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
	535023	A. BUILDING _____ B. WING _____	03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTON COUNTY HEALTH SERVICES	1124 WASHINGTON BLVD NEWCASTLE, WY 82701

(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 recertification survey was conducted by Healthcare Licensing and Surveys from 3/8/21 to 3/11/21. Also reviewed in the course of the survey was complaint intake WY000003195. The following common abbreviations are use used throughout this document. ADL: Activities of Daily Living CNA: Certified Nursing Assistant DON: Director of Nursing MAR: Medication Administration Record MDS: Minimum Data Set TAR: Treatment Administration Record	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to complete a significant change assessment for 1 of 23 residents (#42) reviewed. The findings were:	F 637	1. The significant change documentation was completed for Resident #42 on 02/15/2021. 2. All Residents weights were reviewed by March 31, 2021 with no Residents with	4/9/21

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

Electronically Signed | 03/31/2021

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 637	Continued From page 1 1. Review of the 2/15/21 significant change MDS assessment showed resident #42 had a significant decline in his/her functional status in the areas of bed mobility, transfer status, and eating assistance. In addition, the assessment showed the resident had a weight of 112 pounds, which was a 15.45% weight loss over a 6-month period, from 9/4/20 to 3/4/21. The following concerns were identified: a. Review of the 9/7/20 quarterly MDS assessment showed the resident weighed 132 pounds and required extensive assistance with eating, while previous assessments indicated that s/he only needed supervision. Further review showed the resident had an additional decline in locomotion off of the unit and an increase of aggressive physical behavior directed towards others. These declines did not result in a significant change assessment. b. Review of the 11/22/20 quarterly MDS assessment showed the resident weighed 119 pounds at the time of assessment, which was a weight loss of 9.85% since the previous MDS assessment on 9/7/20. Further review showed the resident was marked as not having 5% weight loss in the previous month or 10% weight loss in the previous 6 months. c. Review of the medical record revealed the resident weighed 131.2 pounds on 10/4/20, 122.9 pounds on 11/6/20, and 116.6 pounds on 11/9/20. The weights obtained showed a weight loss of 11.13% from October to November. d. Interview with the dietary manager on 3/10/21 at 9:28 AM revealed the resident was identified for significant weight loss on 11/9/20, which resulted in a speech therapy evaluation and change in food texture from regular to mechanical soft. e. Interview with the dietitian on 3/11/21 at	F 637	significant weight loss. Ongoing, Residents will be identified weekly for weight loss and eating behaviors prior to care conference by MDS Coordinator. 3. IDT was educated on 03/29/2021 and staff on 4/8/2021 on eating behaviors and weight loss significance and need to report. 4. Weight checks and eating behaviors for residents and finding will be reported by DON or designee for compliance and will report at monthly QA. 5. Completed 04/09/2021	

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F 637	Continued From page 2 8:43 AM revealed the resident was identified as having a significant weight loss in November, which resulted in the use of interventions to prevent additional weight loss. Further interview revealed the resident had a significant weight loss in November, and a significant change assessment would have been needed. f. Interview with the MDS coordinator on 3/11/21 at 9:35 AM revealed the resident's functional decline identified in the 9/7/20 MDS assessment should have resulted in a significant change assessment due to the resident's decline in functional independence, but it was overlooked during the assessment lookback period. Further interview revealed the resident also should have had a significant change identified during the 11/22/20 assessment which would have also triggered a significant change assessment for weight loss, but the Nutritional Status portion of the MDS assessment was not submitted accurately.	F 637		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure 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.	F 686		4/9/21

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F 686	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure residents received care to prevent pressure injuries for 1 of 5 sample residents (#45) who were at risk for pressure injury development. The findings were: 1. Review of the quarterly MDS assessment dated 2/23/21 showed resident #45 had diagnoses which included multiple sclerosis, unspecified skin changes, and hyperglycemia. Further review showed the resident had a brief interview for mental status (BIMS) score of 3 out of 15 (severe cognitive impairment), required total physical assistance of 2 or more people for bed mobility, transfers, and toileting, and required total physical assistance of 1 person for personal hygiene. Review of the "skin" care plan last revised 12/1/20 showed the resident had a history of pressure injuries, used an air mattress, and was to have the lift sling removed while the resident was in bed. The following concerns were identified: a. Review of a late entry progress note dated 3/9/21 and timed 9:42 AM showed the entry was effective for 2/25/21 at 8:33 AM and indicated the resident was at risk for skin breakdown related to a Braden score of 15, bed mobility dependence, bowel incontinence, and a history of skin issues. b. Review of a change of condition note dated 2/27/21 and timed 10:45 AM showed the resident had an "open wound" to his/her right buttock which measured 1.5 cm (centimeters) by 0.5 cm by 0.1 cm. In addition, the resident had an excoriated area which measured 6.0 cm by 4.0 cm. c. Observation on 3/8/21 at 4:27 PM showed	F 686	1. DON and staff removed the lift sling immediately on 03/11/2021. Communication on the proper use of the lift slings was shared with all staff via email and at a staff meeting on 03/18/2021. 2. All residents at risk of skin breakdown were reviewed by 04/09/2021. Ongoing, daily rounding will be done to check all residents to ensure lift slings are properly being used. 3. Educated staff on 03/18/2021 and 04/08/2021 on the proper use of lift slings. 4. Monitoring will be completed on the daily rounding for proper lift sling usage by DON or designee for compliance and will report at monthly QA. 5. Completed 04/09/2021	

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F 686	Continued From page 4 the resident was in bed, lying on an air mattress, with the mechanical lift sling positioned under the resident. d. Observation on 3/8/21 at 4:33 PM showed 2 CNAs entered the resident's room with a mechanical lift. The CNAs performed ADL care and attached the lift sling, which the resident was laying on, to the mechanical lift. The resident was lifted out of the bed and lowered in to a wheelchair. The mechanical lift sling was left under the resident, and the resident was assisted out of the room. e. Observation on 3/9/21 at 4:33 PM showed the resident was in bed, lying on an air mattress, with the mechanical lift sling positioned under the resident. f. Observation on 3/10/21 at 9:15 AM showed the resident had a dressing to his/her coccyx area. g. Observation on 3/11/21 at 10:32 AM showed the resident was in bed, lying on an air mattress with the mechanical lift sling positioned under the resident. CNA #4 and the DON assisted the resident to roll toward the wall, and the dressing to the resident's coccyx was removed. There was no skin breakdown observed under the resident's dressing. At that time, the DON informed the CNA the resident was not to have the mechanical lift sling left under the resident while in bed. h. Interview with the DON on 3/11/21 at 10:30 AM confirmed the resident should not have the mechanical lift sling positioned under the resident while the resident was in bed.	F 686		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse	F 727		4/9/21

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F 727	Continued From page 5 §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on employee timecard records and employee interview, the facility failed to ensure the services of a RN were used for at least 8 consecutive hours a day, 7 days a week. The census was 49. The findings were: 1. Review of the RN timecard records for 10/11/20 through 3/11/21 provided by the facility on 3/11/21 showed a RN did not work for 8 consecutive hours on 10/8/20, 11/14/20, 11/15/20, 11/28/20, 11/29/20, 12/12/20, 12/13/20, 12/26/20, 12/27/20, 1/9/21, 1/10/21, 1/23/21, 1/24/21, 2/20/21, 2/21/21, 3/6/21, and 3/7/21. 2. Interview with the DON on 3/11/21 at 12:26 PM revealed the she did not know the facility was required to have 8 hours of consecutive RN coverage 7 days a week because the facility was connected to a hospital. Additionally, the DON indicated previously the facility had a RN supervisor that worked weekends; however, that position was no longer utilized.	F 727	1. The schedule was adjusted to ensure an RN is on every day for eight consecutive hours per day on 03/12/2021 to ensure no residents were at risk. 2. DON will review the nursing schedule weekly to ensure an RN is scheduled for 8 continuous hours each day to ensure all residents are not at risk. 3. Educated DON and Compliance Education Nurses on the requirement on 03/10/2021. 4. Monitoring will be completed by the weekly review of the schedule showing that an RN is scheduled for 8 continuous hours each day and will be completed by DON or designee for compliance and will report at monthly QA. 5. Completed 04/09/2021	
F 744 SS=E	Treatment/Service for Dementia	F 744		4/9/21

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F 744	Continued From page 6 CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to provide individualized dementia care services for 3 of 5 residents (#1, #16, and #41) reviewed for dementia care. The findings were: 1. Review of the 12/14/20 quarterly MDS assessment showed resident #1 had diagnoses which included hypertension, hyperlipidemia, and dementia without behavioral disturbance. Further review of MDS section E showed the resident had aggressive physical and verbal behaviors towards others, and additional behaviors not directed towards others for 1 to 3 days in the 7-day look back period. These behaviors were identified as significantly interfering with the resident's care and his/her participation in social interactions and putting others at risk of physical injury. The following concerns were identified: a. Review of the care plan dated 2/24/21 showed the resident was to be monitored for behaviors, with interventions which included medication administration, re-approaching, documentation of behavior/mood, and ensuring other residents did not impede on his/her personal space. There were no additional resident-specific interventions related to other behaviors directed towards self or others. b. Review of the TAR from 1/1/21 to 3/10/21 showed the resident was being monitored for	F 744	1. Resident #1 Care Plan was updated on 03/12/2021, Resident #41 Care Plan was updated on 03/29/2021, and Resident #16 Care Plan was updated on 03/29/2021 to include resident specific behavioral interventions. 2. All residents with Dementia related behaviors were reviewed and their respective Care Plans were adjusted by 04/09/2021. Ongoing, all residents will be reviewed and their respective Care Plans adjusted to include non-pharmacological resident specific behavioral interventions and the effectiveness of the intervention. 3. All Staff will be educated by 04/08/2021 on resident specific behavioral interventions and the adjustments in the care plans and the documentation requirements of the effectiveness of the intervention. 4. Monitoring will be completed by reporting the results of the reviews and will be completed by DON or designee for compliance and will report at monthly QA. 5. Completed 04/09/2021	

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F 744	Continued From page 7 "verbal or physical aggression towards self or others" with documented behaviors on 1/11/21 and 1/24/21, with no behaviors documented in February or March of 2021. Further review showed there were no resident-specific interventions identified and no way for the staff to document the type of intervention used or the effectiveness of the intervention(s). c. Review of resident progress notes showed the resident had aggressive verbal and/or physical behaviors towards others on 1/1/21, 1/11/21, 1/17/21, 1/21/21, and 1/24/21. The event on 1/1/21 was the only one that documented what interventions were attempted. 2. Review of the 1/4/21 admission MDS assessment showed resident #16 had diagnoses of renal insufficiency, hyperlipidemia, arthritis, transient cerebral ischemic attack, and dementia without behavioral disturbance. Further review of the MDS showed the resident had verbal behaviors directed towards others for 1 to 3 days of the 7-day look back period, wandered 1 to 3 days of the 7-day look back period, and rejected care 4 to 6 days of the 7-day look back period. These behaviors were identified as putting the resident and others at risk for injury, interfering with his/her care, interfering with his/her participation in social interactions, and significantly disrupting the care or living environment. The following concerns were identified: a. Review of the care plan dated 1/20/21 showed the resident was monitored for mood concerns and barricading his/her room. The identified behavior interventions were limited to medication administration, monitoring changes in mood/behavior, and monitoring for medication side effects/effectiveness. There were no	F 744		

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F 744	Continued From page 8 resident-specific interventions identified. b. Review of the TAR from 1/1/21 to 3/10/21 showed the resident was being monitored for "Verbal or physical aggression, repeatitive (sic) behavior/verbalization" with documented behaviors on 2 days in January 2021 and 8 days in February 2021. Further review showed there were no resident-specific interventions identified and no way for the staff to document the type of intervention used or the effectiveness of the interventions. c. Review of resident progress notes showed the resident displayed concerning behavior 8 days in January 2021 and 9 days in February 2021. Further review failed to show the only resident-specific interventions used were related to wandering. 3. Review of the 2/15/21 quarterly MDS assessment showed resident #41 had diagnoses which included type 2 diabetes, hypothyroidism, rheumatoid arthritis, and dementia with behavioral disturbance. Further review of MDS Section E showed the resident had physical behaviors directed towards others and additional behaviors not directed towards others for 1 to 3 days of the 7-day look back period. The following concerns were identified: a. Review of the care plan dated 2/24/21 showed the resident was monitored for behaviors of crying, agitation, and attempts to pinch or scratch staff. Interventions included medication administration, anticipation of needs, monitor and document changes in behaviors/mood, monitoring for medication side effects/effectiveness, intervening to protect others, and redirection. There were no other resident-specific interventions shown. b. Review of the TAR from 1/1/21 to 3/10/21	F 744		

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F 744	Continued From page 9 showed the resident was monitored for "Aggitation (sic), aggression, excessive tearfulness" with documented behaviors on 2/8/21 and 2/27/21. Further review showed there were no resident-specific interventions identified and no way for the staff to document the type of intervention used or the effectiveness of the intervention(s). c. Review of progress notes showed a Plan of Care note on 2/17/21 that identified behaviors of crying and yelling out, but the only identified interventions were medication administration and behavior monitoring. 4. Interview with CNA #3 on 3/10/21 at 9:49 AM revealed the CNAs working in the secured dementia care unit would refer to a resident preferences book for personalized care, but the book did not include information on resident behaviors. Further interview revealed the CNAs relied on previous experience to help respond to resident behavior. 5. Interview with the social services director on 3/10/21 at 10:05 AM revealed CNAs would document the presence of behaviors for residents, and the resident behavior would be discussed in the morning meetings. From that point, the discussion would be relayed to floor staff through the use of nursing "huddles" that occurred as needed. Further interview revealed she was unaware of additional systems in place to track and manage behaviors and related interventions, and social services did not play a significant role in resident behavior management. 6. Interview with the DON on 3/10/21 at 10:35 AM revealed there was no system in place for the floor staff in the secured dementia care unit to	F 744		

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F 744	Continued From page 10 document the use of resident-specific interventions or to allow CNAs access to view the care-planned interventions. Further interview revealed the nurses check off behaviors and generic interventions in the TAR, but there was no way to document the interventions or their effectiveness. The DON explained this issue was identified, and the facility was in the process of implementing a new behavior tracking system in the near future.	F 744		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		4/9/21

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F 758	Continued From page 11 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents were free from unnecessary medications for 4 of 5 residents (#12, #26, #34, #41) reviewed for unnecessary medications. The findings were: 1. Review of the significant change MDS assessment dated 12/28/29, showed resident #12 had diagnoses which included cerebral vascular accident and dementia, and had a BIMS score of 3 out of 15, indicating severe cognitive impairment. Review of the MAR for March 2021 showed the resident was on duloxetine (antidepressant) 30 mg 1 capsule by mouth at bedtime for neuralgia (nerve pain), and Seroquel (antipsychotic) 25 mg by mouth one time a day	F 758	1. Requests for Resident #12, #26, #34, and #41 were sent to their physician for review of the medications identified for the necessary documentation for medication rational on 03/29/2021. 2. All residents with psychotropic medications were reviewed by 04/09/2021 and referred to their physicians for review on 04/09/2021. Ongoing, all residents medications will be reviewed monthly for appropriateness of psychotropic medication and if gradual dose reduction is recommended. If the physician determines that the medication is needed, further documentation will be obtained. 3. Medical Staff were educated on	

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F 758	Continued From page 12 for unspecified dementia with behavioral disturbance. a. Review of the Gradual Dose Reduction/Risk Benefit Statement dated 1/18/21 for duloxetine failed to show the physician's clinical rationale for why any additional dose reduction would likely impair the resident's function or increase distressed behavior. b. Review of the Gradual Dose Reduction/Risk Benefit Statement dated 2/15/21 for Seroquel failed to show the physician's clinical rationale for why any additional dose reduction would likely impair the resident's function or increase distressed behavior. 2. Review of the annual MDS assessment dated 1/26/21 showed resident #26 had diagnoses which included anxiety disorder and depression, had a BIMS score of 12 (indicating moderate cognitive impairment), and a mood score of 1 (low risk). Review of the physician's orders showed the resident was ordered Wellbutrin ST extended release 12 hour capsule (antidepressant) 100 mg by mouth twice per day for depression. The following concerns were identified: a. Review of the Gradual Dose Reduction/Risk Benefit Statement dated 9/10/20 showed the resident received Wellbutrin 100 mg twice per day and the physician circled a statement that stated "...5. The continued use of the medication for the above resident is due to the clinical or functional benefits beyond any documented or potential risks related to the medication..." Further review showed there was no resident-specific clinical rationale provided to indicate why a dose reduction would likely impair the resident's function or increase behaviors. b. Interview with the social services director	F 758	03/23/2021 and IDT was educated on 03/29/2021 on the documentation requirements for psychotropic medications and gradual dose reduction. 4. Monitoring will be completed reporting all psychotropic medications reviewed by Pharmacist and submitted to their respective Physician with their recommendations and or adjustments. This will be reported by the Pharmacists at monthly QA. 5. Completed 04/09/2021	

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F 758	Continued From page 13 3/11/21 at 9:44 AM revealed the resident went home for a while and had difficult behaviors during the previous stay; however, the resident had not had any behaviors since readmission. Further interview revealed the facility did not have a rationale for continued use and a gradual dose reduction had not been performed since admission. 3. Review of the 2/9/21 quarterly MDS assessment showed resident #34 had diagnoses that included hypertension, dementia, anxiety disorder, depression, and psychotic disorder. Review of the medical record showed an additional diagnosis for delusional disorders. The following concerns were identified: a. Review of the MAR as of 3/11/21 showed the resident began taking Seroquel 50 mg daily for "Behaviors" on 11/20/19, Seroquel 75 mg on 1/29/20 for "delusional disorders", and sertraline HCL (antidepressant) 50 mg for "major depressive disorder" on 5/16/18. b. Review of a Gradual Dose Reduction form dated 12/11/20 showed the facility reviewed the Seroquel 75 mg medication order for a potential dose reduction. Further review showed the physician chose not to decrease the medication, however did not provide a rationale for rejecting the dose reduction. 4. Review of the 2/15/21 quarterly MDS assessment showed resident #41 had diagnoses that included type 2 diabetes, hypothyroidism, rheumatoid arthritis, and dementia with behavioral disturbance. The following concerns were identified: a. Review of the MAR as of 3/11/21 showed the resident began taking Risperdal (antipsychotic) 1 mg for "unspecified dementia	F 758		

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F 758	Continued From page 14 with behavioral disturbance" on 8/1/20 and began taking paroxetine (antidepressant) 30 mg for "s/s [signs/symptoms] depression" on 4/21/20. b. Review of the Gradual Dose Reduction form dated 12/11/20 showed the facility reviewed the Risperdal 1 mg medication order for a potential dose reduction. Further review showed the physician chose not to decrease the dosage of the medication, however did not provide a rationale for rejecting the dose reduction. c. Review of the Gradual Dose Reduction form dated 10/8/20 showed the facility reviewed the paroxetine 30 mg medication order for potential dose reduction. Further review showed the physician chose not to decrease the dosage of the medication, however did not provide a rationale for rejecting the dose reduction. d. Review of the Gradual Dose Reduction form dated 5/7/20 showed the facility reviewed the Risperdal 0.5 mg medication order for potential dose reduction. Further review showed the physician chose not to decrease the dosage of the medication, however did not provide a rationale for rejecting the dose reduction.	F 758		
F 880 SS=E	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	F 880		4/9/21

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F 880	Continued From page 15 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 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	F 880		

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F 880	Continued From page 16 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 infection prevention practices were implemented during 3 random observations, and for 1 of 5 sample residents (#23) who received ADL care. The findings were: 1. Observation on 3/8/21 at 2:47 PM showed 6 residents participated in a card playing activity. All the residents and 1 staff member were positioned around a single table, wearing masks, and were within arm's reach of each other. 2. Extended observations on 3/8/21 from 3:53 PM to 5:11 PM showed no residents in the secured dementia care unit wore face coverings/face masks, and there were no observed attempts to encourage mask use. Observations on 3/9/21 from 8:34 AM to 11:02 AM showed no residents in the secured dementia care unit wore face masks, and there were no observed attempts to encourage mask use. Observation on 3/10/21 at 11:51 AM showed there were no masks worn or	F 880	Corrective Action: 1. The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of 483.80 for the Special Care unit. a. 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). 2. Identify and implement use of personal protective equipment (PPE) procedures consistent with current nursing facility guidelines form the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) a. For resident #23 i. Staff will utilize appropriate PPE when providing care to the resident	

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F 880	Continued From page 17 encouraged for the residents in the secured dementia care unit. 3. Observation on 3/9/21 at 4:39 PM showed resident #16 had multiple snacks provided by staff members, and began hand-feeding snack items to resident #34. When the staff members observed this, there were no attempts to redirect the residents or to encourage social distancing. 4. Observation on 3/9/21 at 11:14 AM showed CNA #1 and CNA #2 performed incontinence care for resident #23. They placed the dirty brief into a plastic bag and touched the resident's clothes without removing their gloves. Further observation showed the CNAs left the gloves on and touched the hoyer lift and sling and transferred the resident to the wheelchair. They removed their gloves after the transfer and then performed hand hygiene. 5. Interview on 3/10/21 at 3:40 PM with the IP revealed the expectation was for residents and staff to attempt to socially distance 6 feet apart and staff should attempt to remind residents to wear masks and socially distance. Further, staff should remove gloves and perform hand hygiene after doing incontinence care and before putting on clean clothes and touching other surfaces. Additionally, the IP revealed staff would be expected to redirect residents who were observed attempting to share food with each other. 6. Review of the facility's "Hand Hygiene" policy, revised 1/21, showed " ...1. Indications for handwashing and hand antisepsis ...G. decontaminate hands if moving from a contaminated-body site to a clean-body site during patient care ..."	F 880	ii. Staff will implement appropriate transmission-based precautions when providing care to the resident. Identification of Others: 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 https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html. System Changes: On or before 4/9/2021 the facility shall complete the following actions: 1. DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: i. Failure to ensure gloves were removed, hand hygiene performed, and new gloves donned before moving from a contaminated body site to a clean body site. ii. Failure to ensure face masks and face shields were worn appropriately. 2. On or before 4/9/2021 the facility will complete the following actions: i. All staff are educated on proper hand hygiene procedures in accordance with the current CDC and CMS guidelines. ii. All residents are educated on the need for proper hand hygiene. iii. All staff are educated on the proper use of PPE in accordance with the current	

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F 880	Continued From page 18 7. Review of the CDC Guideline for "Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare settings", retrieved from cdc.gov/infectioncontrol.guidelines/isolation/index.html on 3/16/21, showed "IV.B.2 Gloves ...IVB.B.2.d Change gloves during patient care if the hands will move from a contaminated body-site to a clean body-site ..." 8. Review of CMS memo QSO-20-39-NH (updated 3/10/21) showed the core infection prevention principles for preventing the spread of COVID-19, which should be adhered to at all times, included the following: "...Hand hygiene (use of alcohol-based hand rub is preferred)...Glove use is not a substitute for hand hygiene...Use enough alcohol-based hand sanitizer to cover all surfaces of your hands, keeping them wet for at least 20 seconds, rubbing them together until dry...Healthcare providers not performing hand hygiene 100% of the time at every opportunity for cleansing, they put themselves and their patients at risk for infections...Face covering or mask (covering mouth and nose)...Social distancing at least six feet between persons ...Cleaning and disinfecting high-frequency touched surfaces in the facility often, and designated visitation areas after each visit...Appropriate staff use of Personal Protective Equipment (PPE)..."	F 880	CDC and CMS guidelines. Monitoring: Monitoring of approaches to ensure infection control and prevention are effective will include: 1. 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: i. Compliance of staff with hand hygiene during resident care. ii. 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 committee and medical director. Date of compliance: 04/09/2021 In addition: 1. Activities staff were reminded of the social distancing of all residents during activities on 03/10/2021. IP met with staff in the Secured Dementia Care Unit to remind of the need to social distance and the requirement of the use of masks and face shields for the staff and that continual reminder for residents to mask use	

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F 880	Continued From page 19	F 880	regardless of disease process on 03/10/2021. IP met with the staff on the proper use of gloves and handwashing during resident cares on 03/10/2021. 2. All residents are at risk and were reviewed for appropriate mask use and social distancing. Ongoing, random monitoring of appropriate PPE and hand hygiene monitoring of staff and residents will be monitored by Infection Preventionist, DON, IDT and/or delegated staff, and are provided immediate education as feedback. 3. All staff were educated on 03/18/2021 and 04/08/2021 on PPE, social distancing, handwashing, glove use, and perineal care. Annual training is completed for all infection control processes via Healthstream and staff meetings. 4. Monitoring for appropriate face masks, social distancing, glove use and handwashing weekly for 12 weeks and then monthly and will be reported to QA monthly by DON or designee. 5. Completed 04/09/2021	