STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535032	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	1330 PRAIRIE AVENUE CHEYENNE, WY 82009

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 1/23/22 to 1/26/22. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set LPN- Licensed Practical Nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		3/4/22

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

Electronically Signed | 02/18/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 657	Continued From page 1 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure care plans were developed to include resident-specific activity plans for 3 of 27 sample residents (#13, #15, #91) reviewed. The findings were: 1. Review of the 11/9/21 quarterly MDS assessment showed resident #13 had moderate cognitive impairment with a BIMS score of 10 out of 15, and had diagnoses which included cerebral vascular accident with hemiplegia, dementia, respiratory failure and depression. The MDS further showed the resident was totally dependant on 2 staff members for transfers, bathing and toileting. Review of the care plan with a revision date of 11/10/21 showed a care area for activity involvement. The following concerns were identified: a. Observations on 1/23/22 at 10:42 AM and at 2:45 PM showed the resident in bed. Another observation on 1/24/22 at 9:46 AM showed the resident in bed. b. Interview with RN #4 and CNA #3 revealed the resident was bed bound, and did not get up. They further stated the activity assistants used to round on the residents who were confined to bed,	F 657	F657 Care plan timing and revision 1. Care plans for residents #13, #15, and #91 will be revised/developed to include specific activity plans for each resident. 2. Audit all residents that are bed bound or choose not to attend group activities with moderate to severe cognition impairment to ensure that the care plan reflects a revised/developed specific activity plan for each resident. 3. During care plan development, review, and change of condition care plan will be audited to ensure that resident specific activity plans are developed. Education will be provided to MDS, and activities by DON, designee. 4. Audit tool will be created and utilized to ensure residents that are bed bound or choose not to attend group activities with a moderate to severe cognition impairment has a specific activity plan for each resident. The ED or designee will present the audits to QAPI monthly for	

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F 657	Continued From page 2 however that was no longer the routine. c. Review of the care plan with a revision date of 11/10/21 showed a care area for activity involvement. The care plan showed interventions that were initiated on 1/28/19 included recording prior level of activity involvement and escorting the resident to activities. Further review of the care plan failed to show updated interventions to reflect the resident's bed bound status. 2. Review of the 11/3/21 annual MDS assessment showed resident #15 had a BIMS score of 99 (unable to complete the interview), and had diagnoses which included obstructive uropathy, dementia and depression. Further, the resident required extensive assistance of 1 staff member for bed mobility, eating, and dressing. Review of the care plan with a revision date of 11/18/21, showed the resident was independent for meeting emotional, intellectual, physical and social needs. The following concerns were identified: a. Observation on 1/23/22 at 3:18 PM and on 1/24/22 at 9:19 AM showed the resident sitting in a chair in his/her room with the television on. b. Review of the care plan with a revision date of 11/18/21 failed to show interventions to engage the resident in activities while in the room. c. Interview on 1/26/22 at 11:35 AM with the interim activities director stated she visited with the resident each morning when she delivered the activity sheet, but this was not recorded as an activity. She further stated she had not learned how to revise the care plans to reflect the resident's current status. 3. Review of the 1/11/22 quarterly MDS assessment showed resident #91 had moderate cognitive impairment with a BIMS score of 12 out	F 657	review and feedback for a minimum of 3 months to ensure compliance as achieved and maintained.	

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F 657	Continued From page 3 of 15, and had diagnoses which included heart failure, respiratory failure, anxiety, and depression. Review of the care plan with a revision date of 10/26/21 showed the resident was independent for meeting emotional, intellectual, physical and social needs. The interventions included 1:1 bedside/in-room visits and activities if unable to attend out of room events. The following concerns were identified: a. Observation on 1/23/22 at 10 AM showed the resident in bed. Further observation showed 2 staff members transferred the resident to the bathroom, then back to bed per resident request. b. Review of the progress notes failed to show documentation for 1:1 activity participation. c. Interview on 1/26/22 at 11:06 AM with the interim activities director confirmed there was no formal 1:1 activity program.	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on medical record review, review of bathing documentation, and resident and staff interview, the facility failed to ensure bathing was provided as scheduled for 3 of 7 sample residents (#17, #76, #192) who required assistance with bathing. The findings were: 1. Review of the 1/10/22 significant change MDS assessment showed resident #17 was cognitively intact with a BIMS score of 15 out of 15, and required extensive assistance with 1 person	F 677	F677 ADL care provided for dependent residents 1. Bathing to be provided as scheduled for residents #17, #76, and #192. 2. Audit tool will be created and utilized to ensure bathing is being provided as scheduled to residents. 3. Education will be created and provided	3/4/22

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F 677	Continued From page 4 physical assist for bathing. Review of the CNA task documentation for bathing showed the resident was to have showers on Tuesdays and Fridays. The following concerns were identified: a. Interview on 1/23/22 at 10:52 AM with the resident revealed s/he was not receiving baths or showers per the schedule. b. Review of the CNA task documentation showed the resident went 7 days without a shower from 1/11/22 through 1/18/22 and another 8 days without a shower from 1/18/22 through 1/26/22. c. Interview on 1/26/22 at 10 AM with the DON revealed it was the facility's expectation for the CNAs on duty to give the residents their showers on the scheduled shower days. 2. Review of the 12/27/21 admission MDS assessment showed resident #76 was cognitively intact with a BIMS score of 15 out of 15, and required supervision assistance of one staff member for bathing. Review of the care plan, last reviewed 1/12/22, showed the resident was non-weight-bearing to his/her left lower extremity. Review of the CNA bathing task documentation showed the resident was scheduled for bathing on Wednesday and Saturday evenings. The following concerns were identified: a. Interview with the resident on 1/24/22 at 10:48 AM revealed s/he had not had a shower or bath "...in at least a week." b. Review of the CNA bathing task documentation showed during the period from 12/26/21 to 1/26/22 the resident received bathing on just two days, 1/8/22 and 1/15/22. c. Interview with the DON on 1/26/22 revealed CNA staff were responsible for coordinating and providing baths/showers. She further revealed a schedule was posted in the	F 677	to Nursing staff by DON or designee. Review of the bathing documentation will be reviewed weekly by nursing staff and audited to ensure bathing is provided as scheduled. 4. Audit tool will be created and utilized to ensure bathing is being provided as scheduled and ED or designee will present the audits to QAPI monthly for review and feedback for a minimum of 3 months to ensure compliance is achieved and maintained.	

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F 677	Continued From page 5 shower room, on the resident's care cards in their rooms, and incorporated into the daily task checklist in the electronic medical record. 3. Review of the 1/11/22 admission collection tool for resident #192 showed his/her level of consciousness was alert, and oriented to person, place, and time. The documentation showed the resident required physical help for bathing. Review of the CNA task documentation for bathing showed the resident was to have showers on Tuesdays and Fridays. The following concerns were identified: a. Review of the CNA task documentation showed the resident went 7 days without a shower from 1/11/22 through 1/18/22. b. Interview on 1/26/22 at 10 AM with the DON revealed it was the facility's expectation for the CNAs on duty to give the residents their showers on the scheduled shower days.	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of activity	F 679	F679 Activities meet interest/needs each resident	3/4/22

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F 679	Continued From page 6 documentation, the facility failed to ensure a program of activities to meet the needs for 3 of 7 sample residents (#13, #15, #91) reviewed for activities. The findings were: Interview on 1/25/22 at 3:04 PM with the interim activities director revealed daily activities for all residents included music that played over the speaker system in the facility, television, staff/family/friend visits, and reality orientation (orientation to time and place). She stated these were documented as activities on the individual resident daily participation records. She further stated there was no formal 1:1 activity program. If a resident was identified to require 1:1 activities, the expectation would be 15 minutes at least 3 times a week. She further stated they had "friendly visits" which were done daily when she or another activity assistant delivered the daily activity sheet to the residents. She stated the purpose of the friendly visit was to encourage the residents to get more active and participate in activities. She acknowledged there was a lack of activities provided for the residents who were bed-bound or stayed in their rooms. The following residents were identified who required 1:1 activity programs: 1. Review of the 11/9/21 quarterly MDS assessment showed resident #13 had moderate cognitive impairment with a BIMS score of 10 out of 15, and had diagnoses which included cerebral vascular accident with hemiplegia, dementia, respiratory failure and depression. Review of the care plan with a revision date of 11/10/21 showed a care need for activity involvement. Review of the activities evaluation dated 6/6/21 showed the resident had interests in animals/pets, educational programs, family/friend visits, and	F 679	1. Ensure a program of activities to meet the needs for residents #13, #15, and #91 is being provided. 2. Create audit tool and identify all residents that are bed bound or choose not to attend group activities with moderate to severe cognition impairment to ensure that an activities program is provided that meet their individual needs. 3. Education provided by ED to activities department on providing activities that meet the interest/needs for each resident. 1:1 activities will be delivered to residents that are bed bound or choose not to attend group activities with moderate to severe cognition impairment. 4. Audit tool will be created and utilized to ensure that residents that are bed bound or choose not to attend group activities with moderate to severe cognition impairment and ED or designee will present the audits to QAPI monthly for review and feedback for a minimum of 3 months to ensure compliance is achieved and maintained.	

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F 679	Continued From page 7	F 679		

movies. The following concerns were identified:

a. Observation on 1/23/22 at 10:42 AM and at 2:45 PM showed the resident stayed in bed. Another observation on 1/24/22 at 9:46 AM showed the resident was in bed.

b. Interview with the RN #4 and CNA #3 revealed the resident was bed bound, and did not get up. They also stated activity assistants used to round on the residents who were confined to bed, however that was no longer the routine.

c. Review of the Individual Resident Daily Participation Record for January 2022 showed family/friend visits, music, television, and reality orientation were the activities marked daily. There were no additional activities documented related to the resident's identified interests.

d. Review of the "Friendly Visit" sheet showed a staff visit to the resident on 1/23/22, 1/24/22, 1/25/22, and 1/26/22.

2. Review of the 11/3/21 annual MDS assessment showed resident #15 had a BIMS score of 99 (unable to complete the interview), and had diagnoses which included obstructive uropathy, dementia and depression. Review of the care plan with a revision date of 11/18/21, showed the resident was independent for meeting emotional, intellectual, physical and social needs. Review of the activities evaluation dated 11/15/19 showed the resident enjoyed animals/pets, arts/crafts, cooking, creative writing, cultural events, current events and movies. The following concerns were identified:

a. Observations on 1/23/22 at 3:18 PM and on 1/24/22 at 9:19 AM showed the resident sitting in a chair in his/her room with the television on.

b. Review of the Individual Resident Activity Daily Participation Record for January 2022 showed family/friend visits, music, television, and

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F 679	Continued From page 8 reality orientation were the activities marked daily. There were no additional activities documented related to the resident's identified interests. c. Interview on 1/26/22 at 11:35 AM with the interim activities director stated she visited with the resident each morning when she delivered the activity sheet, but this was not recorded as an activity. 4. Review of the 1/11/22 quarterly MDS assessment showed resident #91 had moderate cognitive impairment with a BIMS score of 12 out of 15, and had diagnoses which included heart failure, respiratory failure, anxiety, and depression. Review of the care plan with a revision date of 10/26/21, showed the resident was independent for meeting emotional, intellectual, physical and social needs. The interventions included 1:1 bedside/in-room visits and activities if unable to attend out of room events. The following concerns were identified: a. Observation on 1/23/22 at 10 AM showed the resident was in bed. Further observation showed 2 staff members transferred the resident to the bathroom, then back to bed per resident request. b. Review of the progress notes failed to show documentation for 1:1 activity participation. 5. Interview on 1/24/22 at 3:04 PM with RN #4 and CNA #3 stated hall 100 had several residents who were bed bound or stayed in their room, and there was not much activity for them. They further stated there used to be activity assistants who would round and have 1:1 activity programs with the residents, but that was no longer routine.	F 679		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		3/4/22

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F 690	Continued From page 9 §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 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, review of professional standards, and staff	F 690	F690 Bowel/Bladder incontinence, Catheter, UTI	

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F 690	Continued From page 10 interview, the facility failed to ensure appropriate care and services to prevent urinary tract infections for residents with indwelling urinary catheters during 2 random observations (affecting residents #32, #59). The findings were: 1. Observation on 1/24/22 at 2:20 PM showed resident #59 was seated in his/her wheelchair and had a Foley catheter; the catheter bag was not in a privacy bag, and was lying on the floor underneath the wheelchair. Observation on 1/24/22 at 2:36 PM showed RN #1 entered the room and noted the bag was on the floor under the resident. He placed the catheter bag into the privacy bag, and hooked the bag under the wheelchair so it was off the floor. Interview with RN #1 at that time confirmed the catheter bag should not be on the floor due to infection risk. 2. Review of the 11/22/21 admission MDS assessment showed resident #32 had an indwelling catheter and diagnoses that included obstructive uropathy and urinary tract infection within the past 30 days. Review of the care plan dated 11/29/21 for catheter use showed interventions that included catheter care every shift, and check tubing for kinks several times each shift. The following concerns were identified: a. Observation on 1/24/22 at 9:58 AM showed the resident's catheter bag was laying uncovered on the floor under the resident's bed. b. Interview with the infection preventionist on 1/26/22 at 12:07 PM confirmed the expectation was to keep the catheter bag off of the ground and in a protective cover. 3. According to the Centers for Disease Control Guideline for Prevention of Catheter-Associated Urinary Tract Infections (2009), Proper	F 690	1. Ensure that resident #32, and #59 has their catheter bag in a privacy bag and is not resting on the floor. 2. Identify all residents with indwelling catheters and ensure that their catheter bag is in a privacy bag and not on the floor. 3. Education will be provided to all staff by DON/designee. Ongoing audits will be conducted to ensure compliance. 4. Audit tool will be created to and utilized to monitor ongoing compliance and will be presented to QAPI monthly for review and feedback for a minimum of 3 months to ensure compliance is achieved and maintained.	

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F 690	Continued From page 11 Techniques for Urinary Catheter Maintenance showed, " ...Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor." https://www.cdc.gov/infectioncontrol/guidelines/cauti/recommendations.html (Accessed on 2/4/22)	F 690		
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 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		2/24/22

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	535032	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 12 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, policy and procedure review, manufacturer recommendations, and staff interview, the facility	F 880	Corrective action: The facility will immediately implement an	

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F 880	Continued From page 13 failed to ensure infection control procedures were followed during 1 random observation of hand hygiene, 3 random observations of personal protective equipment (PPE) use, and 2 random observations of cleaning resident care equipment. The census was 102. The findings were: Related to proper PPE use: 1. Observation on 1/24/22 at 3:04 PM showed CNA #3 wearing an N95 face mask with only 1 strap. Interview with her at that time revealed she cut the other strap off because it was difficult to breathe and she felt she had a tight fit with only 1 strap. 2. Observation on 1/24/22 at 2:48 PM showed housekeeper #1 wearing an N95 face mask with only 1 strap. Interview with her at that time revealed she cut the top strap because it was hard to breathe and she felt she had a tight fit with 1 strap. 3. Observation on 1/23/22 at 10:03 AM showed RN #2 wearing protective eyewear and an N95 face mask. However, the mask was not worn correctly, with the bottom of the mask folded up inside the mask; there was no seal with the mask, as her chin was clearly visible. 4. Interview on 1/26/22 at 10:49 AM with the infection preventionist stated the N95 face masks still provided a tight fit with only 1 strap. However, she further stated they were not following manufacturer's recommendations for wearing an N95 mask. 5. According to the 3M Aura NIOSH N95 face mask manufacturer's recommendations, one	F 880	appropriate infection prevention and intervention plan consistent with the requirements of 483.80 for the affected unit(s) identified in the deficiency. The infection preventionist (IP) and director of nursing (DON), in conjunction with the medical director, shall complete the following: (1) Identify and implement hand hygiene procedures, for staff and residents, consistent with current nursing facility guidelines from the Centers for Disease Control (CDC and Centers for Medicare and Medicaid Services (CMS). (2) Identify and implement use of personal protective equipment (PPE) procedures consistent with current nursing facility guidelines from the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS). (3) Identify and implement equipment and environmental cleaning procedures consistent with current nursing facility guidelines from the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS). For all residents # All- Census of 102 (1) Staff will utilize appropriate PPE when providing care to the resident. (2) Staff will implement appropriate equipment and environmental cleaning procedures when cleaning the resident's	

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F 880	Continued From page 14 strap was placed on the crown of the head, and the second strap was placed at the back of the neck for proper fit. 6. According to the Centers for Disease Control recommendation for using the N95 respirator, "...N95s must form a seal to the face to work properly....Pull the top strap over your head, placing it near the crown. Then, pull the bottom strap over and place it at the back of your neck, below your ears. Do not crisscross the straps. Make sure the straps lay flat and are not twisted..." https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html. (Accessed on 2/4/22). Related to hand hygiene: 1. Continuous observation beginning on 1/23/22 at 12:17 PM showed RN #3 with the mobile ice cart outside of room 406, entering the room. The following concerns were identified: a. Before entering room 406 the nurse did not perform hand hygiene. She returned to the ice cart with the resident's water mug, removed the lid, filled the cup with ice, re-entered the room, filled the cup with water from the sink, and returned the mug to the resident. She then exited the room without performing hand hygiene. b. Without performing hand hygiene the RN then went to the medication cart and began using the mouse and keyboard of the computer on top of the cart, then opened the medication cart and began removing medications. No hand hygiene was observed before contact with the computer, medication cart, or the medications. c. Interview with RN #3 on 1/23/22 at 12:22 PM confirmed she did not perform hand hygiene	F 880	equipment and/or environment. Identification of Others: The IP and DON, in conjunction with the interdisciplinary team (IDT) will review current COVID-19 nursing facility guidelines from the CDC and CMS. The IP, DON, and applicable IDT members will evaluate the facility's overall compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. Guidelines for COVID-19 can be found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html System Changes: On or before 2/24/2022 the facility shall complete the following actions: Related to hand hygiene: (1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to ensure face masks and face shields were worn appropriately. Related to PPE: (1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for	

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F 880	Continued From page 15 between contact with resident belongings, prior to entry or upon exiting the resident room. d. Review of the facility's Standard Precautions policy with a revision date 2/15/21, showed "(1) hand hygiene...Perform hand hygiene: a. Before and after all resident contact..." Related to equipment cleaning: 1. Observation on 1/23/22 at 2:52 PM showed CNA #2 went into room 211 to obtain vital signs with equipment on a mobile cart. The following concerns were identified: a. The aide used a blood pressure cuff, forehead scanning thermometer and the pulse oximeter all located on the mobile cart to obtain vital signs from resident #36. The CNA cleansed the forehead scanning thermometer with a small single-use alcohol wipe. However, she failed to clean or disinfect the blood pressure cuff or the pulse oximeter prior to using the equipment for the roommate, resident #41. Continued observation showed after use of the equipment for resident #41, the CNA cleaned the thermometer, however, there was no disinfection of the BP cuff or the pulse oximeter. These items were returned to the cart. She washed her hands and took the cart into room 208 to get the vital signs for those residents. Observation at 3:05 PM showed no cleaning or disinfection was done to these items prior to use in room 208. b. Interview with CNA #2 on 1/23/22 at 3:19 PM revealed the expectation was to wipe down the BP cuff and pulse oximeter as well as the thermometer. She stated it had been a hectic day, and verified there were no Sani-wipes available on the cart. However, they were available on the hall counter, and she took them	F 880	non-compliance related to: a. Failure to ensure face masks and face shields were worn appropriately. Related to Environmental and Equipment cleaning: (1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to ensure dedicated or disposable noncritical resident care equipment ()e.g. blood pressure cuffs, blood glucose monitor equipment) was used or in not available then equipment was cleaned and disinfected according to manufacturers' instructions using an EPA-registered disinfectant prior to use on another resident. (2) The DON and IP will ensure education is provided for the following: Related to hand hygiene: a. All staff are educated on proper hand hygiene procedures in accordance with the current CDC and CMS guidelines. Related to PPE: a. All staff are educated on the proper use of PPE in accordance with the current CDC and CMS guidelines. Related to Environmental and Equipment	

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F 880	Continued From page 16 with her and wiped the equipment. 2. Observation on 1/23/22 at 2:22 PM showed CNA #3 obtained vital signs using a blood pressure machine and a pulse oximeter. The CNA left the room without cleaning the equipment and went into another resident's room to obtain vital signs. Further observation showed she did not clean the equipment. Interview with the CNA at that time revealed she knew the expectation was to clean the equipment between resident uses, however, she cleaned the equipment when she finished getting all of the vital signs. 3. Interview on 1/26/22 at 10:49 AM with the infection control nurse revealed the expectation was for staff to clean the equipment between residents. 4. Review of the Standard Precautions policy, with a revision date 2/15/21 showed 6. a. "resident care items and surfaces used for multiple residents are disinfected between use.."	F 880	Cleaning and Disinfecting: a. All staff are educated on the use of dedicated or disposable noncritical resident care equipment, if available, or the procedures for disinfection the equipment between residents in accordance with the current CDC and CMS guidelines. (3) The facility leadership will contact the Mountain Pacific Quality Improvement Organization (QIO) to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility. Monitoring of approaches to ensure infection control and prevention are effective will include: Weekly for no less than 12 weeks, the IP, DON, and applicable IDT will conduct on-going monitoring via observation to ensure staff are complying with requirements for: a. Compliance of staff with hand hygiene during resident care. b. Compliance of staff with appropriate PPE use during resident care. c. Compliance of staff with proper use or disinfection of noncritical resident care equipment. After 12 weeks of monitoring, provided that such monitoring demonstrates expectations are met, monitoring may be reduced to monthly. Monthly monitoring	

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F 880	Continued From page 17	F 880	will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring which demonstrates sustained compliance as approved by the QAPI committee and medical director.	