DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING _____ B. WING _____	12/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted by Healthcare Licensing and Surveys on 12/8/20 - 12/11/20.	F 000		
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 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	F 880		1/11/21

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

Electronically Signed | 01/02/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 880	Continued From page 1 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. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure proper cleaning during 2 of 3 observations of	F 880	Facility has purchased wire racks that will be attached to each hoyer lift. These racks will house cleaning/disinfection	

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F 880	Continued From page 2 mechanical lift transfers. The findings were: 1. Observation on 12/8/20 at 4:10 PM showed CNA #1 brought a hoyer lift out of resident room 311, parked it in the hall and did not wipe it down with a disinfecting wipe. Observation on 12/8/20 at 4:25 PM showed CNA #1 took the hoyer lift to resident room 303 to transfer a resident; CNA #2 brought the hoyer lift out of the room, parked it next to the wall and did not wipe it down with a disinfecting wipe. The following concerns were identified: A. Interview on 12/8/20 at 4:34 PM with the NHA stated wiping down a hoyer lift with a disinfectant wipe was not necessarily the expectation when used on resident's who were not on precautions. B. Review of the Infection Control-Standard Precautions policy, with a revision date 7/1/19,showed "...5.b. Ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed, and single use items are properly discarded...".	F 880	products that will be used. Staff will be required to wipe down (with approved cleaning products) the hoyer lift prior to use. Staff will be shown proper cleaning procedure of these lifts as well as other shared equipment on/before 1/11/2021. Education materials were provided to staff members using hoyer lifts and other reusable equipment via online education app. Staff members were required to complete the learning modules on/before 1/11/2021. Staff members will be required to complete a post-test to demonstrate competency. Audits will be conducted weekly by a designee for a period of 12 weeks. These audits will include cleaning of any reusable patient care equipment, including hoyer lifts. If audits reveal compliance after 12 weeks, the frequency will be changed to monthly for 3 months and as needed thereafter. The results of the audits will be shared with the QAPI committee for additional intervention if necessary. RMC leadership reached out to the quality improvement organization (QIO) for additional guidance and education materials regarding infection control practices and the topic of reusable equipment.	