action is required.

S5054 Ch 12 Sec 7 (e)(I)(A-K) Assisted Living Facility (ALF) Core Services

Ch 12 Sec 7 (e)(i)(D) All positive Covid-19 tests will be reported as an incident, reported to the Licensing Division, and copied to the Resident File by the DON beginning 11/14/20.

Incident Reporting of Covid-19 Tests

1. To resolve the immediate issue regarding incident reporting of Covid-19 tests, the Director of Nursing will file the tests that have not been filed as an incident no later than 11/20/20.
2. Measures to ensure that deficient practices do no recur
    a. The Director of Nursing will be responsible for seeing that all positive Covid-19 tests are filed as incidents on the the Mondell Heights Incident Log the ,State Licensing Incident Reporting System and placed in the Resident File;
    b. The Director will review the Mondell Heights log quarterly to identify compliance;
3. To monitor the corrective action and evaluate for its effectiveness the Quality Enhancement Team will review the status quarterly and determine if additional action is required.

Date of correction for the above identified plan items is 11/20/20.