STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE REHABILITATION AND WELLNESS	**3128 BOXELDER DRIVE CHEYENNE, WY 82001**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 3/16/22 to 3/17/22. The survey was prompted by complaint intakes WY00003374 and WY00003375. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the complaint investigation. In addition, a focused COVID-19 infection control survey, including review for compliance with the Omnibus COVID-19 Health Care Staff Vaccination requirements, was conducted by Healthcare Licensing and Surveys from 3/16/22 to 3/17/22.	F 000		
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	F 880		3/18/22

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

Electronically Signed | 04/07/2022

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F 880	Continued From page 1 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed 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	F 880		

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F 880	Continued From page 2 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, review of infection control documentation, staff interview, and Center for Disease Control (CDC) guidelines, the facility failed to ensure adequate transmission-based precautions were implemented to prevent the spread of COVID-19 during 3 of 4 random observations. The census was 111. The findings were: 1. Observation on 3/16/22 at 5:45 PM showed the doors on rooms 312 and 315 had signage which instructed staff the rooms were on enhanced droplet precautions and gowns, gloves, masks, and eye protection were required to enter. Outside of the door of room 315 was a small cabinet of personal protective equipment (PPE) which contained gloves and gowns. Outside of room 312 was a small cabinet of PPE which contained gloves, gowns, and N95 masks. The following concerns were identified: a. Observation on 3/16/22 at 5:50 PM showed CNA #1 donned a gown and gloves and delivered a food tray to the resident in room 315. The CNA removed her gown and gloves before exiting the room, performed hand hygiene upon exiting, however failed to replace her N95 mask. The CNA returned to the food service area, washed her hands, and then adjusted her mask with her bare hands. Interview with the CNA at that time revealed she knew she was supposed to change her mask and confirmed she had forgotten to do so.	F 880	Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility□s allegation of compliance in accordance with the State Operations Manual. F880 1.The facility has immediately implemented an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected unit identified in the deficiency. The IP, DON, and medical director have identified and implemented the use of PPE procedures consistent with current nursing facility guidelines from the CDC and CMS. □ Infection Preventionist educated the three staff members observed, and all staff, on 3/16 and 3/17 on proper CDC and CMS	

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F 880	Continued From page 3 b. Observation on 3/16/22 at 5:53 PM showed the maintenance assistant was wearing goggles and a N95 mask, donned a gown and gloves at the door to room 315 and entered the room to deliver a food tray. The maintenance assistant removed his gown and gloves before exiting the room and performed hand hygiene upon exiting, however he failed to replace his N95 mask. c. Observation on 3/17/22 at 10:40 AM showed CNA #2 had exited room 312 and was performing hand hygiene. Interview with the CNA at that time revealed she had been assisting the resident with toileting and had doffed her gown and gloves inside the room. The CNA failed to replace her N95 mask. 2. Review of the facility's infection control documentation showed the resident in room 315 had tested positive for SARS-CoV-2 on 3/11/22 and was to remain in isolation until 3/21/22. One of the residents in room 312 had tested positive for SARS-CoV-2 on 3/11/22 and was to remain in isolation until 3/21/22 and the other resident was listed as a PUI (person under investigation). 3. Interview with the infection preventionist (IP) and director of nurses on 3/17/22 at 5 PM revealed the facility had adequate supplies of PPE. The IP stated it was the facility's expectation CDC guidelines be followed and N95 masks be changed upon leaving the resident's room. 4. Review of the CDC guidance titled "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" last revised on 2/2/22	F 880	guidelines to discarding and replacing N95 masks when exiting droplet precaution resident rooms. 2.The IP, DON and IDT have reviewed current COVID-19 nursing facility guidelines from CDC and CMS. The IP, DON, and IDT members have evaluated the facilities overall compliance with guidelines. Facility has developed an action plan to address any newly identified non-compliance. 3.DON, IP and IDT members have conducted a root cause analysis to identify and address the reason of non-compliance: a.Failure to ensure a NIOSH-Approved N95 facemask was discarded after a resident care encounter and a new one donned. DON and IP have educated all staff on b.Proper Use of PPE in accordance with the current CDC and CMS guidelines. 4.Audits will be conducted at least 3x per week for no less than 12 weeks to ensure infection control and prevention are effective for a.Compliance of staff with appropriate PPE use during resident care. b.Compliance of staff with the use of facemasks and faceshields. All monitoring will be reported to the QAPI committee as part of the QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring which demonstrates consecutive compliance as approve by the QAPI committee and medical director.	

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F 880	Continued From page 4 showed "Source control options for HCP [healthcare personnel] include: A NIOSH [National Institute of Safety and Health]-approved N95 or equivalent or higher-level respirator OR a respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (Note: These should not be used instead of a NIOSH-approved respiratory when respiratory protection is indicated) OR A well-fitting facemask. When used solely for source control, any of the options listed above could be used for an entire shift unless they become soiled, damaged, or hard to breathe through. If they are used during the care of patient for which a NIOSH-approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g.,NIOSH-approved N95 or equivalent or higher level respirator) during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on Droplet Precautions, they should be removed and discarded after the patient care encounter and a new one should be donned."	F 880		