STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE REHABILITATION AND WELLNESS	**3128 BOXELDER DRIVE CHEYENNE, WY 82001**

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F 000	INITIAL COMMENTS A recertification survey which included a COVID-19 focused infection control survey was conducted by Healthcare Licensing and Surveys from 4/5/21 to 4/8/21. Also reviewed in the course of the survey were complaint intakes WY00003074, WY00003082, WY00003099, WY00003122, WY00003141, WY00003145, WY00003177, WY00003051, and WY00003056. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing EDCW: Emergency Direct Care Worker IP: Infection Preventionist LPN: Licensed Practical Nurse MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
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	F 686		5/17/21

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

Electronically Signed | 05/02/2021

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F 686	Continued From page 1 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and staff interview, the facility failed to ensure interventions to prevent pressure ulcer development were followed for 1 of 8 sample residents reviewed with pressure ulcers (#71). The findings were: 1. Review of the quarterly MDS assessment dated 3/2/21 showed resident #71 had diagnoses which included congestive heart failure, dementia, Down's syndrome and hypothyroidism. Further, the MDS assessment showed the resident was at high risk for pressure ulcer development, however had no pressure wounds identified. Review of the weekly skin evaluation, dated 9/26/20, showed the resident had a small superficial wound to his/her left heel, which was resolved. Review of the care plan, revised on 1/13/21 showed the resident was at risk for pressure ulcers and the interventions included "heel boots on when in bed for pressure reduction" and "heel-lift boots when in bed". The following concerns were identified: a. Observation on 4/6/21 at 9:21 AM showed the resident was in bed with both heels touching the mattress. b. Observation on 4/6/21 at 7:30 PM showed the skin on the resident's left heel was intact, however a small darkened area was noted. Continued observation showed the resident was in bed with his/her heels touching the mattress, no heel boots were applied, and the resident's heels were not elevated on pillows. c. Interview on 4/7/21 at 3 PM with unit	F 686	Preparation and execution of the response and plan of correction does not constitute an 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 it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual. F686 1. Resident #71 is receiving appropriate pressure relieving device for her heels when she is in bed. 2. The Director of Nursing or designee will complete an audit of residents at high risk for pressure ulcer development to assess for others affected by deficiency. 3. The Staff Development Coordinator or designee will educate nursing staff to validate pressure relieving devices for heels are done per physicians' orders. 4. The Director of Nursing or designee will complete a random visual weekly audit for 90 days to validate that the pressure relieving devices are done per physicians' orders.	

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F 686	Continued From page 2 manager #1 confirmed the resident had darkened areas on his/her heels and the facility had ordered specialized pillows to help float the resident's heels. He stated the expectation was to float the resident's heels using pillows when s/he was in bed.	F 686	The Director of Nursing or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, staff interview, and review of policy and procedure, the facility failed to provide adequate assistance devices to ensure safe transfers for 1 of 3 residents (#71) who required assistance with transfers. The findings were: 1. Review of the quarterly MD'S assessment dated 3/2/21, showed resident #71 was admitted with diagnoses which included Down's syndrome, dementia, congestive heart failure, and calliopsis. Further, the MD'S assessment showed the resident required the extensive assist of 2 staff members for transfers, and staff were to provide weight-bearing support. The following concerns were identified: a. Observation on 4/6/21 at 7:30 PM showed LP #1 and the DON transferred the resident from	F 689	F689 1. Resident #71 is receiving adequate assistance devices to ensure her safe transfer. 2. The Director of Nursing or designee completed an audit to assess for others affected by deficiency to validate adequate assistance devices are used for safe transfers. 3. The Staff Development Coordinator or designee educated staff on appropriate transfer devices including the use of a gait belt. CNAs are educated where to locate a residents transfer status. 4. The Director of Nursing or designee will randomly visualize 5 staff members 2x per week for 90 days to validate adequate assistance devices are used for safe	5/17/21

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F 689	Continued From page 3 the wheelchair to the bed, using their arms and holding the back of the resident's pants. No gait belt was used. Interview with the DON at the time confirmed they did not use a gait belt for the transfer. She also stated they did not use a sit-to-stand lift because the resident did not bear weight. She was not sure why a full mechanical lift was not used. B. Interview with unit manager #1 on 3/7/21 at 4:14 PM, revealed the resident required the assistance of 1 to 2 staff members for transfers. He stated a sit-to-stand or a full mechanical lift could not be used to transfer the resident because S/he became too anxious and thrashed around. He also stated the expectation was for staff to use a gait belt for transfers. 2. Review of the Gait Belt Policy, updated 09/08, showed, "...3. The gait belt is to be used for the following mobility activities: a. to transfer a resident from bed to wheelchair or wheelchair to bed..."	F 689	transfers. The Director of Nursing or designee will report the tracking and trending of the random review to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, and professional	F 695	F695 1. Resident #59 oxygen order was	5/17/21

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F 695	Continued From page 4 standard review, the facility failed to ensure supplemental oxygen was delivered as ordered and oxygen tubing was labeled for 2 of 19 sample residents (#59, #214) who required supplemental oxygen. The findings were: 1. Review of the 3/4/21 admission MDS assessment showed resident #59 was admitted to the facility on 2/25/21 with diagnoses which included chronic respiratory failure with hypoxia, atrial fibrillation, and heart failure. Further review showed the resident had a BIMS score of 15/15 (cognitively intact) and required supplemental oxygen. Review of the resident's care plan initiated on 3/8/21 showed the resident was on oxygen therapy related to cardiac heart failure and chronic respiratory failure. The interventions included "Oxygen Settings: O2 (oxygen) via NC (nasal cannula) per MD orders." The following concerns were identified: a. Observation on 4/5/21 at 10:34 AM showed the resident was on his/her bed wearing a nasal cannula attached to an oxygen concentrator. The oxygen concentrator was set to deliver 4 LPM (liters per minute) and the tubing was not labeled with a date. Interview with the resident at that time revealed the oxygen concentration was usually set at 3 LPM, and the resident stated s/he never adjusted the oxygen level, however the therapists would adjust it when they were working with him/her. b. Review of the physician order dated 2/25/21 showed the facility was to "titrate (a procedure used to adjust oxygen concentration levels) oxygen level to room air during the day and 1-2 LPM at night." Further review of the physician orders showed no evidence the physician had specified the amount of oxygen the resident was to receive during the day.	F 695	clarified at the time of deficient practice. Resident #214 oxygen tubing order has been clarified and tubing was replaced at the time of deficient practice. 2. The Director of Nursing Services will audit residents with oxygen to validate oxygen titration orders are documented on the MAR/ TAR and Oxygen tubing orders are changed PRN, and /or discarded and replaced if heavily soiled. 3. The Staff Development Coordinator or designee will educate nurses to validate oxygen titration orders are documented on the MAR/ TAR and Oxygen tubing orders are changed PRN, and /or discarded and replaced if heavily soiled. 4. The Director of Nursing or designee will randomly monitor one (1) resident weekly for 90 days to validate oxygen titration orders are documented on the MAR/ TAR. The Director of Nursing or designee will randomly audit 10 residents who are on oxygen to validate tubing is changed PRN, and /or discarded and replaced if heavily soiled. The Director of Nursing or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	

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F 695	Continued From page 5	F 695		

c. Interview with RN #1 on 4/6/21 at 3:22 PM revealed the resident had used supplemental oxygen since s/he was admitted, and she had turned the level down at the beginning of her shift because "someone keeps turning it up". In addition, she stated the facility kept the resident on supplemental oxygen if oxygen saturation levels fell below 90%, and interpreted the physician order to mean the resident's oxygen level should be kept at 1 to 2 LPM if the oxygen saturation level of 90% could not be achieved.

d. Review of the oxygen saturation levels from 2/25/21 through 4/7/21 showed the resident's oxygen saturation level via nasal cannula was checked 17 times in February and ranged from 90% to 94%. In March the resident's oxygen saturation level via nasal cannula was checked 68 times with a range of 85% to 98% and 2 times on room air; 93% on 3/8/21 and 92% on 3/29/21. In April the resident's oxygen saturation level via nasal cannula was checked 14 times with a range of 89% to 98%. The documentation did not include the amount of supplemental oxygen the resident was receiving at the time the oxygen saturation level was obtained. There was no evidence the facility had attempted to titrate the resident's oxygen as specified by the physician's order.

e. Interview with the director of rehabilitation on 4/8/21 at 11:47 AM revealed on 4/5/21 the therapist did not work with the resident until 11:45 AM (1 hour after the surveyor interviewed the resident). Further he stated therapists did not adjust a resident's oxygen level without the consent of a nurse.

f. Interview with the DON on 4/7/21 at 10:35 AM revealed the nurses had noted the resident's oxygen level to be turned up to 5 LPM at times, and perhaps the resident was adjusting the level

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F 695	Continued From page 6	F 695		

on his/her own. Further she interpreted the physician's order to mean the resident should be on 1 to 2 LPM of oxygen if an oxygen saturation of 90% could not be achieved. In addition, the DON confirmed there was no evidence the facility had attempted to titrate the resident's supplemental oxygen.

2. Review of the medical record for resident #214 showed s/he was admitted to the facility on 4/2/21 with diagnoses which included chronic obstructive pulmonary disease and emphysema. Review of the physician orders dated 4/2/21 showed the resident was to receive 2 LPMof oxygen via nasal cannula. The following concerns were identified:

a. Observation on 4/5/21 at 2:40 PM showed the resident was sitting on his/her bed wearing a nasal cannula which was attached to an oxygen concentrator. The oxygen concentrator was set to deliver 2 LPM. The oxygen tubing was not labeled with the date it was put into use. Observation on 4/6/21 at 3:30 PM confirmed there was no label on the oxygen tubing.

b. Review of the April 2021 treatment administration record showed no evidence the date the tubing had been applied was documented.

c. Interview with RN #1 on 4/6/21 at 3:30 PM revealed when oxygen tubing was opened and put into use for a resident, the date was placed on a piece of paper tape and wrapped around the tubing. In addition, the RN stated she had admitted the resident so she knew when the oxygen tubing had been opened. At that time the nurse obtained new tubing for the resident, labeled it appropriately, and replaced the tubing.

3. Interview with the DON and IP on 4/8/21 at 12:02 PM revealed oxygen tubing should be

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F 695	Continued From page 7 labeled with the date opened in order to verify the frequency of tubing changes. According to Lippencott Nursing Procedure, Seventh Edition, 2015 page 573 under "Oxygen Administration"; "...Verify the practitioner's order for the oxygen therapy because oxygen is considered a medication or therapy and should be prescribed."	F 695		
F 758 SS=D	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		5/17/21

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F 758	Continued From page 8 §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 2 of 5 residents (#50, #71) reviewed for unnecessary medications had an appropriate diagnosis or indication for use. The findings were: 1. Review of the admission intake information showed resident #50 was admitted to the facility on 7/31/20. Review of the Diagnosis Report showed the resident had diagnoses which included the following: unspecified dementia without behavioral disturbance, cognitive communication deficit, and dementia in other diseases classified elsewhere without behavioral disturbance. The following concerns were identified: a. Review of the Diagnosis Report showed	F 758	F758 1. Gradual dose reduction for Resident #50 was initiated at the time of deficient practice with the goal to discontinue to verify baseline. New Psychotropic Drug and Behavior review completed for Resident #71 to validate current behaviors. 2. The Social Services Director or designee will audit residents on anti-psychotic medication for appropriate diagnosis or indication for use. Those affected, the Director of nursing or designee will contact the primary physician to address the inappropriate diagnosis or validate the indication for use with the goal to discontinue to verify	

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F 758	Continued From page 9 the resident did not have a psychiatric diagnosis related to the use of antipsychotic medications. b. Review of the physician orders showed the resident had a 12/7/20 order for Seroquel (antipsychotic) 25 milligrams (mg) by mouth one time a day related to dementia in other diseases classified elsewhere without behavioral disturbance. Review of the care plan showed the resident had originally been ordered Seroquel on 8/12/20, and the medication was re-ordered on 12/7/20 upon the resident's return from a local hospital stay. Review of the December 2020, January 2021, February 2021, March 2021, and April 2021 medication administration records (MAR) showed the resident received Seroquel as ordered. c. Review of 11/18/20 pharmacy drug regimen review showed the pharmacist requested a gradual dose reduction (GDR) of the Seroquel because the resident "was sleeping too much." d. Review of the 11/11/20 "Psychotropic Drug and Behavior Quarterly & PRN (as needed)" assessment showed the resident's diagnosis was "unspecified dementia without behavioral disturbance." However, a question on the form read, "Describe how medication is assisting the resident in reaching highest functional level," and the answer was, "minimizes behaviors." The team recommendations were, "Resident sleeps all the time, can we get GDR [for the resident's] Seroquel?" The facility failed to obtain an acceptable diagnosis or rationale for continuing the Seroquel. e. Interview with the pharmacist on 4/8/21 at 11:48 AM revealed she had requested a gradual dose reduction of Seroquel for the resident because the resident had no behaviors. The pharmacist could not remember if she asked for an appropriate diagnosis for the resident's use of	F 758	baseline. 3. The Staff Development Coordinator or designee will educate staff to validate Psychotropic medications have appropriate diagnosis or indication for use. The Executive Director or designee will educate the Social Services Director to validate psychotropic medications have appropriate diagnosis, receive gradual dose reductions, and have behavioral interventions, unless clinically contraindicated, in an effort to discontinue these medications. 4. The Social Services Director or designee will complete a weekly audit for 90 days of psychotropic medications for an appropriate diagnosis, gradual dose reduction, and behavioral interventions, unless it is clinically contraindicated. The Social Services Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	

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F 758	Continued From page 10	F 758		

Seroquel, or a physician rationale for continued use of an antipsychotic medication without an acceptable diagnosis. Review of the pharmacy drug regimen reviews showed the medication was not identified as an irregularity, and no request for an appropriate diagnosis regarding the use of the Seroquel, or a physician documented rationale, had been requested.

f. Review of a 4/8/21 (during the survey timeframe) note from the resident's family nurse practitioner showed the resident had received Seroquel for hallucinations/delusions, and was currently receiving a gradual dose reduction. However, review of the 8/6/20 admission MDS assessment showed the resident was not having hallucinations.

2. Review of the quarterly MDS assessment dated 3/2/21, showed resident #71 was admitted with diagnoses which included Down's syndrome, dementia, congestive heart failure, and scoliosis. Further, the MDS assessments dated 1/6/21 and 3/2/21 showed the resident had a BIMS score of 99 (unable to complete 1 or more questions of the interview), and displayed no behavioral symptoms. The following concerns were identified:

a. Review of the MAR for April 2021 showed an order for Zyprexa (antipsychotic) 2.5 mg by mouth twice a day for prophylaxis related to dementia with behavioral disturbance

b. Review of the Psychotropic Drug and Behavior Quarterly and "PRN-V4" assessment, dated 3/2/21, showed the resident was on Zyprexa due to the medical diagnosis of dementia with behavioral disturbance. Further review showed "...3. 2 the medication was assisting the resident in reaching highest functional level by minimizes behaviors..." However, the assessment

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F 758	Continued From page 11 failed to describe which behaviors were minimized. Continued review showed there were no new target behaviors identified. Interview on 4/7/21 at 5:14 PM with the social worker revealed the team was not clear about what behaviors they were trying to minimize and did not identify what behaviors should be the targeted. c. Review of an email from the pharmacist, dated 4/7/21, showed a dose reduction for the Zyprexa was approved on 10/1/20.	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 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,	F 880		5/17/21

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	535013	A. BUILDING _____ B. WING _____	C 04/08/2021

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GRANITE REHABILITATION AND WELLNESS	**3128 BOXELDER DRIVE CHEYENNE, WY 82001**

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F 880	Continued From page 12 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 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.	F 880		

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F 880	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of CDC (Centers for Disease Control) guidelines, the facility failed to maintain an infection prevention program that prevented the transmission of infectious diseases during 4 random observations. These failures had the potential to expose residents, staff, and visiting personnel to COVID-19 (a viral infection that could lead to serious harm or death), health-care associated infections, or blood-borne pathogens. The census was 107. The findings were: 1. Observation on 4/5/21 at 11:50 AM showed 13 residents of the memory care unit were seated in the common dining room and were placed 6 feet apart. Observation at that time showed residents were occupied with activities, watching television, and pacing. At 12:17 PM the food cart was brought into the secure unit and the meal was served to the residents. At no time was hand hygiene provided to the residents prior to the meal being served. Interview with CNA #2 on 4/5/21 at 1:05 PM revealed she provided hand hygiene to residents prior to meal service, however she had stepped out of the unit prior to meal service and was unaware the residents' hands had not been cleaned. 2. Observation on 4/7/21 at 4:39 PM showed CNA #1 and EDWC #1 used the sit-to-stand lift to assist resident #49 to a standing position to provide incontinence care. After transferring the resident back to his/her wheelchair CNA #1 moved the lift to just outside of the resident's room and proceeded to the "Trash" area to dispose of the soiled incontinence products. At 4:50 PM RN #2 touched the sit-to-stand lift, in the	F 880	F880 1. Nursing staff received education regarding assisting residents with cleaning their hands before meals, cleaning of nursing equipment between residents and removing soiled gloves before touching clean items. There are no negative effects to resident #71 involved during this observation. In addition, facility has incorporated the directed plan of correction 2. The Director of Nursing or designee completed audit to assess for other infection control concerns related to hand hygiene. In addition, facility has incorporated the directed plan of correction. 3. The Staff Development Coordinator or designee provided education to Nursing staff regarding cleaning resident hands before meals, cleaning of nursing equipment between residents and removing soiled gloves before touching clean items. In addition, facility has incorporated the directed plan of correction. 4. The Staff Development Coordinator or designee will randomly audit five (5) staff members weekly for 90 days to validate either cleaning resident hands before meals, cleaning of nursing equipment between residents or removing soiled gloves before touching clean items. The Staff Development Coordinator or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or	

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F 880	Continued From page 14 same area the resident used to grip the lift, with her bare hands and moved the lift from outside the resident's door to the hallway. Continuous observation until 5:39 PM showed at no time was the sit-to-stand lift cleaned after the resident had been transferred. Interview with CNA #1 on 4/7/21 at 5:39 PM revealed she had been educated on the necessity of cleaning the lift between residents, however she had failed to do so. 3. Review of the quarterly MDS assessment dated 3/2/21, showed resident #71 was admitted with diagnoses which included Down's syndrome, dementia, congestive heart failure, and scoliosis. Further review of the MDS assessment showed the resident was incontinent of bladder and bowel. The following concerns were identified: a. Observation on 4/6/21 at 9:26 AM showed CNA #3 donned gloves, removed the resident's incontinence briefs, performed perineal care, and placed a clean brief on the resident and pulled the resident's pants up without removing her gloves. Continued observation showed the CNA assisted the resident's roommate without removing the gloves or performing hand hygiene. b. Observation on 4/6/21 at 7:30 PM showed the DON donned gloves, removed the resident's brief and performed perineal care. The DON then placed a clean brief on the resident. While still wearing the same gloves the DON went into the closet and retrieved clean pajamas for the resident. Interview at that time with the DON stated the gloves should have been changed after performing perineal care and before touching clean items. 4. Interview with the DON and IP on 4/8/21 at 12:02 PM revealed it was the facility's expectation for staff to clean resident's hands before meals	F 880	until substantial compliance has been achieved or sustained as directed by the committee. In addition, facility has incorporated the directed plan of correction.	

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F 880	Continued From page 15	F 880		

and for lifts and equipment to be cleaned between residents. In addition hand hygiene had recently been addressed through education provided to staff in March 2021.

Review of CDC guidelines found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#anchor_1604360738701 and retrieved on 4/12/21 showed "Hand Hygiene HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. HCP should perform hand hygiene by using ABHS with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS. Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location."

Review of https://www.cdc.gov/handhygiene/providers/index.html retrieved on 4/12/21 showed under "Glove Use...Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur.
Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. Perform hand

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F 880	Continued From page 16 hygiene immediately after removing gloves. Change gloves and perform hand hygiene during patient care, if gloves become damaged, gloves become visibly soiled with blood or body fluids following a task, moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs. Never wear the same pair of gloves in the care of more than one patient. Carefully remove gloves to prevent hand contamination." Review of https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html retrieved on 4/12/21 showed "Older adults living in congregate settings are at high risk of being affected by respiratory and other pathogens, such as SARS-CoV-2. A strong infection prevention and control (IPC) program is critical to protect both residents and healthcare personnel (HCP). Even as nursing homes resume normal practices and begin relaxing restrictions, nursing homes must sustain core IPC practices and remain vigilant for SARS-CoV-2 infection among residents and HCP in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death.	F 880		