STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG HORN REHABILITATION AND CARE CENTER	**1851 BIG HORN AVE SHERIDAN, WY 82801**

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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 11/15/21 to 11/18/21. Also reviewed in the course of the survey were complaint intakes WY00003326, WY00003320, and WY00003317. The Following common abbreviations are used throughout this document: DON: Director of Nursing RN: Registered Nurse MDS: Minimum Data Set CNA: Certified Nursing Assistant BIMS: Brief Interview for Mental Status Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by:	F 568		12/13/21

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

Electronically Signed | 12/13/2021

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F 568	Continued From page 1 Based on resident and staff interview, and policy and procedure review, the facility failed to ensure quarterly financial statements were provided to 1 of 1 sample residents (#37) reviewed for personal funds. The findings were: 1. Interview with resident #37 on 11/16/21 at 8:57 AM revealed the facility did not provide a balance statement for resident fund accounts managed by the facility. 2. Interview with the business office manager on 11/18/21 at 9:29 AM revealed the facility received statements for resident accounts from the corporate office and she gave them to the residents or sent them to their representatives; however, she confirmed the facility did not a system in place to monitor when statements were sent, or to whom they were sent. 3. Review of the policy titled "Accounting and Records of Resident Funds" last revised 4/2021 showed "...5. Individual accounting records are made available to the resident through quarterly statements and upon request...."	F 568	F568 Corrective Action: Resident #37 was provided with current RFMS Statement on 11/19/2021. Identification of Others: All residents with RFMS accounts have the potential to be affected. Systemic Change: All residents with RFMS accounts were provided or offered current financial statements on 11/19/2021. Consulting Business Office Director will educate Business Office Manager regarding account statements and distribution by December 23, 2021. Business Office Manager or designee will audit all residents with RFMS accounts for correct addresses to ensure statements are being delivered to the correct resident or responsible party. Business Office Manager or designee will ensure delivery of quarterly RFMS statements to residents within the facility. If an address change occurs, Business Office Manager or designee will ensure address is also changed on RFMS account. Ongoing Monitoring: Business Office Manager or designee will conduct random weekly audits of residents with RFMS accounts to ensure responsible party or resident is receiving their RFMS statement for 4 weeks and 2 months to validate continued compliance. Any concerns addressed through the audit process will be monitored and reported to Business Office Manager in summary in the facility monthly QAPI meetings. The QAPI committee will evaluate	

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F 568	Continued From page 2	F 568	effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months then reassess the need for continued monitoring based on compliance.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		12/13/21

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F 584	Continued From page 3 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and policy and procedure review, the facility failed to ensure a sanitary, orderly, and comfortable interior was maintained. The census was 74. The findings were: 1. Interview with resident #10 on 11/16/21 at 9:28 AM revealed the resident had asked for his/her room to be cleaned due to the floor being dirty. After the facility had completed the cleaning, the resident stated the floor remained discolored and s/he was told the floor would need to be stripped and waxed to remove the discoloration; however, the resident revealed s/he was told the facility did not have the equipment to perform the strip and wax. Observation at that time showed the entrance of the room had black discoloration, with build-up of dirt and debris. Observation on 11/18/21 at 9:24 AM showed the entry to the resident's room continued to have black discoloration with a build-up of dirt and debris. 2. Interview with resident #20 on 11/16/21 at 2:25 PM revealed the facility was "not very clean" and the resident felt it was due to the building being "old and rundown." Observation at that time	F 584	F584 Corrective Action: Residents 10 and 20 have since had housekeeping in their room scraping away any dirt or debris buildup. This was completed on 11/19/21 to clean any buildup. The entire hall was completed with team scraping any buildup in the rooms on the floor. Entrances into dining room have also been addressed and have been stripped of discoloration or buildup. Facility has also since acquired the use of a floor stripper to help strip wax buildup that can develop overtime. Identification: It is important for all residents to have a safe and clean environment. This has the potential to affect all residents in their living space if they feel that their room is not completely clean. The buildup was isolated to rooms that had original flooring in the hallway transitioning into the rooms with the original flooring. Going forward, we will perform weekly room audits looking at all aspects of resident□s rooms. This will be conducted	

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F 584	Continued From page 4 showed the resident's floor was discolored, and at the entrance of the room appeared black with a build-up of dirt and debris. Observation on 11/18/21 at 9:26 AM showed the resident's floor remained discolored, with a build-up of dirt and debris in the entrance of the room. 3. Observation on 11/18/21 at 9:40 AM showed the floor at the transition from the hallway into the Ritz dining room had a dark discoloration with a build-up of dirt and debris. 4. Observation on 11/18/21 at 9:41 AM showed the floor at the entrance to the Patio dining room had a dark discoloration. 5. Observation on 11/18/21 at 9:42 AM showed the floor at the transition from the hallway into room 424 had a black discoloration, with a build-up of dirt and debris. 6. Observation on 11/18/21 at 9:44 AM showed the floor at the transition from the hallway into room 401 had a black discoloration, with a build-up of dirt and debris. 7. Observation on 11/18/21 at 9:45 AM showed the floor at the transition from the hallway into room 406 had a black discoloration, with a build-up of dirt and debris. 8. Interview with housekeeper #1 on 11/18/21 at 10:08 AM revealed the facility utilized a "mechanical scrubber" to remove the discoloration and debris in the transitions; however, he was unsure if the machine was able to clean the areas effectively. 9. Interview with the human resource director on	F 584	by Housekeeping Supervisor or designated manager over Housekeeping. Audit will look at cleanliness of room and floors clean. This will go into effect on 12/22/21 for audits to be consistently done on a weekly basis. Floor tech will monitor buildup and discoloration and strip with machine and maintain a high level of cleanliness. Systemic: Housekeeping will be trained on the importance of cleaning all surfaces including the floor. This will training has already been provided and will be brought up in monthly Housekeeping Meetings going froward. Any discoloration or buildup should be treated right away and cleaned. We will have a weekly audit completed to ensure that our facility remains in compliance on this issue. Audits will be done by housekeeping supervisor, Maintenance or designated Housekeeping manager at the time. These will be reported to the Housekeeping Supervisor for record keeping and follow up. Monitoring: Housekeeping Supervisor will report monthly in QAPI meetings to report audits and identify any other cleanliness issues.	

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F 584	Continued From page 5 11/18/21 at 2:47 PM revealed he was also the manager of housekeeping and he was aware of the discoloration in the transition areas. He confirmed the "mechanical scrubber" was not able to effectively clean the transitions and revealed his expectation was for staff to get down and clean the transitions manually. Further interview confirmed the facility did not have the appropriate equipment to strip and wax the floors to eliminate the darkened areas, and revealed a plan was in place to replace the floors in 2022. 10. Review of the facility policy titled "Floors" last revised 12/2009 showed "Floors shall be maintained in a clean, safe, and sanitary manner..."	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		12/13/21

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F 623	Continued From page 6 (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F 623		

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F 623	Continued From page 7 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). 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 residents or residents' representatives	F 623	F 623 Corrective Acton Resident # 2 and # 71 have been	

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F 623	Continued From page 8 received a written transfer notice for 2 of 2 sample residents (#2, #71) reviewed for hospitalization. The findings were: 1. Review of the discharge MDS assessment dated 7/23/21 showed resident #2 discharged from the facility, with return anticipated, on 7/23/21. The following concerns were identified: a. Review of the medical record showed no evidence a written transfer notice was provided to the resident, or resident's representative at the time of transfer. 2. Review of a progress note for resident #71 dated 11/11/21 and timed 3:20 AM showed "Resident in Bed with Yellow/Green Mucus on shirt. Resident O2 fluctuating from 70-90%. Resident is lethargic and nodding off as being talked to. Resident condition changed from [his/her] normal state. Called Ambulance. Family [name] and physician notified." The following concerns were identified: a. Review of the medical record showed no evidence a written transfer notice was provided to the resident, or resident's representative at the time of transfer. 3. Interview with the regional director of clinical services on 11/18/21 at 2:10 PM confirmed a written transfer notice was not provided to either of the residents or their representative at the time of transfer. 4. Review of the policy titled "Bed-Holds and Returns" last revised 3/2017 showed "...Prior to transfer, written information will be given to the residents and the resident representatives that explain in detail: ...d. the details of the transfer (per the notice of transfer)..."	F 623	discharged from the facility. Any future involuntary discharge notices sent from Big Horn Rehab will include the following elements. A: The phone number, mail, and email address of the designated entity to contact related to an appeal. B: The name, address and telephone number of the state Long Term Care Ombudsman and the email address for contact. Identification of Others An audit will be conducted by DON or designee of transfer/ discharges in the last 30 days and informational notices will be provided to any resident identified by 12/22/21. Systemic Change At the time of discharge or transfer the licensed nurse completes the transfer /discharge notice with tall of the required information and gives to the resident/family member. The nurse will document that the notice was provided, and a copy will be scanned into resident's medical record. Education will be provided by the Don or designee to all licensed nurses and social services regarding the process and regulations that residents receive a written notice of transfer and/ or discharge by 12/22/21. Ongoing Monitoring Medical Records will conduct daily audits	

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F 623	Continued From page 9	F 623	(Monday – Friday) for 4 weeks and weekly audits for 2 months on all residents that were transferred or discharged to validate continued compliance. Corrective action will be taken as necessary for any identified concerns. Any concerns addressed through the audit process will be monitored and reported to the DON or designee. Findings and audits will be discussed during monthly QAPI meetings for 3 months. IDT will assess for trends or patterns during these meetings. They will evaluate the effectiveness of the plan based on trends identified and implemented additional interventions as needed to ensure continued compliance monthly for 3 months then will reassess for continued monitoring needs based on compliance.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 625		12/13/21

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F 625	Continued From page 10 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. 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 residents or residents' representatives received a notice of bed-hold for 2 of 2 sample residents (#2, #71) reviewed for hospitalization. The findings were: 1. Review of the discharge MDS assessment dated 7/23/21 showed resident #2 discharged from the facility, with return anticipated, on 7/23/21. The following concerns were identified: a. Review of the medical record showed no evidence a notice of bed-hold was provided to the resident, or resident's representative at the time of transfer. 2. Review of a progress note for resident #71 dated 11/11/21 and timed 3:20 AM showed "Resident in Bed with Yellow/Green Mucus on shirt. Resident O2 fluctuating from 70-90%. Resident is lethargic and nodding off as being talked to. Resident condition changed from [his/her] normal state. Called Ambulance. Family	F 625	F 625 Corrective Acton Resident # 2 and # 71 have been discharged from the facility. Identification of Others An audit will be conducted by DON or designee of residents in the last 30 days discharged without a bed hold notice. Any resident identified will be provided an informational copy by 12/22/21. Systemic Change The nurse that discharges a resident to the hospital or therapeutic leave will have resident/ representative sign a copy of the bed hold notice and place in resident's record. The nurse will document that the bed hold notice was provided in a progress note. DON or designee will provide education to	

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F 625	Continued From page 11 [name] and physician notified." The following concerns were identified: a. Review of the medical record showed no evidence a notice of bed-hold was provided to the resident, or resident's representative at the time of transfer. 3. Interview with the regional director of clinical services on 11/18/21 at 2:10 PM confirmed a notice of bed-hold was not provided to the residents, or their representative at the time of transfer. 4. Review of the facility policy titled "Bed-Holds and Returns" last revised 3/2017 showed "...Prior to transfer, written information will be given to the residents and the resident representatives that explain in detail: a. the rights and limitations of the resident regarding bed-holds; b. the reserve bed payment policy as indicated by the state plan (Medicaid residents); c. the facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents);..."	F 625	all licensed nurses and social services regarding the regulation and procedure for bed hold notices including required documentation by 12/22/21. Ongoing Monitoring Medical Records or designee will conduct daily audits (Monday – Friday) for 4 weeks and weekly audits for 2 months on all residents discharged to the hospital or therapeutic leave to validate compliance. Corrective action will be taken as necessary for any identified concerns. Any concerns addressed through the audit will be monitored and reported in monthly QAPI meeting for 3 months.	
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	F 880		12/13/21

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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

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F 880	Continued From page 13 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, medical record review, and policy and procedure review, the facility failed to ensure infection control techniques were implemented for 1 of 5 sample residents (#20) during wound care. In addition, the facility failed to ensure infection control techniques were implemented for 1 of 1 sample resident (#228) with an indwelling catheter. The following concerns were identified: Related to wound care: 1. Observation on 11/17/21 at 2:07 PM showed RN #1, the DON, the MDS coordinator, and the ADON entered the room of resident #20. The RN performed hand hygiene, applied gloves, and removed the resident's right ankle wound dressing. The RN cleaned the area and applied collagen flakes to the wound bed. The RN cut a piece of silver sheeting and placed it over the wound bed, beyond the wound margins. At that time, the MDS coordinator told the RN the silver sheeting had to be smaller than the wound	F 880	Correction The RN involved was provided education on infection control practices and wound care on 11/19/2021, by James Rhodes, RN IPC Nurse. Identification Resident who currently reside in the facility who have wounds have the potential to be affected by this deficient practice. Systemic Clinical staff have been in-service on 12/8/21 on proper wound care and the sanitation of re-usable instruments. The Infection Preventionist will contact and work with the Mountain Pacific Quality Improvement Organization. Wound care audits will be conducted weekly for 12 weeks by 12/22/2021, of nursing staff to observe infection control practices.	

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F 880	Continued From page 14 margins. The RN removed the silver sheeting from the wound bed and utilized a pair of scissors to cut the sheeting then returned the sheeting to the wound bed. The RN completed the dressing change and placed the contaminated scissors into his right pants pocket. Further observation showed the RN did not disinfect the scissors prior to placing them in his pocket, or prior to entering the next resident room for wound care. 2. Interview with RN #1 on 11/17/21 at 2:42 PM revealed the normal process for disinfecting reusable items like scissors was to be clean them with bleach solution after use at the medication cart. Further interview confirmed the scissors were used to cut the silver sheeting, which had touched the resident's open wound and should have been disinfected upon completion of the wound care dressing change. 3. Interview with the MDS coordinator, ADON, and infection preventionist on 11/17/21 at 4:58 PM revealed nurses should follow proper aseptic technique or sterile procedure if it was called for and should sanitize any utensils used after wound care. Related to catheters: 1. Review of the current physician orders showed resident #228 was admitted to the facility on 11/8/21 with diagnoses that included urinary tract infection (UTI), other retention of urine, long term (current) use of antibiotics, benign prostatic hyperplasia with lower urinary tract symptoms, and disorder of the prostate. Further review showed an order for "Foley Catheter Size: 16 Fr [French] 10cc [cubic centimeters] Diagnosis:	F 880	Monitoring: Issues identified from the audits will be brought to the weekly, monthly QAPI meetings X3 to ensure that compliance is maintained.	

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Urinary Retention Change catheter and bag monthly. Perform catheter care q [every] shift." Further review showed "Cefepime HCl [antibiotic] Solution Use 2 gram intravenously two times a day related to Urinary Tract Infection." Continued review showed "Foley catheter care every shift." The following concerns were identified:

a. Observation on 11/18/21 at 8:19 AM showed RN #2 and the DON passing medications to the resident. Upon entering the resident's room, it was noted the resident had a catheter drainage bag hanging from the side of the bed. It was also noted the bed was in the lowest position, leaving approximately half the catheter drainage bag lying on the floor. The bag was approximately 2/3 of the way full of urine, prompting the DON to remind RN #2 the bag needed emptying after medication administration was complete. The DON then stated the resident was on antibiotics for a UTI, left the room, returned with a privacy bag for the Foley catheter bag, placed the Foley bag inside the privacy bag, and hooked the Foley bag back onto the side of the bed, leaving the bag to again rest on the floor. Upon completion of the medication administration, RN #2 left the room, and the DON retrieved the resident's urinal. He removed the catheter drainage bag from the privacy bag, positioned the urinal, placed the drain spigot into the urinal, and began draining the catheter drainage bag into the urinal. With the catheter drainage bag only partially emptied and the urinal full, the DON hooked the Foley bag back onto the side of the bed, leaving the drain tubing and bag resting on the floor. He then emptied the urinal, returned to drain the remaining urine from the catheter drainage bag, and again hooked the bag to the bed with the drain tubing and bottom portion of the bag resting on the floor. After

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F 880	Continued From page 16 emptying the urinal the final time, he closed the drain tubing, placed the catheter drainage bag back into the privacy bag, hooked the bag on the edge of the bed, and then raised the resident's bed enough so the bag was off of the floor. b. Review of the resident's care plan, last revised 11/11/21, showed "Urinary Incontinence and/or Indwelling Catheter: [the resident] requires the use of indwelling catheter related to urinary retention." Interventions included "Keep catheter bag off the floor" as well as "Provide privacy bag." 3. Interview with RN #2 on 11/18/21 at 8:37 AM revealed she " ...was new and didn't know that was a Foley bag." She also stated she didn't know it was on the floor, or that the bag couldn't be on the floor. Interview with the DON at that time confirmed the bag should not have been on the floor or placed on the floor while draining, and should have been in a privacy bag. 4. Review of facility policy "Catheter Care, Urinary", last revised September 2014, showed "Review the resident's care plan to assess for any special needs of the resident" and "Be sure the catheter tubing and drainage bag are kept off the floor". Review of facility policy "Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing", last revised September 2017, showed "Do not allow drainage spigot to contact non-sterile collection container when emptying" and "Do not place the drainage bag on the floor."	F 880		
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.	F 925		12/13/21

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F 925	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of pest control treatment records, and policy and procedure review, the facility failed to maintain an effective pest control program to ensure the facility is free from pests. The following concerns were identified: 1. Observation of room 513 on 11/16/21 at 10:28 AM showed the resident seated in his/her recliner in front of the window. Upon approaching the resident, numerous small black and orange bugs were observed crawling in the window, along the window ledge, on the resident's recliner, and on the resident's bed. The resident stated s/he was aware of the bugs, but had not reported them because s/he didn't think they would harm him/her. 2. Observation of room 513 on 11/18/21 at 12:30 PM showed the resident again seated in his/her recliner in front of the window. Further observation showed numerous small black and orange bugs crawling on the floor near the doorway to the room, in the window, on the curtains, on the window ledge, and on the back of the recliner. 3. Interview with the maintenance director on 11/18/21 at 12:42 PM revealed she was aware of the issue, and utilized a vacuum to eliminate the bugs when observed or reported. She further stated she was not aware of the present status of room 513 and she had called the pest control company regarding the bugs to schedule a time for spraying, but did not have record of the call, or documentation of a scheduled appointment for the extermination.	F 925	F925 Corrective Action: Room 513 was eradicated of all insects that had entered the room via the window being open. Facility sprayed inside of the window and on the outside to help eliminate the seasonal insects. Maintenance completed pest control spraying around exterior of building on 11/23/21. Identification of Others: Insects can affect all residents if the nuisance is not resolved right away. If a preventative program is not in place, they can become invasive and cause issues throughout the entire facility. We will maintain a regular schedule for pest control and audit monthly going forward to maintain compliance. Will also do maintenance as needed for circumstances that require immediate action. Systemic Change: All staff will be educated about the importance of reporting any pests or insects to maintenance immediately. Maintenance will handle all pest control issues and will contact outside vendor as needed to eliminate pests. We will do routine checks of rooms to ensure that we no longer have an ongoing problem with insect or pest control. Audits will be done monthly by Maintenance Director overseeing all pest control applications. Maintenance director will maintain files of audits and report to Administrator any issues or concerns.	

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F 925	Continued From page 18 4. Interview with the maintenance director on 11/18/21 at 2:33 PM revealed she had observed the status of room 513, and confirmed the presence of numerous black and orange bugs in the room. 5. Review of a 10/15/21 service record from the pest control company showed rodent service was applied to the exterior of the building. Further review showed no services were provided to the interior of the building at that time. 6. Review of facility policy "Pest Control", last revised May 2008, showed the facility " ...maintains an on-going pest control program to ensure that the building is kept free of insects ..." Further review showed "Maintenance services assist, when appropriate and necessary, in providing pest control services."	F 925	Ongoing Monitoring: Maintenance Director will report monthly to the QAPI Committee and discuss any issues. They will be reviewed monthly going forward to maintain a high level of compliance on this issue. Maintenance Director will keep records of application of pest control and do routine checks through the facility.	