STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING _____ B. WING _____	11/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASPER MOUNTAIN REHABILITATION AND CARE CENTER	4305 S POPLAR CASPER, WY 82601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted by Healthcare Licensing and Surveys from 11/8/21 through 11/9/21.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		12/10/21

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

Electronically Signed | 11/30/2021

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F 880	Continued From page 1 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure hand hygiene practices were followed to prevent	F 880	1. On or before 12/10/21, DON or designee will educate the nurse regarding hand hygiene policies and procedures.	

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F 880	Continued From page 2 the spread of infection for 1 of 3 observations. The findings were: 1. Observation on 11/8/21 at 4:29 PM of the COVID unit showed registered nurse (RN) #1 donned gloves and entered a resident's room with medications. The RN exited the room, removed the gloves and put new gloves on, without performing hand hygiene. The RN entered another resident's room, then exited the room and removed the gloves. The RN failed to perform hand hygiene before donning another pair of gloves, and entering another resident's room. Interview with the RN at that time revealed she only performed hand hygiene after the third time of wearing gloves. 2. Interview on 11/9/21 at 10:46 AM with the infection prevention nurse and the director of nursing revealed the expectation was for staff to perform hand hygiene after removing gloves. 3. Review of the Handwashing/Hand Hygiene policy dated 8/15, showed, "...7. Use an alcohol-based hand rub containing at least 62% alcohol; and water for the following situations:...m. after removing gloves...".	F 880	2. Identification of others-All other nurses have potential for deficient hand hygiene/glove use. 3. On or before 12/10/21 DON, IP or designee will perform return demonstration on hand hygiene with nursing staff working in facility. They will ensure that nursing staff will also be educated on hand hygiene policies and procedures. 4. IP will instruct Department Heads on how to complete return demonstrations on hand hygiene. 5. All staff will be educated regarding hand hygiene policies and procedures on or before 12/10/21. 6. IP/DON will complete random audits, of at least 2 per week, (if facility census accommodates this) of staff in isolation rooms to ensure that they are following appropriate hand hygiene practices. The outcome of these audits will be reviewed through the weekly/monthly QAPI meeting monthly X3. 7. The NHA will assign various Department Heads to obtain return demonstrations on at least 7 staff members per week, on various shifts, to be reviewed at the daily stand up meeting. 8. IP will review issues identified with these at the weekly and monthly QAPI meetings monthly x3. Directed POC Corrective Action: The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the	

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F 880	Continued From page 3	F 880	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: 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). 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. System Changes On or before 12/10/2021, the facility shall complete the following actions: DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: Failure to ensure hand hygiene was performed after contact with blood, body fluids, or visibly contaminated surfaces. The DON and IP will ensure education is	

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F 880	Continued From page 4	F 880	provided for the following: Failure to ensure gloves were removed, hand hygiene performed, and new gloves donned when required. 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 prevention and control within the facility. Monitoring: Monitoring of approaches to ensure infection control and prevention are effective will include: 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: Compliance of staff with hand hygiene during resident care. After 12 weeks of monitoring, provided that such monitoring demonstrates expectation 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.	