| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **WIND RIVER REHABILITATON AND WELLNESS** | **1002 FOREST DRIVE RIVERTON, WY 82501** |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>A recertification survey which included a COVID-19 focused infection control survey was conducted by Healthcare Licensing and Surveys from 12/6/21 to 12/9/21. Also reviewed in the course of the survey was complaint intake WY00003251.<br><br>The following common abbreviations are used throughout this document:<br><br>BIMS: Brief Interview for Mental Status<br>CNA: Certified Nursing Assistant<br>DNS: Director of Nursing Services<br>ED: Executive Director<br>LPN: Licensed Practical Nurse<br>MDS: Miniumum Data Set<br>RN: Registered Nurse<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F 000 | | |
| F 623 SS=D | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(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.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in | F 623 | | 1/7/22 |

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

Electronically Signed | 12/30/2021

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| F 623 | Continued From page 1 | F 623 | | |

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 (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

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| F 623 | Continued From page 2 | F 623 | | |

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;
(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

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| F 623 | Continued From page 3<br>well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, staff interview, and policy and procedure review, the facility failed to provide a written notice of transfer to 2 of 2 sample residents (#53, #72) reviewed for a facility-initiated transfer. The findings were:<br><br>1. Review of the medical record for resident #53 showed the resident was hospitalized on 6/7/21 following an acute change of condition. A bed-hold agreement was signed by the resident's representative on 6/7/21 and the transfer notice indicated the resident's representative provided "verbal" acknowledgement; however, there was no evidence a written transfer notice had been provided to the resident's representative.<br><br>2. Review of the medical record for resident #72 showed the resident was hospitalized on 6/7/21 and again on 10/21/21 following an acute change of condition. There was no evidence a written transfer notice had been provided to the residents' representative.<br><br>3. Interview on 12/8/21 at 11:32 AM with the ED and again on 12/9/21 at 10:53 AM confirmed a written notice of transfer had not been provided to the resident's representatives.<br><br>4. Review of the policy titled "Transfer and Discharge" updated March 2017 showed "...5. When the transfer or discharge is initiated, the resident receives written notice using the Resident Notice of Transfer or Discharge which includes the includes [sic] the following items: a. | F 623 | F623<br>POC must contain the following:<br>- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>- How you will identify other residents having the potential to be affected by the same deficient practice(s) and what corrective actions will be taken;<br>- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice(s) does not occur; and,<br>- How you will monitor the corrective action(s) performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implanted and the corrective action(s) evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction dates will be the date of the revisit; and<br>- Must include dates when corrective action(s) will be completed. The corrective action completion dates must be within acceptable time frames. If the plan of correction is unacceptable for any reason, | |

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| F 623 | Continued From page 4<br>Date notice is given. b. Effective date of the transfer/discharge. c. Reason for the transfer/discharge. d. Where the resident is to be mover. e. Contact information for the State Long-Term Care Ombudsman. f. Contact information for protection and advocacy agency for residents with a mental disorder, intellectual disability, developmental disability, or other related disability. g. Explanations of right to appeal the transfer or discharge. h. Additional information required by applicable. 6. The Center sends a copy of the notice to the State Long-Term Care Ombudsman..." | F 623 | you will be notified by this office. If the plan of correction is acceptable, you will be notified by telephone, e-mail, etc. Please note that your facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of your plan of correction is not made timely. The plan of correction will serve as your facility□s allegation of compliance.<br>Regulation<br>F623 Notice Requirements Before Transfer/Discharge:<br>Deficient Behavior<br>Based on Medical Record review, staff interview, and policy and procedure review, the facility failed to ensure a discharge notice was issued to 2 of 2 sample residents (#53, 72) reviewed for transfer and discharge. Further the facility failed to ensure the ombudsman was notified and appropriate protection and advocacy information was provided for 2 of 2 sample residents (#53,72) who discharged or transferred from the facility.<br>Corrective Actions:<br>Resident #72 Discharged on 10/21/21. RCM obtained a transfer and discharge notice for residents #53, SSD sent via email, the ombudsman the appropriate protection and advocacy information for residents #53.<br><br>Identification of Others:<br><br>Transfer and Discharge notices along with Ombudsman Notification was Audited for the past month of-December 2021. Any | |

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| F 623 | Continued From page 5 | F 623 | deficiencies were immediately corrected.<br>Systemic Changes<br><br>Licensed Nurses and IDT members have been educated on the Transfer and Discharge expectations by DNS on 12/08/21. SSD was trained on 12/10/21 on the expectations of the Notice to Ombudsman along with advocacy information.<br><br>Monitoring for Compliance<br><br>Recent Transfers/Discharge Residents out of the facility will be reviewed in the am clinical meeting M-F by IDT. Specifically, the SSD and RCM will ensure the transfer/discharge documentation is complete. Recent Residents that have transferred/discharged will be reviewed by SSD and DNS to ensure Ombudsman and appropriate protection and advocacy has been notified. BOM will mail out/or email to the POA, with a mail receipt to satisfy the written part of the regulation.<br>Audits of Transfer/Discharge Notices will be conducted by the RCM or designee X 1-week X 12 weeks<br>Audits of Notice to the ombudsman and appropriate protection advocacy will be conducted by the SSD or designee X 1-week X 12 weeks.<br>Results of Audits will be brought to monthly QAPI for 3months for discussion and further recommendations.<br>An AdHoc QAPI meeting was held on December 15th, 2021 to discuss this POC and its adaptation.<br>Date of compliance: 1/7/22 | |

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| F 644 SS=D | Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br>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:<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to complete a preadmission screening and resident review (PASRR) level II as required for 1 of 2 residents (#18) reviewed with a qualifying diagnosis. The findings were:<br><br>1. Review of the 5/14/19 admission MDS assessment showed resident #18 had diagnoses which included non-Alzheimer's dementia and depression. The following concerns were identified.<br>a. Review of the 6/25/21 annual MDS assessment showed the resident had an additional diagnosis of bipolar disorder.<br>b. Review of the physician's diagnosis list | F 644 | F644<br>POC must contain the following:<br>- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>- How you will identify other residents having the potential to be affected by the same deficient practice(s) and what corrective actions will be taken;<br>- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice(s) does not occur; and,<br>- How you will monitor the corrective action(s) performance to make sure that | 1/7/22 |

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| F 644 | Continued From page 7<br>dated 11/18/21 showed vascular dementia with behavioral disturbance had been added.<br>c. Review of the medical record failed to show evidence of a completed PASRR level II<br>d. Interview with the ED on 12/8/21 at 4:45 PM revealed the facility was unaware a new qualifying diagnosis would trigger the need for a PASRR level II evaluation. | F 644 | solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implanted and the corrective action(s) evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction dates will be the date of the revisit; and<br>- Must include dates when corrective action(s) will be completed. The corrective action completion dates must be within acceptable time frames. If the plan of correction is unacceptable for any reason, you will be notified by this office. If the plan of correction is acceptable, you will be notified by telephone, e-mail, etc.<br>Please note that your facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of your plan of correction is not made timely. The plan of correction will serve as your facility□s allegation of compliance.<br>Regulation<br>F644 Coordination of PASRR and Assessments CFR(s): 483.20 ¿(1)(2)<br>Deficient Behavior<br>Based on Medical Record review, staff interview, and policy and procedure review, the facility failed to complete a preadmission screening and resident PASRR level II as required for 1 of 2 residents (#18) reviewed with a qualifying | |

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| F 644 | Continued From page 8 | F 644 | diagnosis.<br>Corrective Actions:<br>Resident #18 had a completed PASRR level II determination on 12/16/21.<br>Identification of Others:<br>Audit of all residents Diagnosis to ensure no resident review were missed, Five residents were found to have a need for a PASRR. Those five residents have had a completed level II determination. On 12/29/21 by Pam Kaplon.<br>Systemic Changes<br><br>IDT was educated on Policy and Expectation of the PASRR and resident review on 12/10/21.<br>Monitoring for Compliance<br><br>Audits of all diagnosis changes will be conducted by the RCM, MDS or designee X 1-week X 12 weeks<br>and results will be brought to the monthly QAPI for discussion and review.<br><br>An AdHoc QAPI meeting was held on December 15th, 2021 to discuss this POC and its adaptation.<br>Date of compliance: 1/07/22 | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 | F 656 | | 1/7/22 |

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| F 656 | Continued From page 9<br>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(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<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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 local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to ensure the care plan was implemented for 1 of 21 sample residents (#42). The findings were: | F 656 | F656<br>POC must contain the following:<br>- What corrective action(s) will be accomplished for those residents found to | |

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| F 656 | Continued From page 10<br><br>1. Review of the 8/26/21 admission MDS assessment showed resident #42 was admitted to the facility on 8/19/21 with diagnoses which included stage III pressure ulcer to the sacral area, adult failure to thrive, and Down's syndrome. The review showed the resident required extensive assistance of 2 staff members for transfer and mobility and required extensive assistance with all activities of daily living. Review of the 8/19/21 and 11/22/21 Braden assessments (a tool used to predict the risk for developing a pressure ulcer or injury) showed a score of 13 (moderate risk). Review of the care plan showed the following problem was identified on 8/19/21 and with a revision on 9/10/21: "[Resident #42] has a Stage 3 Pressure Ulcer to coccyx r/t (related to) extensive assist with bed mobility and bony prominences d/t (due to) immobility and cachexia. At risk for pressure ulcer development r/t extensive assist with bed mobility, bony prominences, potential for pressure induced tubing, and moist skin d/t immobility, cachexia, low BMI (body mass index) indwelling catheter, and bowel incontinence." The review showed interventions included, "...Assist to shift weight in W/C (wheelchair) q 15 minutes (every 15 minutes)...Educate the resident/family/caregivers as to the causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning." The following concerns were identified:<br>a. Observation on 12/7/21 from 1:52 PM until 4:47 PM (2 hours and 55 minutes) showed the resident was in a recliner on his left side across from the back nursing station near the aviary. Staff were frequently in the area, and with the exception of staff placing a blanket on the | F 656 | have been affected by the deficient practice;<br>- How you will identify other residents having the potential to be affected by the same deficient practice(s) and what corrective actions will be taken;<br>- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice(s) does not occur; and,<br>- How you will monitor the corrective action(s) performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implanted and the corrective action(s) evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction dates will be the date of the revisit; and<br>- Must include dates when corrective action(s) will be completed. The corrective action completion dates must be within acceptable time frames. If the plan of correction is unacceptable for any reason, you will be notified by this office. If the plan of correction is acceptable, you will be notified by telephone, e-mail, etc.<br>Please note that your facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of your plan of correction is not made timely. The plan of correction | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **WIND RIVER REHABILITATON AND WELLNESS** | **1002 FOREST DRIVE RIVERTON, WY 82501** |

| (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 |
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| F 656 | Continued From page 11<br>resident, no other assistance was provided. The resident never attempted to reposition during the observation and the resident remained on his/her left side during the observation.<br>b. Observation on 12/8/21 from 10:37 AM until 11:47 AM (1 hour and 10 minutes) showed the resident was at the front of the facility near the front door in his/her wheelchair. Staff were in the area at intervals, however the resident was not repositioned at any time during the observation. The resident never attempted to reposition during the observation.<br>c. Review of the 9/21/21 Skin and Wound Evaluation showed the resident's sacral wound had no measurable depth, with a length of 2.3 centimeters (cm), and a width of 1.5 cm. Review of the 11/30/21 Weekly Skin Evaluation showed the resident's sacral wound had a category of "Worsening." At that time, the sacral wound measurements were of 3.2 cm long, 3.0 cm wide, and 0.3 cm deep.<br>d. Observation of the sacral wound with the DNS and charge nurse on 12/8/21 at 3:50 PM showed the measurements of the wound to be 4.7 cm long and 3.7 cm wide, with no depth. The area was pink and dry without any eschar area, and the wound care was adequate.<br>e. Interview with the DNS and corporate nurse on 12/8/21 at 5:36 PM revealed the DNS's expectation was to reposition the resident approximately every 2 hours when not in his/her wheelchair and confirmed the 2 hours and 55 minute observation was too long. In addition, the DNS confirmed staff were to follow the care plan when repositioning the resident, which included the requirement of staff to reposition the resident every 15 minutes while in his/her wheelchair. | F 656 | will serve as your facility□s allegation of compliance.<br>Regulation<br>F656 Develop/Implement Comprehensive Care Pan CFR (s): 483.21(b)(1)<br>Deficient Behavior<br>Based on observation, staff and family interview, and medical record review, the facility failed to ensure the care plan was implemented for 1 of 21 sample residents (#42) reviewed for individualized plans of care.<br>Corrective Actions:<br>Care Plans for the identified residents #42 have been revised on 12/08/21 by Kayla Schubach RN MDS; to address individualized care.<br><br>Identification of Others<br>Care Plans have been reviewed on 12/08-12/09/21 for of the current residents, to ensure individualized care.<br>Systemic Changes<br>Licensed Nurses and IDT members have been educated on the Care Plan expectations ensuring they are individualized by Jessica Ortiz RN DNS on 12/08/21.<br><br>Monitoring for Compliance<br>New Admits will be reviewed in clinical meeting, at 72-hour meeting to ensure the care plan is individualized. LTC residents will be reviewed quarterly during their assessment and at any change of condition. In addition, the PCC Dashboard | |

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| F 656 | Continued From page 12 | F 656 | will be used to monitor daily (M-F), for upcoming Care Plan revisions to alert the IDT.<br>Audits of Care Plans will be conducted by the MDS nurse or designee weekly X 1 week X 4weeks then Monthly X 2 Months. Results of Audits will be brought to monthly QAPI for 3months for discussion and further recommendations<br>An AdHoc QAPI meeting was held on December 15th,2021 to discuss this POC and its adaptation. Date of compliance:_____1/7/22 | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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; | F 880 | | 1/7/22 |

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| F 880 | Continued From page 13<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. | F 880 | | |

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| F 880 | Continued From page 14<br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and policy and procedure review, the facility failed to ensure infection prevention practices were followed for 3 random observations of wound care and enteral feeding which affected residents #3, #9, and #44. The findings were:<br><br>1. Observation on 12/8/21 at 11:15 AM showed LPN #1 performed wound care for resident #3. The LPN carried supplies in and places them on an uncleaned over-the-bed table (OBT), and donned gloves without performing hand hygiene. The nurse dropped the tube of protective zinc cream on the floor, picked it back up, and proceeded to perform the resident's wound care. LPN #1 failed to perform hand hygiene before performing an aseptic task and after contact with a contaminated surface.<br><br>2. Observation on 12/8/21 at 11 AM showed LPN #1 performed wound care for resident #9. The nurse carried in the dressing change supplies and a trash bag and placed them on an uncleaned OBT. The LPN donned gloves without performing hand hygiene, opened the dressing packets and put the supplies on the OBT. The nurse cleaned the stool off of the resident's buttocks, removed the old dressing, and took off the dirty gloves. Without performing hand hygiene LPN #1 donned new gloves and proceeded with the dressing change. The nurse failed to perform hand hygiene before performing an aseptic task and after contact with the resident's stool. | F 880 | F880<br>POC must contain the following:<br>- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>- How you will identify other residents having the potential to be affected by the same deficient practice(s) and what corrective actions will be taken;<br>- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice(s) does not occur; and,<br>- How you will monitor the corrective action(s) performance to make sure that solutions are sustained. You must develop a plan for ensuring that correction is achieved and sustained. This plan must be implanted and the corrective action(s) evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction dates will be the date of the revisit; and<br>- Must include dates when corrective action(s) will be completed. The corrective action completion dates must be within acceptable time frames. If the plan of correction is unacceptable for any reason, | |

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| F 880 | Continued From page 15<br>3. Observation on 12/8/21 at 2:15 PM showed LPN #1 gathered supplies and placed them on an uncleaned OBT to perform the tube feeding for resident #44. Without performing hand hygiene LPN #1 donned gloves and proceeded with the tube feeding. LPN #1 failed to perform hand hygiene before performing an aseptic task.<br><br>4. Interview with LPN #1 on 12/8/21 at 2:37 PM confirmed she always performed the procedure as demonstrated.<br><br>5. Interview with the DNS on 12/8/21 at 4:05 PM revealed it was the facility's expectation that hand hygiene be performed before donning gloves and after removing gloves. Interview with the ED on 12/9/21 at 8:35 AM confirmed hand hygiene should be done as per facility policy.<br><br>6. Review of policy "Handwashing/Hand Hygiene" ... updated March 2018 showed "...7. Use an alcohol-based hand rub containing at 62% alcohol, or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; ...f. Before donning sterile gloves; g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; ...j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc., l. After contact with objects (e.g. medical equipment in the immediate vicinity of the resident; m. After removing gloves. | F 880 | you will be notified by this office. If the plan of correction is acceptable, you will be notified by telephone, e-mail, etc. Please note that your facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of your plan of correction is not made timely. The plan of correction will serve as your facility□s allegation of compliance.<br>Regulation<br>F880- Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br>Deficient Behavior<br>This Requirement is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure infection prevention practices were followed for 3 random observations of wound care and enteral feeding which affected residents #3, #9, and #44.<br>Corrective Actions:<br>Resident #3 is receiving wound care, ensuring infection prevention practices are followed.<br>Resident #9 is receiving wound care, ensuring infection prevention practices are followed.<br>Resident #44 is receiving enteral feeding, ensuring infection prevention practices are followed.<br>Identification of Others<br>Audit of 20 residents for wound care was conducted with multiple Licensed Nurses by Jessica Ortiz RN, DNS, IP on 12/10/2021 and 12/13/2021 to ensure infection prevention practices were | |

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| F 880 | Continued From page 16 | F 880 | followed. Any discrepancies found were corrected immediately. No other residents receiving enteral feeding at this time.<br>Systemic Changes<br>Immediate education to staff on hand hygiene per CDC and CMS guidelines conducted on 12/10/2021 by Jessica Ortiz RN, DNS, IP. Appropriate competencies will be reviewed and renewed with appropriate staff and Licensed Nurses.<br>Ongoing audits will be conducted via Jessica Ortiz RN, DNS, IP and/or appointed designee(s) for affected residents along with other residents at random.<br>Monitoring for Compliance<br>Audit to ensure appropriate infection prevention practices are followed will be completed by IP or designee(s): No less than weekly X12 weeks, no less than monthly X3 months, until the facility completes sustained compliance. Results of audits will be brought to monthly QAPI meeting X3 months for discussion and further recommendations.<br>An AdHoc meeting was held on December 15th, 2021 to discuss this POC and its adaptation.<br>Date of compliance 01/07/2022 | |