| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 535025 | A. BUILDING _____ B. WING _____ | C 12/09/2020 |

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| **CHEYENNE HEALTH CARE CENTER** | **2700 E 12TH STREET CHEYENNE, WY 82001** |

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| F 000 | INITIAL COMMENTS<br><br>A complaint survey was conducted by Healthcare Licensing and Surveys on 12/3/20 to 12/9/20. The survey was prompted by complaint intakes WY00003116, WY00003151, WY00003155, WY00003162, WY00003164, WY00003165, WY00003170.<br><br>In addition, a COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted by Healthcare Licensing and Surveys on 12/3/20 through 12/9/20.<br><br>The following common abbreviations are used throughout this document:<br><br>ADLs- Activities of Daily Living<br>ARD- Assessment Reference Date<br>CNA- Certified Nurse Assistant<br>DON- Director of Nursing<br>LPN- Licensed Practical Nurse<br>MAR- Medication Administration Record<br>MDS- Minimum Data Set<br>RN- Registered Nurse<br>TAR- Treatment Administration Record<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F 000 | | |
| F 684 SS=E | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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 | F 684 | | 1/6/21 |

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

Electronically Signed | 12/31/2020

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| F 684 | Continued From page 1<br>that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, and medical record review, the facility failed to ensure wound care was provided as ordered for 2 of 4 residents reviewed (#8, #9). The findings were:<br><br>1. Review of the medical record showed resident #8 was admitted on 10/30/20. Review of the admission MDS assessment with an ARD of 11/5/20 showed the resident had 1 surgical wound and 1 skin tear. Treatment being provided included surgical wound care and application of dressings. Review of the physician orders showed an 11/11/20 order to "Remove wound VAC [vacuum] and apply normal saline wet to dry dressing. Change wet to dry dressing twice per day until [resident] is seen by wound clinic. Two times a day for Wound care." However, this order was shown to be discontinued on 11/13/20. Review of the November 2020 TAR showed this order was documented as being completed. The following concerns were identified:<br>a. Review of the 11/9/20 revised care plan showed the surgical wound and skin tear were not addressed.<br>b. Review of the November 2020 TAR showed there were no orders for wound care or dressing changes from 11/13/20 until the resident discharged on 11/24/20.<br>c. Interview with the DON on 12/10/20 at 4:58 PM revealed the resident was admitted to the facility with a wound vac applied to the inside of his/her right upper arm. She stated the device | F 684 | Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. The plan of correction serves as the facility□s allegation of compliance.<br><br>F 684<br><br>Quality of Care<br><br>CORRECTIVE ACTION<br><br>Resident #8 no longer resides in the facility.<br><br>The wound care orders were reviewed for resident number #9 on 12/29/20 by the DON/designee and updated as needed.<br><br>IDENTIFICATION OF OTHERS<br><br>Care plans were reviewed for all residents with wound by the RCMD on 12/29/20 to ensure that all residents with wounds have an appropriate updated care plan. Care plans were updated as needed. | |

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| F 684 | Continued From page 2<br>was in place due to " ...either drainage or removal of an abscess of some kind ..." The DON stated " ...we just kept doing the same dressing that was on there ..." The DON confirmed they continued to provide care to the wound without orders. She also verified the lack of orders for wound care or dressing changes for the right upper arm wound after 11/13/20. The DON confirmed there was no documentation of the care being provided in the TAR, stating, " ... since there weren't orders, nothing would show up in the TAR for us to chart on. So there's no way of knowing if it was getting done or not."<br><br>2. Review of the medical record showed resident #9 had an admission date of 8/31/2016. Review of the quarterly MDS assessment with an ARD of 11/6/20 showed the resident had moderately impaired cognition with a brief interview for mental status (BIMS) score of 10/15. Review of the resident's care plan, last reviewed 11/25/20, showed the resident had an " ...infection of wound to right lower leg." Further, the goal initiated on 5/21/20 showed "Wound to right shin will show signs of healing through the review date." Interventions included "Provide treatment as ordered" (initiated 9/11/19), and "weekly head to toe skin check and document. Notify physician & family of any change of skin condition." (initiated 9/4/2018). Review of physician orders showed 11 separate orders for wound care to the right lower leg (identified as a non-pressure ulcer) were written between 8/14/20 and 11/18/20. The following concerns were identified:<br>a. Observation on 12/8/20 at 4:50 PM showed RN #2 performed a dressing change of the wound to the resident's right lower leg. Removal of the dressing showed multiple open wounds to the front and inside of the resident's | F 684 | An audit was conducted by the DON/designee on 12/31/20 of all residents with wounds to ensure that all residents have wound care orders in place, dressings are dated and all treatments are documented on the TAR.<br><br>SYSTEMIC CHANGE<br><br>In-service training was provided to the licensed nurses related to the proper process of following wound care orders, care planning wounds, dating treatments and documenting wound care provided on the TAR, by the DON/designee and completed by 1/6/20.<br><br>The RCMD reviews 3 random care plans per week of residents with wounds to ensure that the care plan is in place and current. If an issue with the care plan is identified it is corrected immediately by the RCMD.<br><br>Upon admission/readmission the DON/designee reviews the skin assessment and verifies that each identified wound has an appropriate treatment order. If an order is needed the physician is contacted regarding what treatment he would like to order. A member of the nurse management team verifies the accuracy of the initial skin assessment and corresponding order. SBARs are completed upon identification of wounds and the SBARs are reviewed by the IDT the following business day to ensure that a corresponding treatment has been ordered written. | |

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| F 684 | Continued From page 3<br>shin. The dressing that was removed from the area was not dated.<br>b. Review of the October 2020 TAR showed an order written on 10/1/20, and discontinued 10/13/20, for "Wound care: clean RLE [right lower extremity] with wound wash and apply urea cream BID [two times a day] for wound care." This order was not documented as being completed on day shift (8 AM shift) on 10/3/20, 10/4/20, 10/12/20, or 10/13/20.<br>c. Review of the November 2020 TAR showed an order written on 11/18/20 for "Wound care: clean wound to right lower leg, apply calcium alginate with border drsg daily and prn [as needed]. One time a day for wound." This order was not documented as being completed by the day shift (5:30 AM shift) on 11/21/20, 11/24/20, 11/26/20, 11/29/20, or 11/30/20. Further, review of the December 2020 TAR showed this order was not completed by the 5:30 AM shift on 12/1/20 or 12/3/20.<br>d. Interview with the resident on 12/8/20 at 2:59 PM revealed the dressing changes were not done daily. The resident stated s/he knew there were " ...orders for them to come change this thing [the right lower extremity dressing] every day, but sometimes there's 2 or 3 days where they don't touch it at all." | F 684 | The DON/designee reviews the orders on the TARs daily to ensure that the treatments are documented as complete. Any identified concerns are addressed with the nurse at the time the omission is identified.<br><br>The DON/designee checks 3 random dressings 5 days per week to ensure the dressing has been dated. Any identified concerns with dating are addressed with the nurse at the time it is identified.<br><br>MONITORING<br><br>The Director of Nursing reports any identified patterns or trends from the orders audit, dating of dressings and TAR audits and the RCMD reports on any identified Care plan patterns or trends to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. These observations will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue. | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure | F 686 | | 1/6/21 |

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| F 686 | Continued From page 4<br>ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to promote the prevention and development of pressure ulcer injuries, or promote the healing of existing pressure ulcer injuries for 1 of 2 sample residents (#5). The findings were:<br><br>Review of the closed medical record showed resident #5 was admitted to the facility on 4/2/20, with no diagnosis of pressure ulcer injury. A nursing progress note dated 4/2/20 documented an area of concern as a " ... blister on back of R [right] heel ..." A progress note by the DON on 4/14/20 showed the resident " ... is being followed for a community acquired PI [pressure injury] to [his/her] Right heel that was present on admission ... The area will continue to be monitored weekly by the wound team." Review of the quarterly MDS assessment with an ARD of 10/9/20 showed the resident required extensive assistance with 2 person physical assist for ADLs except locomotion and bathing which required total assistance with 2 person physical assistance. The resident was at risk for pressure ulcers and had 1 unstageable pressure ulcer that was present on admission or readmission.<br>Review of a skin/wound progress note dated 6/23/20 showed the DON documented the wound to the right heel had "...healed and has reoccurred." Review of a progress note dated | F 686 | F 686<br><br>Treatment/Services to Prevent/Heal Pressure Ulcers<br><br>CORRECTIVE ACTION<br><br>Resident #5 no longer resides in the facility.<br><br>IDENTIFICATION OF OTHERS<br><br>An audit was conducted by the DON/designee on 12/31/20 of all residents with wounds to identify any omissions of documentation on the TARs.<br><br>SYSTEMIC CHANGE<br><br>In-service training was provided to the licensed nursing staff related to documenting completion treatment on the TAR by the Don/designee on and completed by 1/6/21.<br><br>The DON/designee reviews the orders on the TARs daily to ensure that the treatments are documented as complete. Any identified concerns are addressed | |

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| F 686 | Continued From page 5<br>8/4/20 showed the resident was being followed by the facility wound team, and "Treatment is effective and wound is improving ..." Review of a progress note dated 8/18/20 and written by the DON showed " ...Treatment is not effective as of today as wound has declined AEB [as evidenced by] odor and increased serous drainage." An additional progress note dated 8/14/20 stated the resident had been started on Keflex [antibiotic]. Review of a progress note dated 8/31/20 showed results from culture and sensitivity wound culture to the right heel, identifying a bacterial infection of 3 different types of bacteria in the wound. Vancomycin (an antibiotic) was ordered on 9/2/20, requiring the resident to have a PICC (peripherally inserted central catheter) line inserted for IV (intravenous) administrations. The following concerns were identified:<br><br>a. Review of the September 2020 TAR showed an order written on 8/28/20 for "Wound care to right heel: cleanse with wound cleanser, cover wound bed with silver alginate and then ABD [a brand of dressing]. Secure with rolled gauze bandage. Change every day and PRN [as needed]." This order was not documented as being completed on 9/1/20, 9/6/20, or 9/10/20.<br>b. Review of a 9/3/20 nursing progress note showed "...Wound has deteriorated... Per family request [resident] will be seen at [hospital] wound clinic next week ... they will take over her wound care ..."<br>c. Review of the September 2020 TAR showed a 9/11/20 order for "Wound care to right heel: soak with acetic acid for 10 minutes then rinse with normal saline. Apply a thin layer of Santyl to wound bed and cover with xeroform. Cover with heel cup. Change daily." This order was not documented as being completed on | F 686 | with the nurse at the time the omission is identified.<br><br>MONITORING<br><br>The Director of Nursing reports any identified patterns or trends from the TAR audits to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. These observations will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue. | |

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| F 686 | Continued From page 6<br>9/11/20, 9/12/20, 9/14/20, or 9/16/20.<br>d. Review of a nursing progress note dated 9/15/20 showed "...Dressings [to the right heel] to be changed daily and as needed. Treatment is not effective as of today as wound has declined AEB [as evidenced by] odor and increased serous drainage..."<br>e. Review of a progress note dated 10/14/20 showed the resident had a Stage III pressure ulcer to the right heel, indicating progression of the wound.<br>f. Review of the September and October 2020 TAR showed an order written on 8/12/20 that showed "Off load heels while in bed at all times every shift for Preventative." This order was not documented as completed by the 6 AM (day) shift on 9/1/20, 9/4/20, 9/9/20, 9/10/20, 9/14/20, 9/15/20, 9/18/20, 9/19/20, 9/20/20, 9/23/20, 9/24/20, 9/28/20, or 9/29/20. This order was not documented as being completed by the 6 PM (night) shift on 9/1/20, 9/11/20, 9/12/20, 9/14/20, or 9/16/20. This order was not documented as being completed in October by the 6 AM (day) shift on 10/3/20, 10/4/20, 10/12/20, or 10/13/20.<br>g. Review of the September and October 2020 TAR showed an order written on 9/2/20 that stated "Resident to have blue wedge placed to keep right heel offloaded while in bed. Blue prafo boots to be worn when in wheelchair. Every shift for Pressure reduction/wound healing." This order was not documented as being completed by the 0600 shift on 9/4/20, 9/9/20, 9/10/20, 9/14/20, 9/15/20, 9/18/20, 9/19/20, 9/20/20, 9/23/20, 9/24/20, 9/28/20, or 9/29/20. This order was not documented as being completed by the 1800 shift on 9/11/20, 9/12/20, 9/14/20, or 9/16/20. This order was not documented as being completed in October by the 0600 shift on 10/3/20, 10/4/20, 10/12/20, or 10/13/20. | F 686 | | |

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| F 686 | Continued From page 7<br>h. Interview with the DON on 12/17/20 at 1:56 PM revealed she was the only member of the facility staff that was wound care certified, and she had been out sick. She stated shift nurses performed the daily dressing changes, and other facility nurses assisted when needed, and confirmed those treatments should be documented. | F 686 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. | F 690 | | 1/6/21 |

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| F 690 | Continued From page 8<br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure catheter care was performed per physician orders for 2 of 4 sample residents (#5, #19) with catheters. The findings were:<br><br>1. Review of the closed medical record admission information showed resident #5 had diagnoses that included neuromuscular dysfunction of bladder, urinary tract infection, personal history of urinary tract infection, cognitive communication deficit, and need for assistance with personal care. Review of the care plan with a 9/2/20 reviewed date showed the resident suffered from bowel and urinary incontinence. The care plan also showed the resident was admitted with an indwelling Foley catheter; interventions included "hand washing before and after delivery of care...observe for s/sx [signs or symptoms] of discomfort on urination and frequency...observe/document for pain/discomfort due to catheter...observe/record/report to MD for s/sx UTI", and "perineal care each shift and after bowel movements, document when peri care done in TAR/ family's request. Notify nurse of any redness or irritation at insertion site." The following concerns were identified:<br><br>a. Review of the TAR for September 2020 | F 690 | F 690<br><br>Bowel/Bladder Incontinence<br><br>CORRECTIVE ACTION<br><br>Resident #5 no longer resides in the facility.<br><br>The record for resident #19 was updated with an order for the Foley Catheter and catheter care and monitoring orders on 12/21/20 by the DON. A care plan was developed for resident #19 regarding her need for a Foley Catheter and care and monitoring on 12/28/20 by the RCMD.<br><br>IDENTIFICATION OF OTHERS<br><br>An audit was conducted of all residents to identify any resident with a catheter on 12/31/20 by the DON/designee. Any necessary updates were completed at the time of the audit.<br><br>An audit was conducted by the RCMD on 12/29/20 of all residents with catheters to verify that a care plan was in place and up to date. Care plans were updated as needed. | |

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| F 690 | Continued From page 9<br>showed an order dated 9/11/20 to "Insert indwelling urinary catheter...Change on the 11th of every month one time a day starting on the 11th and ending on the 12th every month". This order was not documented as being completed on 9/11/20 or 9/12/20 or any other date in September.<br>b. Review of the September 2020 TAR showed orders dated 9/7/20 and 9/9/20 to "Perform peri/catheter care each shift", with shift times of 6 AM and 6 PM for documentation. The TAR showed these cares were not documented as performed on the 6 AM shifts on 9/1/20, 9/4/20, 9/9/20, 9/10/20, 9/14/20, 9/15/20, 9/18/20, 9/19/20, 9/20/20, 9/23/20, 9/24/20, 9/28/20, or 9/29/20. Additionally, the TAR showed these cares were not documented as performed on the 6 PM shifts on 9/11/20, 9/12/20, 9/14/20, or 9/16/20.<br>c. Review of the October 2020 TAR showed an order dated 9/9/20 to "Perform peri/catheter care each shift" with shift times of 6 AM and 6 PM for documentation. The TAR showed these cares were not performed on the 6 AM shift on 10/3/20, 10/4/20, 10/12/20, or 10/13/20. The record also showed that cares were performed on the 6 PM shift of 10/15/20, 10/16/20, 10/17/20, 10/18/20 and the 6 AM shift of 10/19/20; however, the resident was admitted to the hospital the morning of 10/15/20, and was not in the facility during those times of documented cares.<br>d. Interview with the DON on 12/17/20 at 1:56 PM revealed CNAs were responsible for emptying the catheter bags, while CNA-IIs, LPNs, and RNs were responsible for the catheter cares themselves so that assessments could be performed of the catheter and it's environment at that time, and she confirmed those cares should be documented. | F 690 | SYSTEMIC CHANGE<br><br>In-service training was provided to the licensed nurses by the DON/designee regarding the requirements of all residents with a catheter to have an order for the catheter and catheter treatment/monitoring. This training was complete by 1/6/21.<br><br>The IDT reviews each resident at the time of admission and with a change of condition requiring a catheter for an order for the catheter, and care/monitoring orders for the catheter and care plan 5 days a week. If an omission is identified it is addressed with the nurse providing care at that time.<br><br>MONITORING<br><br>The Director of Nursing reports any identified patterns or trends from the catheter audits to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. These observations will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue. | |

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| F 690 | Continued From page 10 | F 690 | | |

e. Review of the facility policy regarding catheter cleansing and maintenance showed guidelines included "Daily and as need cleaning of the outside of the catheter and the tissue surrounding the meatus with warm soap and water." As well as "Standard precautions are used during the procedure." Guidelines for documentation included "In the Nurse's notes, document pertinent observations and interventions."

2. Review of the quarterly MDS assessment with an ARD of 9/28/20 showed resident #19 had an indwelling catheter and diagnoses that included placement of a neurotransmitter, type 2 diabetes mellitus, urge urinary incontinence, and hemiplegia and hemiparesis. Review of the 10/16/20 timed 3:37 PM nursing note showed the resident had a "Foley" catheter placed without incident or complication. Review of the 11/6/20 timed at 2:24 PM nursing note showed the catheter had been replaced with "immediate urine return noted, cloudy/yellow urine no odor noted." Review of the 12/8/20 timed 1:10 PM daily nursing note showed the resident continued to have an indwelling catheter. Observation on 12/9/20 at 11:30 AM showed the resident was sleeping in bed and the catheter bag and tubing was visible hanging from the bed. The following concerns were identified:

a. Review of medical record showed there were no physician orders for catheter placement or management.

b. Review of the November and December 2020 TAR showed the catheter was not addressed.

c. Review of the care plan with a review date of 10/29/20 showed it lacked any information to show the resident had an indwelling catheter.

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| F 690 | Continued From page 11<br>d. Interview with RN #2 on 12/9/20 at 9:51 AM revealed she reviewed the record and was unable to find physician orders for the catheter and a TAR had not been generated. She stated standard care was being provided, and the physician had been notified. | F 690 | | |
| F 880 SS=H | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other | F 880 | | 1/6/21 |

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| F 880 | Continued From page 12<br>persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of infection control program data, medical record review, and staff and resident interview, the facility failed to ensure | F 880 | F 880<br><br>Infection Prevention and Control | |

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| F 880 | Continued From page 13<br>elements of the infection prevention program were effective in preventing spread of COVID-19. These elements included adherence to transmission based precautions, proper cleaning of equipment, and proper hand hygiene. This pattern of infection control breaches contributed to the continuation of the COVID-19 outbreak at the facility, resulting in harm to residents as COVID-19 infections continued to rise. The facility census was 88 (12/3/20). The findings were:<br><br>Review of the infection control data provided on 12/3/20 by the infection preventionist (IP) showed there were 51 residents in the facility who were on droplet precautions related to positive results of COVID-19. Interview with the infection preventionist on 12/3/20 at 11:38 AM revealed due to the number of COVID-19 Positive cases all residents were currently being isolated in their rooms both positive and negative for COVID-19. Testing was being continued for all residents and staff as required. The expectation was for staff to wear appropriate personal protective equipment (PPE) when entering rooms for all residents who were on droplet precautions and to ensure staff did not cross contaminate between positive resident interactions and interactions for residents who were known to be negative of COVID-19. The PPE expected to be worn include: N95 mask, eye protection, gown and gloves. Review of a facility map provided by the IP on 12/3/20 showed 11 rooms scattered throughout the facility that were occupied by residents who were negative of COVID-19. The following concerns were identified:<br><br>1. Observation on 12/8/20 at 6:31 AM showed RN #3 performing a medication pass for room 152, which was on droplet precautions. She was | F 880 | Corrective action:<br><br>The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected unit(s) identified in the deficiency.<br><br>The infection preventionist (IP) and director of nursing (DON), in conjunction with the medical director, shall complete the following:<br><br>(1) Identify and implement hand hygiene procedures, for staff and residents, consistent with current nursing facility guidelines from the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS).<br><br>(2) Identify and implement use of personal protective equipment (PPE) procedures consistent with current nursing facility guidelines from the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS).<br><br>(3) Identify and implement transmission-based precautions procedures consistent with current nursing facility guidelines from the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS).<br><br>(4) Identify and implement equipment and environmental cleaning procedures | |

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| F 880 | Continued From page 14<br>observed standing inside the room, wearing a gown, N95 mask, and eye protection, but no gloves. Her cart was parked in front of the doorway, across its entry. After collecting the medications for one resident (#27), she donned gloves, and assisted the resident in moving her tray table and a positioning adjustment. The resident took the medications, and the nurse came back to the med cart. She did not remove her contaminated gloves, and touched the surface and drawers of the med cart, and the keyboard and mouse of the computer. She then removed her gloves, did not perform hand hygiene, then touched the keyboard and mouse again. She then touched the med cart drawer handles, and all the medications of the other resident in the room. Next, she donned gloves, and took the second resident (#28) his/her medications, along with a forearm blood pressure cuff and finger pulse oximeter. After she applied both devices to the resident, she brought them back and placed them on top of the cart, not cleansing either device after use. The nurse was then observed at 6:51 AM entering room 148, where both residents were negative for COVID and the room was not on droplet precautions. She was seen applying the contaminated finger pulse oximeter to resident #2 in this room.<br><br>2. Observation on 12/3/20 at 10:34 AM showed physical therapist (PT) #1 was observed leaving the COVID unit with a bag of trash and two bags of soiled linens. She was not wearing gloves. She then touched the keypad and door handle to enter the soiled utility room, and exited seconds later. No hand hygiene was observed. She then left the unit.<br><br>3. Observation on 12/3/20 at 10:40 AM showed | F 880 | consistent with current nursing facility guidelines from the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS).<br><br>For all residents - Census of 88<br><br>(1) Staff will utilize appropriate PPE when providing care to the resident.<br><br>(2) Staff will implement appropriate transmission -based precautions when providing care to the resident.<br><br>(3) Staff will implement appropriate equipment and environmental cleaning procedures when cleaning the resident's equipment and/or environment.<br><br>Identification of Others:<br><br>The IP and DON, in conjunction with the interdisciplinary team (IDT) will review current COVID-19 nursing facility guidelines from the CDC and CMS. The IP, DON, and applicable IDT members will evaluate the facility's overall compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. Guidelines for COVID -19 can be found at htt ps:// ww w.cdc.gov/co ronavirus/ 2019-ncov/hcp/ long-term-care.html<br><br>System Changes:<br><br>On or before 1/6/2021 the facility shall complete the following actions: Related to hand hygiene: | |

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| F 880 | Continued From page 15<br>occupational therapy assistant (OTA) #1 was observed coming out of room 126, which was a room on droplet precautions, wearing full PPE (face shield, N95 mask, gown, and gloves). She looked down the hall to the left and the right, came out of the room without removing any of her contaminated PPE, and began pulling open all the drawers to the supply cart outside the room in the hallway using gloved hands that had been contaminated from being inside the room on droplet precautions.<br><br>4. Observation on 12/3/20 at 12:14 PM showed RN #1 pulling a new packing of sterile gauze out of the medication cart. She opened the package, removed the top few pieces, and plunged her bare hand into the trash bin on the side of the cart to simultaneously smash the trash down and discard the pieces of gauze. No hand hygiene was performed after, and the nurse then began applying her PPE with the contaminated hands.<br><br>5. Observation on 12/8/20 at 5:33 AM showed CNA #1 exiting room 127, which was on droplet precautions, wearing full PPE. She was carrying bags of trash, and left the room without doffing any PPE. She then walked to the soiled utility room, touching the keypad and door handle with the contaminated gloves. She exited the room seconds later, still in all of her PPE. She then walked back to room 127, removed her PPE, did not perform hand hygiene, and then grabbed the ice cart with soiled hands to take with her down the hall to the next resident.<br><br>6. Observation on 12/8/20 at 5:46 AM showed CNA #1 carrying trash bags and a resident's water pitcher to the soiled utility room without gloves. She entered the soiled utility room with all | F 880 | (1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to:<br><br>a. Failure to ensure hand hygiene was performed before and after contact with a resident.<br>b. Failure to ensure hand hygiene was performed after contact with blood, body fluids, or visibly contaminated surfaces.<br>c. Failure to ensure hand hygiene was performed after contact with objects and surfaces in the residents' environment.<br>d. Failure to ensure hand hygiene was performed before donning and after the removal of personal protective equipment (PPE).<br><br>Related to PPE:<br><br>(1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to:<br><br>a. Failure to ensure gloves were worn when potential contact with blood or body fluid, mucous membranes, or non-intact skin occurred.<br>b. Failure to ensure gloves were removed after contact with blood or body fluids, mucous membranes, or non-intact skin.<br>c. Failure to ensure PPE was appropriately removed and discarded after resident care and hand hygiene performed. | |

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| F 880 | Continued From page 16<br>items, and exited seconds later, only carrying the water pitcher. No hand hygiene was observed after exiting the soiled utility. She then walked down the hall, opened the doors to the next hallway with contaminated hands, and placed the contaminated water pitcher on a cart sitting outside the door to the kitchen.<br><br>7. Observation on 12/8/20 at 5:53 AM showed CNA #1 exiting room 154, properly doffing her PPE, but not performing hand hygiene after its removal. She then touched the keypad and door handle to the shower room, entered, and exited seconds later. She then walked to the nurse's station, and was observed touching multiple items in and around the station, including the med cart, phone, and the computer keyboard and mouse.<br><br>8. Observation on 12/8/20 at 6:16 AM showed CNA #1 and CNA #2 both entered droplet precaution room 140 after donning full PPE. A few minutes later CNA #1 was seen exiting the room with bags of trash and soiled linen. She did not doff the PPE, and wore it down the hall to the soiled utility room, touching the door handle and keypad. She exited the soiled utility room seconds later not wearing PPE, and no hand hygiene was observed.<br><br>9. Observation on 12/8/20 at 6:20 AM showed CNA #1 and CNA #3 entered the soiled utility room, and came out pushing wheeled trash cans full of garbage. Neither were wearing gloves. They pushed the containers down the hall, and out a door on the west side of the building to the outside dumpster. Upon re-entering the building, no hand hygiene was observed. CNA #3 touched the keypad and door handle to enter the soiled utility room, and both entered to return the trash | F 880 | d. Failure to ensure extended/reused PPE was used according to national guidelines.<br><br>Related to Transmission-Based Precautions:<br><br>(1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to:<br><br>a. 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.<br>b. 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 the location of affected residents).<br><br>Related to Environmental and Equipment cleaning:<br><br>(1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to:<br><br>a. Failure to ensure dedicated or disposable noncritical resident-care equipment (e.g. blood pressure cuffs, blood glucose monitor equipment) was used or if not available then the equipment was cleaned and disinfected | |

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| F 880 | Continued From page 17<br>cans. Upon exiting the soiled utility room, neither staff member was observed performing hand hygiene. CNA #3 then headed down the hall to the clean utility cart, touching the cart, packages of briefs, and clean towels and hospital gowns.<br><br>10. Observation on 12/8/20 at 5:20 AM showed rooms 101, 102, 104-107, 113, 120, 130-132, and 134-136 all had their doors open. All of these rooms were on droplet precautions.<br><br>11. Observation on 12/8/20 at 7:08 AM showed rooms 101, 102, 104, 105, 113, 120, 121, 124, 125, and 143 were all on droplet precautions, and their doors were open at this time.<br><br>12. Observation on 12/8/20 at 9:52 AM showed rooms 101, 105, 113, 120, 124, 125, 131, 132, 135, 136, 144, and 152 were all on droplet precautions, and their doors were open at this time.<br><br>13. Observation on 12/8/20 at 9:56 AM showed resident #26 was out wandering the hallway. He/she was wearing a visibly used N95 mask, which also had a hole in it. It was later confirmed that the resident resided in room 151, a room on droplet precautions for COVID positive residents.<br><br>14. Observation on 12/8/20 at 9:57 AM showed the activity director was exiting room 141, which was on droplet precautions. She had a cart full of activities and reading materials she was handling and taking around to the residents. She was wearing full PPE, but did not doff any of the PPE upon exiting room 141. She then used hand sanitizer on the outside of the gloves. Next, she headed down the hall wearing all of her contaminated PPE, and entered room 149, which | F 880 | according to manufacturers' instructions using an EPA-registered disinfectant prior to use on another resident.<br><br>(2) The DON and IP will ensure education is provided for the following:<br>Related to hand hygiene:<br><br>a. All staff are educated on proper hand hygiene procedures in accordance with the current CDC and CMS guidelines.<br>Related to PPE:<br><br>a. All staff are educated on the proper use of PPE in accordance with the current CDC and CMS guidelines.<br>Related to Transmission-Based Precautions:<br><br>a. All staff are educated on each type of transmission-based precaution and the proper use of PPE for each type of in accordance with the current CDC and CMS guidelines.<br>Related to Environmental and Equipment Cleaning and Disinfecting:<br><br>a. All staff are educated on the use of dedicated or disposable noncritical resident-care equipment, if available, or the procedures for disinfecting the equipment between residents in accordance with the current CDC and CMS guidelines.<br><br>(3) The facility leadership will contact the Mountain Pacific Quality improvement Organization (QIO) to inquire about the assistance and services available from | |

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| F 880 | Continued From page 18<br>was also on droplet precautions. When asked about this practice, she stated "... I just go to all the negative rooms first, and then do all the positives..."<br><br>15. Observation on 12/8/20 at 6:39 AM showed one of the residents of room 144 was heard coughing heavily. The cough sounded very wet and forceful. Observation showed on approach to the room, the room was on droplet precautions and the door was about 1/3 of the way open.<br><br>16. Interview with the Infection Preventionist (IP) on 12/3/20 at 4:10 PM revealed the expectation was for staff to apply full PPE to enter all rooms on droplet precautions. She stated it was facility policy to perform hand hygiene after handling linens and trash. She further stated it was expected that every staff member don and doff PPE for every entry and exit of rooms on precautions, and it was not advised to use hand sanitizer to clean gloved hands.<br><br>17. Interview with the IP on 12/8/20 at 11:43 AM revealed the expectation was to " ... change gloves between contact with every resident, positive or not ..." and to "... remove all PPE when exiting a droplet room ..." She also stated she expected all rooms on droplet precautions to keep their doors closed " ... as much as possible ..." She expected all staff to perform hand hygiene between glove donning and doffing, as well as after doffing gloves "...especially after handling things like soiled linens and trash." It was also her expectation for staff to clean all equipment after use and between each resident.<br><br>18. Review of the updated map provided by the IP on 12/9/20 showed 6 residents (#1, #21, #22, | F 880 | the QIO in improving infection prevention and control within the facility.<br><br>Monitoring:<br><br>Monitoring of approaches to ensure infection control and prevention are effective will include:<br><br>Weekly for no less than 12 weeks, the IP, DON, and applicable IDT will conduct on-going monitoring via observation to ensure staff are complying with requirements for:<br><br>a. Compliance of staff with hand hygiene before and after the use of PPE.<br>b. Compliance of staff with appropriate PPE use during resident care.<br>c. Compliance of staff using the appropriate PPE for all types of transmission-based precautions.<br>d. Compliance of staff the proper use or disinfecting of noncritical resident-care equipment.<br><br>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 assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring which demonstrates sustained compliance as approved by the QAPI | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535025 | A. BUILDING _____ B. WING _____ | C 12/09/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CHEYENNE HEALTH CARE CENTER** | **2700 E 12TH STREET CHEYENNE, WY 82001** |

| (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 880 | Continued From page 19<br>#23, #24, #25) in 4 of the 11 negative rooms (room 102, room 129, room 144, room 154) had become positive. | F 880 | committee and medical director.<br>Date of compliance:<br><br>1/6/2021 | |