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 _____	C 12/17/2021

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

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 12/12/21 to 12/17/21. Also reviewed in the course of the survey was complaint intake WY00003336. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living ADON- Assistant Director of Nursing BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide CMS- Centers for Medicare and Medicaid Services MDS- Minimum Data Set NIOSH-National Institute for Occupational Safety and Health RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
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;	F 623		1/14/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/14/2022

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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 receives such requests; and information on how

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F 623	Continued From page 2	F 623		

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 well as the plan for the transfer and adequate

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F 623	Continued From page 3 relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review, and resident and staff interview, the facility failed to include all required elements of notification for 1 of 2 sample residents (#52) reviewed for discharge notices. The findings were: 1. Review of the 9/9/21 admission MDS assessment showed resident #52 was admitted to the facility on 9/2/21. On 12/1/21, the facility initiated a discharge for the resident, with the discharge effective 12/31/21. The following concerns were identified: a. Interview with the resident on 12/14/21 at 10:15 AM revealed the facility had notified the resident s/he would be discharged "... at the end of the month..." S/he further stated the facility had given her a letter explaining the circumstances surrounding the discharge, and that facility staff were helping him/her "... make plans for when I get out of here." b. Review of the 12/1/21 involuntary discharge notification letter showed a discharge effective date of 12/31/21, along with instruction resources for appeal. These instruction resources included contact information for the facility social worker, the county health department, the state and local ombudsmen, and resources for the developmentally disabled and those with mental illness. However, there was no contact information for the Wyoming Department of Health Aging Division, Healthcare Licensing and Surveys. c. Interview with the Admissions/Marketing Director on 12/17/21 at 10:12 AM confirmed the letter issued to the resident did not contain the	F 623	F623 Correction: Facility issued a new thirty-day notice of discharge letter to Resident #52, which included the Wyoming Department of Health Aging Divisions, Healthcare Licensing and Surveys. This was done on 12/17/22. Identification: Residents currently residing in the facility has been reviewed to ensure that any Residents who are in possession of a discharge notice initiated by the facility, contains all the appropriate notifications. New letters will be issued with corrected dates if necessary. This was completed by the Director of Admissions. Systemic: The Administrator has provided education with the Social Services Director and Assistant on all the required components for notification prior to issuing a 30-day discharge notice, that must be on the letter per CMS regulation F623. All discharge notices will be reviewed by Social Services Consultant prior to being given to be sure that all notifications and information has been made and is clearly outlined on the notice. Monitoring: The NHA will trend any issues from these reviews and report on them to the QAPI Committee Monthly x3 to make sure that this process is maintained.	

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F 623	Continued From page 4 contact information for the Wyoming Department of Health Aging Division, Healthcare Licensing and Surveys, or reference the resident's right to appeal the involuntary discharge to that agency. She further stated the mistake would be corrected, and a new letter would be issued to the resident; the new letter would contain a new effective date 30 days from the date of notification.	F 623		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of manufacturer's instructions, the facility failed to ensure accident hazards were evaluated for 1 of 10 sample residents (#10) reviewed for falls. The findings were: 1. Review of the 9/2/21 quarterly MDS assessment showed resident #10 was admitted to the facility on 6/16/14 with diagnoses that included dementia, chronic pain, localized edema, and muscle weakness. Review of current physician orders showed an 8/4/21 order for "Occupational Therapy Evaluation and Treatment for [wheelchair] positioning and mobility" an order dated 6/30/20 to "Check	F 689	F689 Correction: Resident #10 has had a Pre-physical Restraint Assessment completed by 1/17/22. His/her care plan has been updated to reflect the current use of his interventions. Identification: Residents currently resident in the facility who have bed bolsters in place have had a Pre-Physical Restraint Assessment completed by the IDT, to ensure that they are appropriate for the Resident. Their care plans have been updated. Systemic:	1/17/22

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F 689	Continued From page 5 Air-Mattress to ensure properly inflated every shift", and a 3/13/20 order for "Fall Precautions every shift." Review of the resident's 1/16/21 Interdisciplinary Post Fall review showed the resident fell out of bed, sustaining a laceration to his/her left eyebrow and a wound to his/her left cheek. Further review showed intervention recommendations were "...inflated bolsters on air bed." Review of the resident's current care plan, last revised 9/9/21, showed ADL interventions included "Bed Mobility: [resident] is anywhere from supervision/set-up to extensive assistance of 1-2 with bed mobility" and fall risk interventions included "Air mattress with bolsters." Observation on 12/13/21 at 1:58 PM showed the resident sitting up in bed, with the head of the bed raised. The resident was on a specialty air mattress that appeared to be curved and raised along the outer edges, with additional triangular pads that appeared to be attached to the mattress along the edges of the bed. The following concerns were identified: a. Review of the resident's 12/13/21 Interdisciplinary Post Fall Review showed the resident fell out of bed. Further review showed "[The resident] was given a new air mattress and it did not have bolsters. This is the cause of fall" and "Therapy was notified and bolsters are being ordered." b. Interview with the therapy director on 12/16/21 at 1:16 PM confirmed the resident had sustained falls from his/her bed, and bolstered mattresses were used as an intervention. She further stated the resident had recently received a new air mattress that did not have bolsters, and the resident fell out of bed on 12/13/21. She stated the old bolsters were attached and correct ones had been ordered. When asked about a safety evaluation performed for the bolstered	F 689	Interdisciplinary Team will be educated by on initiating appropriate assessments when they implement interventions for falls, this will be completed by the Director of Clinical Operations. Facility Nurses have been educated on the appropriate assessments to complete, when, why and how often they need to be completed. This will be done by the DON/designee. Maintenance will be educated by the Therapy Director on importance of when a request for changing out mattresses are made if the new mattress is not equipped with the same interventions as the mattress being removed to ask the therapy department prior to removal of the mattress. Ambassadors are making rounds on their designated residents at least 3x per week, at different times of the day. They will specifically look for areas that may be considered enabling or restraining to the resident. Ambassador Rounds are reviewed at the AM Morning Meeting Monday through Friday, issues noted during these rounds will be brought up so that the IDT can follow up and ensure assessments are in place. Monitoring: The NHA/designee will track and trend the issues they have been brought up at AM meeting and will submit a report to the monthly QAPI Committee X3 to ensure that compliance is maintained.	

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F 689	Continued From page 6 mattress, she confirmed the facility had no documented risk assessment for the resident and his/her bolstered mattress. c. Interview with the regional nurse on 12/15/21 at 12:40 PM revealed "...a bolstered mattress is implemented after a resident has a fall ..." When asked about evaluating safety risk for the bolstered mattresses on 12/15/21 at 5:35 PM, she revealed "...the bolsters were designed specifically for the mattress...so we don't do that." d. Review of the 11/24/21 Occupational Therapy Discharge Summary showed the resident had been evaluated for wheelchair positioning, safety, and ability. Further review showed no documentation related to mobility, or risk assessments in relation to the air mattress, or the bolsters. e. Review of the undated manufacturer's operation manual for the air mattress showed "...variations in...conditions such as dementia...could create an entrapment risk. Proper patient assessment, monitoring, equipment use, and maintenance are required to reduce entrapment risk."	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		1/19/22

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F 690	Continued From page 7 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure appropriate indwelling catheter care was performed for 2 of 2 sample residents (#33, #50) with an indwelling catheter. The findings were: 1. Review of the quarterly MDS assessment dated 10/5/21 showed resident #33 had diagnoses which included diabetes mellitus, anxiety disorder, depression, parastomal hernia with obstruction, pressure ulcer of right hip, muscle wasting and atrophy, and acute pyelonephritis. The resident had a BIMS score of	F 690	F690 Correction: Resident #33 and #50 are receiving appropriate indwelling catheter care per order. Identification: Residents currently residing in the facility with an indwelling catheter have been reviewed to ensure that they are showing no signs or symptoms of improper catheter care which would lead to an infection. Systemic: Facility C.N.A□s and MA-C□s have	

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F 690	Continued From page 8 14 out 15 which indicated the resident was cognitively intact. Further review showed the resident had an indwelling catheter, and required total physical assistance of 2 or more people for transfers, required extensive physical assistance of 2 or more people for bed mobility, dressing, and toilet use, and required extensive assistance of 1 or more people for personal hygiene. Review of the "Urinary Indwelling Catheter" care plan last revised on 12/15/21 showed interventions which included "...position catheter bag and tubing below the level of the bladder..." The following concerns were identified: a. Observation on 12/15/21 at 3:35 PM showed medication aide (MA-C) #1 and CNA #2 entered the resident's room, explained care, and applied gloves. MA-C #1 removed the resident's brief and CNA #2 performed incontinence care. The CNA used the wipe in a back and forth manner without changing the side of the wipe used and wiped toward the resident's genitals. The CNA and MA-C assisted the resident to lay on his/her right side toward the window, at that time, stool was visible on the resident's buttocks. The CNA performed incontinence care by wiping back and forth 3 times with a wipe, wiping stool toward the resident's genitals. The CNA obtained a pair of pants while the MA-C removed the catheter drainage bag from the side of the bed. The MA-C handed the drainage bag to the CNA, who attempted to thread the bag through the resident's pants. At that time, the drainage bag was observed to be above the level of the resident's bladder, and urine in the tube was observed to flow backward toward the resident's bladder. The MA-C and CNA dressed the resident in his/her pants and prepared the resident for transfer by placing a lift sling under the resident. The sling was attached to the mechanical lift, and	F 690	completed return demonstrations on completing catheter care, by the Staff Develop Coordinator/designee. This was completed by 1/19/22. Facility Nursing Staff have completed transfer training with return demonstration of catheter placement while completing transfers in various ways to include while utilizing a lift while keeping the catheter below the level of the bladder, and with positioning catheters on beds, to avoid causing tension, and using a leg strap if resident will allow. This was completed by DON/designee by 1/19/22. DON/designee completed random observations of catheter care, transfers observing placement and tension of catheters. She will observe 10 per month x1 month, then 5 per month x2 months. Monitor: DON/designee will trend issues identified from her audit and education given, and report on this to the QAPI Committee Monthly x3, to ensure that compliance is maintained.	

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the MA-C then attached the drainage bag to the lift sling. As the resident was lifted in the sling, the drainage bag was elevated above the resident's bladder and urine was observed to flow backward toward the resident's bladder. After positioning the resident in the wheelchair, the MA-C disconnected the drainage bag from the mechanical lift sling and placed the drainage bag directly on the floor.

2. Review of the 10/20/21 quarterly MDS assessment showed resident #50 was admitted to the facility with diagnoses that included rhabdomyolysis, acute kidney failure, benign prostatic hyperplasia with lower urinary tract symptoms, other obstructive and reflux uropathy, retention of urine, urinary tract infection, and other specified sepsis. Review of current physician orders showed orders written 6/17/21 that included "Encourage resident to drink at least 2-3[liters] per day to prevent catheter clogging every shift ... Encourage use of leg catheter bag during day while awake and bed bag at night. Document refusals of leg bag every day shift ... Flush foley catheter every 6 hours ... Insert 18 [French] Urethral indwelling urinary catheter, 10 [cubic centimeter] balloon due to urinary retention with closed drainage system ... Provide catheter cleansing and perineal hygiene daily and [as needed] if soiled every shift" and "Use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow. Rotate site of securement daily and [as needed] every day shift." Review of the current care plan, last updated 12/15/21, showed the resident " ...is at risk for back flow and UTI" with interventions that included "... Position catheter bag and tubing below the level of the bladder", "Check tubing for kinks frequently each shift", and

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F 690	Continued From page 10 "Observe/document for pain/discomfort due to catheter." The following concerns were identified: a. Observation of the resident on 12/13/21 at 2:35 PM showed the resident lying on his back on his bed. S/he was crying out, and pulling at his/her catheter tubing. The tubing was stretched somewhat tight, with very little slack, and the catheter bag was attached to the side of the bed. The bed was in its lowest position, resulting in the catheter bag lying on the floor. b. Observation of the resident on 12/13/21 at 4:51 PM showed the resident asleep in his/her bed. The catheter bag was attached to the side of the bed, with the bed in the lowest position, again leaving the bag lying on the floor. 3. Interview with the infection preventionist on 12/16/21 at 11:15 AM revealed the expectation during incontinence care was to use a wipe one time, wipe front to back, and discard the wipe. Further interview with the infection preventionist and ADON on 12/16/21 at 12:40 PM revealed the expectation for the catheter bag was " ...to be below the bladder and hanging of the side of the bed." Both staff members confirmed the bag should never be lying on the floor. 4. Review of the policy titled "Catheter Care, Urinary" last revised on September 2014 showed "...Maintaining Unobstructed Urine Flow...3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder...Infection Control...2...b. Be sure the catheter tubing and drainage bag are kept off the floor..."	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)	F 693		1/14/22

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F 693	Continued From page 11 §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. 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 standards and orders were followed for 1 of 1 sample residents (#67) related to an enteral feeding tube. The findings were: 1. Review of the current physician orders showed resident #67 was admitted to the facility on 10/22/21 with diagnoses that included gastrostomy status, acute embolism and thrombosis of left femoral vein, hypertensive crisis, muscle weakness, dementia, atrial fibrillation, personal history of transient ischemic	F 693	F693 Correction: Resident #67 is no longer residing at the facility. Identification: Residents currently residing in the facility who receive their medication through the peg tube were reviewed to ensure that their medications are ordered and being given appropriately. This was completed by Nurse Management. Systemic: Facility Nurses have been educated and are completing a return demonstration on	

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F 693	Continued From page 12 attack (TIA), hypertension, chronic embolism and thrombosis of unspecified femoral vein and tibial vein, drug induced subacute dyskinesia, dysphagia, and bed confinement status. Further review showed 10/22/21 orders for "Enteral Feed Order every shift Flush with 30-60ml water before and after meds, before initiating feedings or when there is an interruption of feeding to maintain tube patency" and "Enteral Feed Order every shift Flush with 5-10mLs [water] between each medication." The following concerns were identified: a. Observation of medication administration on 12/16/21 at 8:27 AM showed RN #2 preparing medications for the resident. She prepared one diltiazem (treats high blood pressure) 30 milligram (mg) tab, one apixaban (for blood clot prevention) 5 mg tab, one Lisinopril (treats high blood pressure) 5 mg tab, 10 milliliters (mL) of levetiracetam (seizure prevention), and 10 mL of amantadine (used to help control involuntary muscle movements). The three pills were all crushed together and placed into a cup, then the two liquid medications were added to the cup. RN #2 then stirred all the medications together with a tongue depressor. After entering the resident's room, she stopped the continuous enteral feed pump, clamped the tubing, placed a washcloth on the resident's abdomen, and disconnected the tubing from the enteral tube, placing the enteral tube on the washcloth. After checking placement and stomach residual, she drew the mixture of medications up into a large syringe, inserted the syringe into the enteral tube, unclamped the tubing, and administered the medications by pushing the plunger of the syringe, administering all the medications at once. She then drew up approximately 50 mL of water into the same syringe, and flushed the enteral tube by	F 693	administrating medications via peg tube. Making sure medications are given separately with a flush given in between unless ordered otherwise. Upon admission of a resident with a tube feed, the DON will complete random observations of the nurses completing medication pass via tube feed. She will complete 5 per month x3 months. Newly hired nurses will be educated on the appropriate process for administration of medication via peg tube by the SDC. Monitoring: DON/designee will report on issues that become identified from doing audits on medications administered via tube feed to the QAPI, once a Resident is admitted with one. This will be done for 3 months to make sure that staff are complaint with the correct process.	

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F 693	Continued From page 13 administering the water. She stated she didn't want to do additional flushes since the resident was incontinent, and received water through his/her feedings. The RN then reattached the continuous enteral feed tubing and restarted the pump. b. Interview with RN #2 on 12/16/21 at 11:27 AM confirmed she administered all the medications at once. She further revealed she was not aware the medications needed to be administered separately, or to administer flushes between each medication. c. Review of the facility policy "Administering Medications through an Enteral Tube", last revised November 2018, showed "Preparation 1. Verify that there is a physician's medication order for this procedure." "General Guidelines...3. Administer each medication separately and flush between medications...6. Use warm, purified water for diluting medications and for flushing." "Steps in the Procedure...7. Stop feeding and flush tubing with at least 15 mL warm purified water (or prescribed amount)...9. Dilute medication: ...b. Dilute crushed (powdered) medication with at least 30 mL purified water (or prescribed amount). c. Dilute liquid medication with 30 mL or more (depending on viscosity) purified water. 10. Administer each medication separately...13. If administering more than one medication, flush with 15 mL of warm purified water (or prescribed amount) between medications."	F 693		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		1/14/22

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F 759	Continued From page 14 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to maintain a medication error rate of less than 5%. Errors occurred with 5 out of 27 medications observed resulting in an error rate of 18.52%. The findings were: 1. Observation of medication administration on 12/16/21 at 8:27 AM showed RN #2 prepared one diltiazem (treats high blood pressure) 30 milligram (mg) tab, one apixaban (for blood clot prevention) 5 mg tab, one Lisinopril (treats high blood pressure) 5 mg tab, 10 milliliters (mL) of levetiracetam (seizure prevention), and 10 mL of amantadine (used to help control involuntary muscle movements). The three pills were all crushed together and placed into a cup, then the two liquid medications were added to the cup. RN #2 stirred all the medications together with a tongue depressor. After entering the resident's room, she stopped the continuous enteral feed pump, clamped the tubing, placed a washcloth on the resident's abdomen, and disconnected the tubing from the enteral tube, placing the enteral tube on the washcloth. After checking placement and stomach residual, she drew the mixture of medications up into a large syringe, inserted the syringe into the enteral tube, unclamped the tubing, and administered the medications by pushing the plunger of the syringe, administering all the medications at once. She then drew up approximately 50 mL of water into the same syringe, and flushed the enteral tube by administering the water. She stated she didn't want to do additional flushes since the resident	F 759	F759 Correction: The facility currently has no residents receiving medications via peg tube. Identification: Residents currently residing in the facility who receive their medication through the peg tube were reviewed to ensure that their medications are ordered and being given appropriately. This was completed by Nurse Management. Systemic: Facility Nurses have been educated and are completing a return demonstration on administrating medications via peg tube. Making sure medications are given separately with a flush given in between unless ordered otherwise. Upon admission of a resident with a tube feed, the DON will complete random observations of the nurses completing medication pass via tube feed. She will complete 5 per month x3 months. Newly hired nurses will be educated on the appropriate process for administration of medication via peg tube by the SDC. Monitoring: DON/designee will report on issues that become identified from doing audits on medications administered via tube feed to the QAPI, once a Resident is admitted with one. This will be done for 3 months to make sure that staff are complaint with the correct process.	

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F 759	Continued From page 15 was incontinent, and received water through his/her feedings. The RN then reattached the continuous enteral feed tubing and restarted the pump. The following concerns were identified: a. Interview with RN #2 on 12/16/21 at 11:27 AM confirmed she administered all the medications at once. She further revealed she was not aware the medications needed to be administered separately, or to administer flushes between each medication. b. Review of the facility policy "Administering Medications through an Enteral Tube", last revised November 2018, showed "Preparation 1. Verify that there is a physician's medication order for this procedure." "General Guidelines...3. Administer each medication separately and flush between medications...6. Use warm, purified water for diluting medications and for flushing." "Steps in the Procedure...7. Stop feeding and flush tubing with at least 15 mL warm purified water (or prescribed amount)...9. Dilute medication: ...b. Dilute crushed (powdered) medication with at least 30 mL purified water (or prescribed amount). c. Dilute liquid medication with 30 mL or more (depending on viscosity) purified water. 10. Administer each medication separately...13. If administering more than one medication, flush with 15 mL of warm purified water (or prescribed amount) between medications."	F 759		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		1/14/22

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F 812	Continued From page 16 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of cleaning schedules, the facility failed to ensure hand hygiene practices were followed and that kitchen and dish room surfaces were maintained in a clean and sanitary manner for 1 of 1 kitchens and 1 of 1 dish room. The census was 83. The findings were: 1. Observation showed the following hand hygiene concerns: a. On 12/15/21 at 11:25 AM cook #1 handled the walk-in door with her gloved hands and put food into the microwave oven with no disposal of the gloves. She then proceeded to dish up the resident's food while continuing to wear the gloves. b. On 12/15/21 at 11:42 AM cook #1 handled the walk-in door with her gloved hands and without hand hygiene or changing gloves she handled the ham and bread to make grilled sandwiches. c. On 12/15/21 at 11:43 AM dietary aide #1 entered the kitchen wearing gloves and handled	F 812	F812 Correction: Facility Dietary Staff have been educated on hand hygiene and changing of gloves by 1/14/22. The Hood vents were re-cleaned by 1/14/22. The Dietary floors have been cleaned, including scrubbing in the corners and cleaning under the equipment. Under the sink in the Kitchen has been cleaned. The ceiling vent has been cleaned and the surrounding tile has also been cleaned. The ceiling vent in the dish room has been cleaned and the area around the dish machine on the wall and the floor has been scrubbed. Identification: Residents currently residing in the facility are at potential risk for this deficient practice. Systemic:	

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F 812	Continued From page 17 the closed door into the kitchen. Without removing the gloves, the aide left the kitchen and when she returned a couple of minutes later she continued to be wearing gloves. The aide then disposed of the gloves; however, there was no hand washing or hand hygiene prior to donning new gloves and proceeding to dish up food for the residents. 2. Observation on 12/13/21 at 1:55 PM showed the following concerns related to cleanliness in the kitchen: a. The hood vents were soiled with a coating of grease and dust. b. The kitchen floor was soiled around the room edges and under equipment with food, grime, and paper debris. c. The area under the sink was soiled with accumulated grime and crumbling flooring. d. Two ceiling vents and the surrounding tiles in the kitchen above food preparation areas were soiled with dust and grease. 3. Observation in the kitchen on 12/15/21 at 11:18 AM showed the hood vents had been cleaned, however, the other items remained in need of cleaning. 4. Observation in the dish room on 12/15/21 at 10:55 AM showed the ceiling vent in the center of the room had thick accumulated dust in the visible interior/exterior spaces. In addition, the area under the dish machine was in poor condition with greenish/black discoloration on the wall and floor. 5. Review of the cleaning schedules showed the hood vents and floors in the kitchen and dish room were included to be deep cleaned weekly.	F 812	Dietary Manager has been educated by the Administrator on the cleanliness of the Kitchen and they have reviewed the cleaning schedule together. The Dietary Manager and the Administrator have added a monthly deep cleaning of both the kitchen and dish room to the monthly calendar. Dietary Staff have been educated on Hand Hygiene and have also completed a return demonstration with Infection Preventionist. The education also included appropriate glove use, when to discard gloves, cleaning schedules, monthly deep cleaning addition. Maintenance has installed 2 new glove stations by the kitchen sinks. The NHA and IP will complete weekly rounds in the Dietary department weekly for 1 month then bi-weekly for 2 months. They will monitor for cleanliness, glove use, handwashing. Education will be given as needed. New hires will be educated on Hand Hygiene and have also completed a return demonstration with Infection Preventionist. The education also included appropriate glove use, when to discard gloves, cleaning schedules, monthly deep cleaning as part of the orientation process. Monitoring: The NHA will trend the issues from his dietary audits and present them to the Monthly QAPI Committee x3 months, to ensure that the cleanliness of the dietary is maintained. The SDC will trend the issues from his glove use audits and hand hygiene return	

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F 812	Continued From page 18 6. Interview with the dietary director on 12/15/21 at 12:30 PM verified these items needed to be cleaned more frequently, including the ceiling tiles, and the floors. He further confirmed the staff should be changing gloves when they became contaminated and prior to new gloves. 7. According to Food Code 2017, U.S. Public Health Service: 2-301.14 "FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLE and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that	F 812	demonstrations and present them to the Monthly QAPI Committee x3 months, to ensure that staff remains compliant.	

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F 812	Continued From page 19 contaminate the hands." 8. According to Food Code 2017, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		1/19/22

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F 880	Continued From page 20	F 880		

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.

§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

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F 880	Continued From page 21 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 appropriate infection control practices to prevent cross-contamination were met during 1 of 3 observations of resident care care (resident #33). Further, the facility failed to ensure COVID-19 policies and procedures were reviewed at least annually. The findings were: Related to infection control practices: 1. Review of the quarterly MDS assessment dated 10/5/21 showed resident #33 had diagnoses which included diabetes mellitus, anxiety disorder, depression, parastomal hernia with obstruction, pressure ulcer of right hip, muscle wasting and atrophy, and acute pyelonephritis. The resident had a BIMS score of 14 out 15 which indicated the resident was cognitively intact. Further review showed the resident had an indwelling catheter, and required total physical assistance of 2 or more people for transfers, required extensive physical assistance of 2 or more people for bed mobility, dressing, and toilet use, and required extensive assistance of 1 or more people for personal hygiene. The following concerns were identified: a. Observation on 12/15/21 at 3:35 PM showed medication aide (MA-C) #1 and CNA #2 entered the resident's room, explained care, and applied gloves. MA-C #1 removed the resident's brief and CNA #2 performed incontinence care. The CNA used the wipe in a back and forth manner without changing the side of the wipe used and wiped toward the resident's genitals. The CNA and MA-C assisted the resident to lay	F 880	F880 Correction: The policies in relation to covid have been updated to reflect that the facilities will refer to the latest CMS directives for the most updated changes. All of these have been reviewed through the QAPI process. Resident #33 are receiving appropriate indwelling catheter care per order. C.N.A #2 and the MA-C #1, have been educated on handwashing and glove usage. Both have had return demonstration on hand hygiene and peri care completed by the Staff Development Coordinator. Identification: Residents who currently reside in the facility are at potential risk for this deficient practice. Systemic: Facility C.N.A□s and MA-C□s have completed return demonstrations on completing proper peri care/catheter care, by the Staff Develop Coordinator/designee. This was completed by 1/19/22. The NHA has been educated by the Director of Clinical Operations to ensure that the Policies are reviewed on an Annual basis, and that any updates that CMS sends to NHA□s that indicates a Final Rule must be reviewed through QAPI, communicated and referenced to as a facility Policy. This was completed by 1/14/22 The facility will educate the staff on all	

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F 880	Continued From page 22 on his/her right side toward the window, at that time, stool was visible on the resident's buttocks. The CNA performed incontinence care by wiping back and forth 3 times with a wipe, wiping stool toward the resident's genitals. After removing the stool, the CNA placed her gloved hands on the resident's thigh without removing gloves. Observation showed the CNA moved her hands to the resident's back, onto the resident's shirt to assist the resident with positioning while the MA-C performed wound care. The CNA did not change her gloves prior to touching the resident's clothing. While performing the wound care, the CNA removed her gloves and returned her ungloved hands to the resident's contaminated shirt. Further observation showed the MA-C and CNA assisted the resident out of bed and into his/her wheelchair, and the resident's shirt was not changed. b. Interview with the infection control nurse on 12/16/21 at 11:15 AM confirmed the CNA should not have wiped back and forth while performing perineal care, and should have changed gloves prior to touching the resident or resident's clothing to prevent cross-contamination. Related to COVID-19 policies and procedures: 2. Review of the infection control policies showed the facility used the "Infection Control Policy and Procedure Manual" produced by MED-PASS, Inc. for the majority of the Coronavirus Disease (COVID-19) related policies. Further review showed the following COVID-19 policies and procedures were not reviewed or updated annually: a. Education and Training (Revised July 2020) b. Managing Supplies and Resources	F 880	updates to the Facility Covid Policies by the NHA/designee by 1/19/22. The NHA will review any updates for newly implemented Final Rules on guidance□s from CMS, bring it through an Ad-Hoc QAPI process with the Committee. These will be passed to the Infection Preventionist and SDC to educate the appropriate staff, a copy will be placed in the Infection Control Policy Manual affected Policy, until an updated policy is received from Med Pass to reflect the most recent changes. DON/designee completed random observations of peri care/catheter care. She will observe 10 per month x1 month, then 5 per month x2 months. Monitor: DON/designee will trend issues identified from her audit and education given, and report on this to the QAPI Committee Monthly x3, to ensure that compliance is maintained. NHA/designee will track updates on Covid Policies and report on them monthly to the QAPI Committee.	

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F 880	Continued From page 23 (Revised July 2020) c. Overview of Prevention and Control Strategies (Revised July 2020) d. Phased Reopening (Dated July 2020) e. Reporting Facility Data to Residents and Families (Dated May 2020) f. Occupational Health (Revised July 2020) g. Testing and Return to Work Criteria for Healthcare Personnel (Dated August 2020) h. Visitation (this policy and procedure was undated and was not part of the MED-PASS, Inc. manual). 4. Interview with the administrator on 12/17/21 at 9:45 AM verified they had not reviewed all COVID-19 policies annually. Further, when there were updates from CMS they would usually print out the guidance and use the CMS issued memos as the current process. However, the administrator confirmed he was unaware of the CMS memo or guidance from the "QSO-20-38-NH Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements." Revised on 9/10/21.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883		1/19/22

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F 883	Continued From page 24 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883		

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F 883	Continued From page 25 and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on medical record review, immunization reports, policy and procedure review, and staff interview, the facility failed to ensure all required documentation was included in the resident's medical record for 4 of 5 sample residents (#25, #38, #62, #65) reviewed for immunizations. The findings were: 1. Review of the medical record showed resident #25 was administered an influenza vaccination on 11/11/21. Review of the immunization report showed the resident was administered the Pneumovax 23 immunization on 4/15/21. However, further review failed to show evidence the resident or resident's representative was provided education regarding the benefits and potential side effects of either immunization. 2. Review of the medical record showed resident #38 was administered an influenza vaccination on 11/11/21. Review of the immunization report showed the resident was administered the pneumovax immunization on 4/22/21. However, further review failed to show evidence the resident or resident's representative was provided education regarding the benefits and potential side effects of either immunization. 3. Review of the medical record showed resident #62 was administered an influenza vaccination on 11/17/21. Review of the immunization report	F 883	F883 Correction: Facility has obtained the appropriate form to obtain consent for the Influenza and/or Pneumococcal vaccines, which prompts the Nurse when calling or talking with them to obtain consent, to discuss the risk and benefits associated with the Resident□s receiving the vaccines prior to them giving their consent. Residents cited will use this form to ensure education and consent prior to next immunizations. Identification: Residents who currently reside in the facility are at potential risk for this deficient practice. Systemic: Nurse Managers have been educated on utilization of the correct form and making sure that they explain the risks and benefits associated with the vaccines and document such, prior to obtaining consent/refusal. This was completed by the Director of Clinical Operations by 1/19/22. The Facility Nursing staff were educated on utilization of the correct form and making sure that they explain the risks and benefits associated with the vaccines and document such, prior to obtaining	

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F 883	Continued From page 26 showed the resident refused the pneumovax immunization on 2/25/21. However, further review failed to show evidence the resident or resident's representative was provided education regarding the benefits and potential side effects of either immunization 4. Review of the medical record showed resident #65 refused an influenza vaccination on 11/11/21. Review of the immunization report showed the resident was not eligible for a Pneumovax 23 immunization on 4/13/21 related to refusal of the physician. However, further review failed to show evidence the resident or resident's representative was provided education regarding the benefits and potential side effects of either immunization 5. Interview with the infection preventionist, the regional RN, and the MDS coordinator on 12/16/21 at 2:48 PM revealed although education was provided to the residents regarding the immunizations, it was not documented as provided in the resident's medical record. 6. Review of the Pneumococcal Vaccine policy showed it was revised August 2016. The policy showed "3. Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine...Provisions of such education shall be documented in the resident's medical record..." 7. Review of the policy "Influenza, Prevention and Control of Seasonal" showed it was revised August 2014 and failed to include aspects of required information and education regarding the benefits and potential side effects of the influenza	F 883	consent/refusal. This was completed by the DON/designee on 1/19/22. DON/designee will complete reviews on New Admissions to ensure that the appropriate consent form is completed, and the appropriate documentation is done. Monitoring: The DON/designee will trend any issues identified from her review and submit a report on this to the QAPI Committee Monthly x3, to ensure that compliance is maintained.	

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F 883	Continued From page 27 vaccine. Further, there was no mention of needed documentation in the resident's medical record related to the resident's acceptance or refusal of the vaccination.	F 883		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for	F 886		1/14/22

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F 886	Continued From page 28 conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of infection control policies and procedures, review of CMS guidance, and review of Centers for Disease Control and Prevention's (CDC) standards, the facility failed to ensure personal protective equipment, social distancing and disinfection requirements were followed during 1 of 1 observation of COVID-19 testing procedures. Further, the facility failed to ensure COVID-19	F 886	Correction: The Infection Preventionist is currently wearing the appropriate PPE, following appropriate standards for social distancing when appropriate and ensuring that disinfecting of surfaces is being done as required during COVID-19 testing. The facility is now testing at a frequency required by CMS guidance.	

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F 886	Continued From page 29 testing was completed at a frequency required by CMS guidance. The census was 85. The findings were: 1. Interview with the infection preventionist and the administrator on 12/16/21 at 10 AM revealed the infection preventionist wore her personal prescription eye glasses, a N95 mask, and gloves during COVID-19 specimen collection unless the individual being tested had symptoms. If the individual had symptoms of COVID-19, the infection preventionist revealed she also applied a gown. Further interview revealed she tested staff and sometimes residents in her office, and the only surface she sanitized after specimen collection was her "cart." The administrator revealed, the facility was testing all residents and staff for COVID-19 weekly. He stated the testing frequency was based on the county's positivity rate, which was at 6%. The following concerns were identified: a. Review of CMS guidance found in QSO-20 -38-NH, updated 9/10/21 showed "The facility should test all unvaccinated staff at the frequency prescribed in the Routine Testing table based on the level of community transmission reported in the past week. Facilities should monitor their level of community transmission every other week (e.g., first and third Monday of every month) and adjust the frequency of performing staff testing according to the table above." Review of the routine testing table in the memo showed facilities located in an area of "High" community transmission should test unvaccinated staff twice weekly. Review of the CDC COVID Data Tracker found at https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=Risk and retrieved on	F 886	The infection Preventionist and the DON, in conjunction with the Medical Director, have completed the following: Completed a hand hygiene procedure for the staff and residents which is consistent with the current nursing facility guidelines from the Centers for Disease Control and Centers for Medicare and Medicaid Services. Identification: The Infection Preventionist, in conjunction with the interdisciplinary team will review current COVID-19 nursing facility guidelines. Systemic: The Facility has contracted an outside consultant who has her Infection Preventionist Certification through CDC to conduct an ICAR with the facility to assess IPC practices r/t to covid- 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 observations to ensure staff are complying with the requirements for hand washing. DON/designee will complete reviews regarding PPE and testing frequency to ensure that the new guidelines and policy are followed. The DON/designee will trend any issues identified from her review and submit a report on this to the QAPI Committee Monthly x3, to ensure that compliance is	

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F 886	Continued From page 30 12/17/21 showed Natrona County was an area of "High" community transmission. b. Follow up interview with the administrator on 12/17/21 at 9:45 AM revealed he was unaware of the updated testing guidance found in QSO-20-38-NH, revised 9/10/2021. 2. Observation on 12/16/21 at 2:56 PM showed the infection preventionist entered her office, opened a clean N95 mask and applied it. The infection preventionist performed hand sanitation with alcohol based hand gel and then applied gloves. She obtained a specimen bag, removed the nasal swab, and inserted it into an employee's nares. The infection preventionist placed the swab into a vial, placed the vial in a biohazard bag, and sealed the bag. The following concerns were identified: a. Observation at that time of the infection preventionist's office showed it was a small area which housed computer networking equipment as well as a desk, some shelves, and a small plastic cart. The office opened directly into a common area where residents were frequently observed to gather. b. At the time of collection, the infection preventionist wore gloves, an N95 mask, and personal prescription eye glasses. No gown or eye protection were worn. c. The employee being tested stood just outside the door of the office (in the common area), and this is where the infection preventionist obtained the specimen. d. After obtaining the specimen, the infection preventionist disinfected only the top of the plastic cart where the specimen was handled. No other surfaces within six feet of the specimen collection site, including handrails and doorknobs, were disinfected.	F 886	maintained. 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 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 and medical Director Directed Plan of Correction	

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F 886	Continued From page 31	F 886		

3. Review of the policy "Coronavirus Disease (COVID-19)- Testing and Return to Work Criteria for Healthcare Personnel" showed it was dated August 2020. The policy and procedure referred to the county positivity rate for the frequency of testing, however, was not updated to include the new CMS guidance and tables for frequency of testing. In addition, the policy did not cover collecting and handling of clinical specimens for COVID-19 testing.

4. Review of the CMS memo QSO-20-38-NH, page 9, last revised on 9/10/21 showed "....Collecting and handling specimens correctly and safely is imperative to ensure the accuracy of test results and prevent any unnecessary exposures. The specimen should be collected and, if necessary, stored in accordance with the manufacturer's instructions for use for the test and CDC guidelines. During specimen collection, facilities must maintain proper infection control and use recommended personal protective equipment (PPE), which includes a NIOSH-approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown, when collecting specimens."

5. Review of the Centers for Disease Control and Prevention's (CDC) "Interim Guidelines for Collecting and Handling of Clinical Specimens for COVID-19 Testing" last revised on 10/25/21 showed "...Collecting and Handling Specimens Safely...For healthcare providers collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2, maintain proper infection control and use recommended personal protective equipment

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F 886	Continued From page 32 (PPE), which includes an N95 or higher-level respirator (or face mask if a respirator is not available), eye protection, gloves, and a gown..." 6. Review of the CDC's "NIOSH Eye Safety" archive last revised on 7/29/13 showed "...The Centers for Disease Control and Prevention (CDC) recommends eye protection for a variety of potential exposure settings where workers may be at risk of acquiring infectious diseases via ocular exposure... Workers should understand that regular prescription eyeglasses and contact lenses are not considered eye protection..."	F 886		