STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CODY REGIONAL HEALTH LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(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 8/23/21 to 8/26/21. The following common abbreviations are used throughout this document: DON: Director of Nursing CNA: Certified Nursing Assistant MDS: Minimum Data Set RN: Registered Nurse CDC: Centers for Disease Control and Prevention LPN: Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	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 medical record review, staff interview,	F 637	1. Resident #44 was identified as being	9/17/21

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

Electronically Signed | 09/20/2021

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F 637	Continued From page 1 and review of the CMS MDS 3.0 Resident Assessment Instrument (RAI) manual, the facility failed to ensure a significant change assessment was completed 1 of 3 sample residents (#44) with an identified change in condition. The findings were: 1. Review of the annual MDS assessment dated 4/21/21 showed resident #44 had diagnoses which included non-Alzheimer's dementia, depression, psychotic disorder, dysphagia, and auditory hallucinations. The MDS showed the resident had a brief interview for mental status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. The resident required supervision with set-up help for eating. Further review showed the resident had no identified weight loss, was at risk for pressure ulcers, and had no identified pressure ulcers at the time of the assessment. The following concerns were identified: a. Review of the quarterly MDS assessment dated 7/21/21 showed the resident required extensive assistance of 1 person for eating and had weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months which was not physician prescribed. Further review showed the resident had an unstageable pressure ulcer, which was not previously coded. b. Interview with the MDS coordinator on 8/26/21 at 9:43 AM confirmed the quarterly MDS assessment should have been a significant change assessment because of the identified areas. c. Review of the CMS "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.17.1" last revised October 2019 showed "...A 'significant change' is a major decline or improvement in a resident's	F 637	affected. A significant change MDS was completed on Resident #44. 2. Any residents with a significant change have the potential to be affected. All residents were reviewed to determine if any change in condition has occurred that would require a significant change MDS. 3. The Care Plan team was re-educated on criteria for when a significant change MDS is required to be completed. The DON or designee will review resident statuses during IDT morning meetings for any potential change in condition that would require a significant change MDS and will verify the MDS was completed as appropriate. These audits will occur at least 1 time weekly for the next 60 days. 4. DON or designee will report results of the audits to the QAPI Committee monthly for the next 60 days to monitor compliance. Additional training and/or audits will be instituted as appropriate to ensure ongoing compliance.	

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F 637	Continued From page 2 status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered 'self limiting'; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan..."	F 637		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure Preadmission Screening and Resident Review (PASARR) requirements were met for 2 of 4 residents (#11, #44) reviewed. The findings were: 1. Review of the 5/29/21 MDS quarterly	F 644	1. Resident #'s 11 and 44 were identified as being affected. Level I PASARR's were completed and entered into WY Medicaid portal for processing of Level II PASARR's. 2. All residents with qualifying mental illness have the potential to be affected.	9/17/21

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F 644	Continued From page 3 assessment showed resident #11 was admitted to the facility on 4/18/18, and had no identified psychiatric diagnoses. The following concerns were identified: a. Review of the medical record showed the resident received a new diagnosis of delusional disorders on 2/23/20. Further review showed no PASARR level I or PASARR level II were completed for the new psychiatric diagnosis. b. Interview with the social services director on 8/26/21 at 1:37 PM confirmed delusional disorders was a psychiatric diagnoses, and required an evaluation of the resident through the PASARR Level 1 screening. Further interview confirmed neither the PASARR level I, nor the level II, were completed for the new diagnosis. 2. Review of the annual MDS assessment dated 4/21/21 showed resident #44 had diagnoses which included depression and psychotic disorder. The following concerns were identified: a. Review of the resident's diagnosis list showed the resident had a diagnosis of major depressive disorder dated 10/5/17. Further review showed the resident received a diagnosis of unspecified psychosis not due to a substance or a known physiological condition on 8/22/19. b. Review of a PASARR level I completed on 10/5/17 showed no psychiatric diagnoses were listed and the mental illness questions indicated the resident did not have a psychiatric diagnosis. Review of the electronic medical record showed no other PASSARs were completed for the resident. c. Interview with the MDS coordinator on 8/26/21 at 10:32 AM revealed the facility did not complete a new PASSAR when the resident received a new psychiatric diagnosis and did not complete PASSAR screening when a significant	F 644	All residents were reviewed to determine if any others were in need of a PASARR's. 3. The IDT team and Admissions Coordinator were re-educated on the criteria for when a PASARR II is required. During morning IDT meetings, the IDT team will review new admissions and any residents who have received a new mental illness diagnosis or met any other qualifying criteria to ensure a PASARR II is completed as appropriate. These reviews will be conducted weekly for the next 60 days. 4. The Administrator or designee will report results of reviews monthly for the next 60 days to the QAPI Committee to ensure compliance. Additional training and/or audits will be instituted as appropriate to ensure ongoing compliance.	

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F 644	Continued From page 4 change assessments performed.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		9/17/21

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F 656	Continued From page 5 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, and policy and procedure review, the facility failed to ensure the comprehensive care plan addressed necessary care and treatment for 1 of 22 sample residents (#21). The findings were: 1. Review of the 3/26/21 admission MDS assessment showed resident #21 was admitted to the facility on 3/22/21, had diagnoses which included end stage renal disease, and received dialysis treatment. The review showed the resident had a BIMS (brief interview for mental status) score of 13 out of 15 which indicated the resident was cognitively intact. Interview with the resident on 8/24/21 at 10:23 AM revealed s/he received dialysis twice per week. Observation at that time showed the resident had a left arm A-V (arterial venous) fistula utilized for dialysis treatments. The following concerns were identified: a. Observation on 8/24/21 at 10:23 AM showed no signage in the resident's room to alert staff not to complete lab work blood draws or blood pressure readings on the resident's left arm. b. Review of the care plan showed the facility failed to address the resident's need for dialysis treatment, which would include no blood draws or blood pressure readings from the resident's left arm.	F 656	1. Resident #21 was identified as being affected. Resident #21's care plan was updated to include dialysis treatments and related care. 2. All residents have the potential to be affected. An audit was completed to verify that care plans were comprehensive for all other residents. 3. The care plan team was re-educated on ensuring care plans are comprehensive and updated as changes occur. DON or designee will review 3 care plans per week for the next 60 days to verify the care plans are comprehensive. 4. DON or designee will report results of reviews to the QAPI Committee monthly for the next 60 days to monitor compliance. Additional training and/or audits will be instituted as appropriate to ensure ongoing compliance.	

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F 656	Continued From page 6 c. Interview with the unit manager #1 on 8/25/21 at 6:54 PM revealed the facility did not have post-dialysis requirements except to check the fistula for bleeding. d. Interview with the DON on 8/26/21 at 10:11 AM revealed she would expect the dialysis, fistula care and monitoring, and all other precautions including no blood draws or blood pressures performed on the affected arm to be addressed in the care plan. Further interview confirmed there was no dialysis care plan in place e. Review of the policy titled "Dialysis, Care of the Resident in LTC Setting" provided by the facility on 8/24/21 showed "...Follow-up care of dialysis resident...A. Observe for bleeding at the access site. If graft site bleeds, apply pressure with 2X2 gauze and notify the dialysis unit during regular hours or the ER if after hours. B. Observe for infection/bacteremia/septic shock which will cause fever and/or chills. If this occurs, notify the dialysis unit during regular hours or the ED if after hours. C. Do not give resident a meal for one hour after dialysis. D. Encourage resident to eat. Monitor intake. Maintain fluid intake per dialysis department recommendations. E. In end stage renal disease, be aware of resident's nutritional needs as well as emotional and social well-being...Proper Care of the Dialysis Vascular Access A. Do not take BP [blood pressure] on an extremity with a fistula or graft. B. Do not draw blood from any dialysis access site for any reason..."	F 656		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If	F 700		9/24/21

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F 700	Continued From page 7 a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure bed rail assessments indicated safe use for 3 of 5 sample residents (#34, #44, #52) with bed rails. The findings were: 1. Review of the quarterly MDS assessment dated 7/7/21 showed resident #34 had diagnoses which included non-Alzheimer's dementia and a brief interview for mental status (BIMS) score of 7 out of 15 which indicated severe cognitive impairment. Further review showed the resident required extensive physical assistance of 2 or more people for bed mobility and extensive physical assistance of 1 person for transfers and personal hygiene. The following concerns were identified: a. Observation on 8/24/21 at 11:43 AM	F 700	1. Resident #'s 34, 44 and 52 were identified as being affected. An assessment was conducted on these residents to verify safe use of bed rails. 2. All residents who use bed rails have the potential to be affected. An audit was conducted to verify that all residents who use bed rails were assessed for safety regarding the use of the rails. 3. For the next 60 days, DON or designee will review 3 residents per week who use bed rails to verify safety assessments were completed. 4. DON or designee will report results of reviews to the QAPI Committee monthly for the next 60 days to verify compliance and coordinate additional education and/or audits if needed.	

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F 700	Continued From page 8	F 700		

showed the resident was in bed and enablers/assist bars were in place to the bilateral upper portion of the bed.

b. Observation on 8/25/21 at 9:18 AM showed the resident was in bed and enablers/assist bars were in place to the bilateral upper part of bed.

c. Observation on 8/26/21 at 11 AM showed the enablers/assist bars were designed with two separate gaps which maintenance staff #1 measured as 6 1/2 inches by 3 7/8 inches, and 12 1/4 inches by 3 7/8 inches.

d. Review of the medical record showed no evidence the enablers/assist bars were assessed for entrapment risk.

2. Review of the quarterly MDS assessment dated 7/21/21 showed resident #44 had diagnoses which included non-Alzheimer's dementia and psychotic disorder and had a BIMS score of 10 out 15 which indicated moderate cognitive impairment. Further review showed the resident required extensive assistance of 2 or more people for bed mobility and transfers and extensive assistance of 1 person for personal hygiene. The following concerns were identified:

a. Observation on 8/24/21 at 2 PM showed the resident was in bed and enablers/assist bars were in place to the bilateral upper part of the bed.

b. Interview with CNA #1 on 8/25/21 at 6:52 PM revealed the resident was not able to reposition him/herself.

c. Observation on 8/26/21 at 11:02 AM showed the enablers/assist bars were designed with two separate gaps which maintenance staff #1 measured as 6 1/2 inches by 3 7/8 inches, and 12 1/4 inches by 3 7/8 inches.

d. Review of the medical record showed no evidence the enablers/assist bars were assessed

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F 700	Continued From page 9 for entrapment risk. 3. Review of the admission MDS assessment dated 7/27/21 showed resident #52 was admitted to the facility on 7/23/21 with diagnoses which included reduced mobility, weakness, muscle weakness (generalized), displaced bimalleolar fracture of right lower leg, displaced bimalleolar fracture of left lower leg, unspecified fracture of the lower end of right radius, presence of left artificial ankle joint, serous retinal detachment of the left eye, and unsteadiness on feet. The resident had a BIMS score of 14, which indicated s/he was cognitively intact. Review of current physician orders showed a 7/26/21 order stating "Non-weightbearing right foot x 6 weeks (8/31/2021) or per new orders from Dr. Emery. Two times a day for R ankle fracture". The following concerns were identified: a. Observation on 8/23/21 at 4:54 PM showed the resident seated in his/her wheelchair next to his/her bed, and enablers/assist bars were in place to the bilateral upper part of the bed. b. Observation on 8/26/21 at 11:06 AM showed the enablers/assist bars were designed with two separate gaps measured by maintenance staff #1 as 6 1/2 inches by 3 7/8 inches, and 12 1/4 inches by 3 7/8 inches. c. Review of the medical record showed no evidence the enablers/assist bars were assessed for entrapment risk. 4. Interview with the DON on 8/26/21 at 11:06 AM revealed the facility did not assess the rails for entrapment risk and the use of the devices should be on the care plan.	F 700		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		9/24/21

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F 758	Continued From page 10 §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; §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	F 758		

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F 758	Continued From page 11 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, staff interview, and policy and procedure review the facility failed to ensure unnecessary psychotropic medications were not used for 2 of 5 sample residents (#39. #44). The findings were: 1. Review of the significant change MDS assessment dated 7/12/21 showed resident #39 had diagnoses which included anxiety disorder and depression, and had a brief interview for mental status (BIMS) score of 14 out 15 which indicated the resident was cognitively intact. Further review showed the resident had no symptoms of depression, and no behaviors were coded on the assessment. Review of the care plan showed the resident had "...a mood problem r/t [related to] diagnosis of major depressive disorder" and interventions included "...Document and report PRN [as needed] any risk for harm to self; suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgement or safety awareness..." The following concerns were identified:	F 758	1. Resident #'s 39 and 44 were identified as being affected. Both residents were reviewed and targeted behaviors related to psychoactive medications they receive are now being monitored and documented on their treatment records. 2. All residents who receive psychoactive medications have the potential to be affected. All residents who receive psychoactive medications were reviewed to ensure targeted behaviors are being monitored and documented. 3. Weekly for the next 60 days, the DON or designee will review 3 residents who receive psychoactive medications to verify targeted behaviors are being monitored and documented appropriately for each resident. 4. DON or designee will report results of the reviews monthly for the next 60 days to the QAPI Committee to verify compliance and coordinate additional training and/or audits as needed.	

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a. Review of the medication administration record (MAR) for August 2021 showed the resident received Sertraline (antidepressant) 50 milligrams (mg) by mouth daily and there was no evidence of identified target symptoms for the resident. Further review showed the resident's behavior monitoring was discontinued on 8/3/21.

2. Review of the quarterly MDS assessment dated 7/21/21 showed resident #44 had diagnoses which included non-Alzheimer's dementia, depression, and psychotic disorder other than schizophrenia, and had a BIMS score of 10 out 15 which indicated moderate cognitive impairment. Further review showed the resident did not exhibit any behaviors. Review of the care plan last revised on 2/24/21 showed "The resident has a history of hallucinations and delusional thinking i.e. thinking there is someone under [his/her] bed." The following concerns were identified:

a. Review of the MAR for August 2021 showed the resident received Seroquel (anti-psychotic) 25 mg by mouth every morning, Seroquel 50 mg by mouth every evening, and Paxil (antidepressant) 10 mg by mouth daily. Further review showed there was no evidence of identified target symptoms or behavior monitoring identified for individual medication use.

3. Interview with the social services director on 8/26/21 at 10:20 AM confirmed the residents did not have any identified target symptoms for use of the psychotropic medication and the facility would be unable to determine the effectiveness of the medication.

4. Review of the policy titled "Monitoring Chemical/Physical Restraints" provided by the

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F 758	Continued From page 13 facility on 8/26/21 showed "...I. Chemical restraints...2. Upon recognizing a specific behavior that does/or could adversely affect a patient, the RN/LPN or C.N.A observing the behavior will start a Behavior Monitor. Place the Behavior Monitor in the Medication Administration Review (MAR) notebook. A Behavior Monito from [sic] will be initiated before a new order (or change in an order) for a psychoactive medication is started. The Social Worker will review behavior monitors on an ongoing basis and will recommend any further approaches to be used for behavior management...4. Behavior monitors will be used to monitor for possible side effects and/or efficacy of medication..."	F 758		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions,	F 838		8/27/21

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physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.

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F 838	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on the facility assessment review and staff interview the facility failed to conduct the annual assessment for 1 of 1 facility. The findings were: Review of facility assessments showed the facility completed assessments for the years of 2018, 2019, and partially completed the assessment for 2021. Further review showed the facility failed to complete the assessment for 2020. Interview with the administrator on 8/26/21 at 9:40 AM revealed the last facility assessment was completed in 2019. Further interview revealed she had just finished the 2021 facility assessment.	F 838	1. No residents were identified as being affected. 2. All residents have the potential to be affected. 3. The facility assessment for 2021 was completed on 8/25/21. 4. The QAPI Committee will review the facility assessment quarterly to verify it is updated as needed and at least annually.	
F 880 SS=J	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,	F 880		9/24/21

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F 880	Continued From page 16 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 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.	F 880		

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F 880	Continued From page 17 §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, review of professional standards, review of manufacturer recommendations, and policy and procedure review, the facility failed to ensure appropriate infection control practices were implemented. Specifically, the facility failed to ensure blood glucose monitors were disinfected between uses during 1 of 5 observations (resident #2). This failure resulted in an unacceptable risk to resident health and a determination of immediate jeopardy. In addition, the facility failed to ensure appropriate infection prevention practices during 1 of 1 observations of wound dressing changes (which affected resident #111). The findings were: Regarding blood glucose monitoring: 1. Observation on 8/25/21 at 11:43 AM showed LPN #1 obtained a blood glucose reading for resident #24 using a glucometer. After obtaining the result, the LPN did not clean the glucometer. The LPN then entered the main dining area to find the remaining residents on whom she needed to check blood glucose levels. At 11:49 AM the nurse loaded a glucometer strip into the glucometer and approached resident #2. The nurse set the supplies down on the resident's table, and cleaned the resident's finger. Once it became apparent the nurse was going to utilize	F 880	Corrective Action: The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of 483.80 for the affected unit identified in the deficiency. The Infection Preventionist (IP) and Director of Nursing (DON), in conjunction with the medical director, shall complete the following: 1. Identify and implement device sanitation procedures for glucometers for staff, consistent with current nursing facility guidelines from the CDC and CMS. 2. Develop and implement hand hygiene procedures for staff during wound care. 3. Develop and implement donning and doffing of ppe procedures for staff during wound care. 4. Develop and implement clean technique and supply storage procedures during wound care. 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	

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F 880	Continued From page 18 the same glucometer without disinfection, the surveyor intervened to stop the glucose check. 2. Interview with LPN #1 on 8/25/21 at 11:49 AM revealed she was going to obtain all the residents' blood glucose measurements before she sanitized the glucometer. At that time, the LPN left the cart and obtained a "Dispatch" (bleach disinfectant towels) wipe to sanitize the glucose monitor. She stated the "Dispatch" contact time (time the disinfectant must remain wet in are being disinfected) was 3 minutes. 3. Interview with the DON on 8/25/21 at 12:20 PM revealed it was the facility's expectation for staff to clean the glucometer between each resident use. Staff were to use the Sani-wipes with the contact time of 1-3 minutes. 4. Review of the manufacturer recommendations showed " ... Cleaning the exterior surface of the Precision Xceed Pro Monitor daily recommended. Follow your facility's policies and procedures for infection control, which may require more frequent cleaning. ...Bleach or hydrogen peroxide based cleaners will fade the monitor keypad ...wipes are not recommended..." 5. Review of the policy and procedure titled "Glucometer Use Guidelines" provided by the facility on 8/25/21 showed "...7. c. Proficiency Testing: i. Proficiency tests are performed quarterly by those that routinely use the system... ...8. Cleaning of the glucometer units: a. Cleaning of glucometer units is performed after each patient use. b. Glucometer units are cleaned with the PDI Super Sani-Cloths. Instruments will be wiped thoroughly until visibly wet and must sit for at least 2 minutes before being used on another	F 880	evaluate the facility□s overall compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. System Changes: On or before 9/25/21 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: a. Failure to ensure device sanitation procedures for staff, consistent with current nursing facility guidelines from the CDC and CMS. b. Failure to ensure guidelines were implemented for hand hygiene while performing procedures during wound care. c. Failure to ensure guidelines for donning and doffing of ppe procedures for staff during wound care. d. Failure to ensure guidelines were implemented for clean technique and supply storage procedures during wound care. 2. The DON and IP will ensure education is provided for the following: a. All staff are educated on glucometer device sanitation procedures for staff, consistent with current nursing facility guidelines from the CDC and CMS b. All staff are educated on hand hygiene while performing procedures during wound care c. All staff are educated on donning and doffing ppe procedures for staff during wound care	

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F 880	Continued From page 19 patient." a. Review of LPN #1's "FreeStyle Precision Pro Blood Glucose and B-Ketone Monitoring System Learning Assessment" showed the LPN was last assessed for proper use and disinfecting of the glucometer on 5/21/19. 6. Review of the CDC's "Frequently Asked Questions (FAQs) regarding Assisted Blood Glucose Monitoring and Insulin Administration"(found at https://www.cdc.gov/injectionsafety/providers/blood-gluecose-monitoring_faqs.html and retrieved on 8/25/21) showed "...Blood Glucose Meters...Infectious agents, such as HBV, can be transmitted through indirect contact transmission, even in the absence of visible blood [4]. Indirect contact transmission is defined as the transfer of an infectious agent (e.g., HBV) from one patient to another through a contaminated intermediate object (e.g., blood glucose meter) or person (e.g., healthcare personnel hands) [12].With some blood glucose meters that require pre-loading of the test strip, the device may come into direct or close contact with the patient's finger stick wound. If blood is transferred from the patient to the meter, and the meter is not cleaned and disinfected after use, subsequent patients can be exposed to this blood when the meter is used on them. Indirect contact transmission can also occur even if the patient never directly contacts the meter. Healthcare personnel's hands can become contaminated with blood at various points while performing assisted blood glucose monitoring including pricking the patient's finger or handling the test strip. Blood can then be transferred to the meter when healthcare personnel handle the meter to obtain the reading. If the meter is not cleaned and disinfected after	F 880	d. All staff are educated on clean technique and supply storage procedures during wound care 3. The facility leadership will contact the Mountain Pacific Quality Improvement Organization (QIO) to inquire about the assistance and services available from the QIO in improving infection and prevention control within the facility 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: a. Compliance with glucometer device sanitation procedures for staff b. Compliance with hand hygiene while performing procedures during wound care c. Compliance with donning and doffing ppe procedures for staff during wound care d. Compliance with clean technique and supply storage procedures during wound care. 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	

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F 880	Continued From page 20 use, the blood remaining on the meter can be transferred to subsequent patients via healthcare personnel hands when they handle the meter and then assist with fingerstick procedures. Numerous outbreaks have implicated this mechanism in the spread of HBV infections [3, 4]. Contamination of equipment and transmission of HBV can also occur if healthcare personnel fail to change their gloves and perform hand hygiene between patients. For these reasons, blood glucose meters should be cleaned and disinfected after each use, unless they are dedicated to a single patient and appropriately stored to prevent inadvertent contamination..." On 8/25/21 at 2:05 PM the administrator was informed of an immediate jeopardy situation in the area of infection control related to a failure to disinfect blood glucometers between resident uses. The facility submitted an action plan which included the following immediate changes: 1. Both glucometers were disinfected immediately by the Interim DON: The first floor machine at 1425 [2:45 PM] with a super sani cloth wet time 2 minutes and at 1445 [2:45 PM] the second floor unit was cleaned with super sani cloth wet time 2 minutes. 2. All licensed nurses currently on duty will be re-educated immediately by the DON or RN Manager designee and competencies checked on proper disinfecting of glucometers between use. 3. All licensed nurses not currently on duty will be re-educated and competencies checked of the same by the Interim DON and/or Nurse Supervisors prior to their next scheduled shift.	F 880	three consecutive rounds of monthly monitoring which demonstrates sustained compliance as approved by the QAPI committee and medical director.	

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4. Verification of compliance-any licensed nurse who conducts a glucometer check will document that disinfecting of the machine occurred before and after use with a resident and a second staff member must also witness and document verification the disinfecting occurred. The 2 Nurse managers will conduct 10 random observations per week of the licensed nurses conducting glucometer check to verify ongoing compliance after re-education is completed.

The action plan was accepted on 8/26/21 at 9:30 AM.

The implementation of the action plan was removed on 8/26/21 at 2:15 PM; however, verified and immediate jeopardy was deficient practice remained at a scope and severity of "D."

Regarding infection prevention practices during dressing changes:

1. Observation of on 8/25/21 at 9:59 AM showed LPN #1 entered the room of resident #111. The LPN set her wound care supplies out on the, without placing a barrier down, donned gloves, and removed the dressing to the resident's right lower leg. She cleaned the wound with a solution and 4X4's and cut the dressing supplies before placing her shears on top of the resident's belongings on the over bed table, without a barrier. The LPN placed a blue chux on the floor under the resident right lower leg, and moved the supplies for the dressing change down to the blue chux on the floor. The nurse obtained tape from the resident's night stand and placed the roll on the blue chux between applications. No hand hygiene or doffing of gloves was performed until

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the completion of the dressing change.

2. Interview with LPN #1 on 8/25/21 at 10:15 AM revealed she always performed wound care on the resident in the manner observed.

3. Interview with the DON on 8/26/21 at 9:45 AM revealed the facility expectation was to change gloves and perform hand hygiene upon entry to the resident room, between dirty and clean dressing changes, and before leaving the resident room. Further interview revealed supplies should be stored in areas where clean items can not be contaminated by dirty items.

4. Review of the policy and procedure titled "Infection Prevention and Control - LTCC" provided by the facility on 8/26/21 showed "...Hand hygiene will be consistent with acceptable standards of practice-using hand washing versus alcohol-based hand rub (ABHR) (Standard Precautions Policy)...Resident care to include catheters, skin/wound care, point-of care testing...(Lippincott)."

5. Review of "Nursing Interventions & Clinical Skills (6th edition) by P.A. Perry - 2016, pages 688 - 689, showed "... 3. Apply clean gloves. ...Draping provides access to wounds while minimizing exposure. Avoids contamination of supplies. 4. Gently remove tape, bandages... 8. Apply clean gloves, remove gauze cover over wound, and then cleanse wound... 11. ...Dispose of gloves. Perform hand hygiene. 12. (1) Apply clean gloves. Apply dressing."