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	535027	A. BUILDING _____ B. WING _____	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CODY REGIONAL HEALTH LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 9/26/22 to 9/29/22. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set LPN- Licensed Practical Nurse SSD- Social Services Director BIMS- Brief Interview for Mental Status Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758		10/28/22

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

Electronically Signed | 10/17/2022

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F 758	Continued From page 1 specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policy and procedure, the facility failed to ensure appropriate behavior monitoring and interventions were in place for 2 of 5 sample residents (#7, #55) reviewed for unnecessary medications. The findings were: 1. Review of the admission MDS assessment	F 758	F-758 1. Resident #7 and #55 were identified as being affected. Both residents□ care plans and behavior tracking documentation were revised to include documentation of specific targeted behaviors for each resident. 2. All other residents who receive	

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F 758	Continued From page 2 dated 6/24/22 showed resident #7 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included non-Alzheimer's dementia and insomnia. Further review showed the resident had mild depression with a severity score of 2 out of 30 and no additional coded behaviors. Review of the physician orders showed the resident received doxepin hydrochloride (antidepressant) 50 milligrams (mg) by mouth daily at bedtime for adjustment disorder with depressed mood. Review of the depression care plan last revised on 8/2/22 showed interventions which included "...Document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgement or safety awareness...Document/report PRN any s/sx [signs or symptoms] of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statements, repetitive anxious or health-related complaints, tearfulness..." The following concerns were identified: a. Review of the medication administration record (MAR) and treatment administration record (TAR) for July 2022, August 2022, and September 2022 showed the facility had monitoring in place for withdrawal symptoms related to the use of psychotropic medication; however, there was no evidence the facility was monitoring the resident for identified target symptoms. b. Interview with the administrator on 9/29/22 at 9:35 AM confirmed behavior symptoms related	F 758	psychoactive medication(s) were reviewed to ensure their care plans and behavior tracking documentation describe individual targeted behaviors to be monitored. 3. The IDT team and nursing staff were in-serviced on documenting specific targeted behaviors for any resident who receives a psychoactive medication. 4. The DON or designee will conduct weekly audits for the next 90 days of at least 4 different current residents and any new admission(s) who receive psychoactive medications. These audits will verify specific targeted behaviors are being monitored and documented on the MAR/TAR and CNA Point of Care Behavior Monitoring. 5. The DON or designee will report results of audits to the QAPI Committee monthly for the next 90 days. Additional training and/or audits will be completed as appropriate to ensure ongoing compliance	

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F 758	Continued From page 3	F 758		

to medication withdrawal were listed on the TAR; however, there was no monitoring of identified target symptoms for the medication.

c. Review of the CNA "Behavior Monitoring and Interventions report" from 6/28/22 through 9/28/22 showed "panic" was observed on 7/24/22, expressions of frustration/anger, other behaviors not directed at others, and refusing care was observed on 9/3/22, anxious/restless and refusing care was observed on 9/12/22, and expressions of frustration/anger, agitation, and withdrawn/isolation was observed on 9/17/22. No other behaviors were observed during the time period and resident-specific identified target symptoms identified on the care plan were not monitored.

d. Review of the behavior care plan last revised on 8/2/22 showed no identified non-pharmacological interventions related to identified target symptoms.

2. Review of the significant change MDS assessment dated 9/2/22 showed resident #55 had a BIMS score of 9 out of 15, which indicated the resident had moderate cognitive impairment, and had diagnoses which included depression, and insomnia. Further review showed the resident had mild depression with a severity score of 5 out of 30 and no additional coded behaviors. Review of the physician orders showed the resident received escitalopram oxalate (antidepressant) 10 mg by mouth daily for major depressive disorder and eszopiclone (sedative-hypnotic) 3 mg by mouth at bedtime for insomnia. Review of the depression care plan last revised on 8/5/22 showed interventions which included "...Document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying

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F 758	Continued From page 4	F 758		

goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness...Document/report PRN any s/sx of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statements, repetitive anxious or health-related complaints, tearfulness..." The following concerns were identified:

a. Review of the medication administration record (MAR) for July 2022, August 2022, and September 2022 showed no evidence the facility was monitoring the resident for identified target symptoms.

b. Review of the sedative/hypnotic care plan last revised 8/8/22 showed no resident-specific target symptoms for use of the medication or identified non-pharmacological interventions.

c. Review of the depression care plan last revised on 8/5/22 showed no identified non-pharmacological interventions related to identified target symptoms.

d. Interview with the DON, SSD, and first floor unit manager on 9/29/22 at 8:44 AM revealed the resident was on as needed behavior monitoring and was not being monitored for target symptoms unless the symptoms occurred.

3. Interview with the DON, SSD, and first floor unit manager on 9/29/22 at 8:42 AM revealed resident care plans should have the target symptoms identified for each medication. Behavior tracking is performed by the CNAs in ADL charting; however, specific identified target symptoms were not part of the CNA tracking. Further interview revealed the facility staff should utilize progress notes for charting of target

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F 758	Continued From page 5 symptoms. 4. Review of the policy titled "Monitoring Chemical/Physical Restraints" which was un-dated and provided by the facility on 9/29/22 showed "...A...2. Upon recognizing a specific behavior that does/or could adversely affect a patient, the RN/LPN or C.N.A. observing the behavior will start a Behavior Monitor. Place the Behavior Monitor in the Medication Administration Review (MAR) notebook. A Behavior Monitor from [sic] will be initiated before a new order (or change in an order) for a psychoactive medication is started. The Social Worker will review behavior monitors on an ongoing basis and will recommend any further approaches to be used for behavior management...B...1. Before a resident is started on psychoactive medication, nursing service will document specific behaviors on the Behavior Monitor form. 2. If a new psychoactive medication is ordered or a medication change is begun, the Behavior Monitor will also be used. The resident's behavior will be monitored to assess change, including side effects and adverse reactions..."	F 758		
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.	F 880		10/28/22

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F 880	Continued From page 6	F 880		

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 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

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F 880	Continued From page 7 (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, staff interviews, review of the Centers for Disease Control (CDC) guidance, and policy review, the facility failed to ensure oxygen tubing and nasal cannulas were stored in a way that ensured they were protected from contamination for 2 of 6 sample residents (#8, #27) reviewed for oxygen use. Additionally, the facility failed to ensure appropriate personal protective equipment (PPE) was used during 2 random observations. The census was 59. The findings were: 1. Review of the significant change MDS assessment dated 7/28/22 showed resident #27 had a BIMS score of 9 out 15, which indicated moderate cognitive impairment, diagnoses which included multiple sclerosis and chronic obstructive pulmonary disease (COPD), and required extensive physical assistance of 1 person for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene. Further review showed the resident had	F 880	F-880 The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected unit 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 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). (2) 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	

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F 880	Continued From page 8	F 880		

shortness of breath or trouble breathing with exertion and used oxygen therapy. Review of the oxygen therapy care plan last revised on 8/10/22 showed interventions which included "Oxygen Settings: O2 via nasal cannula." The following concerns were identified:

a. Observation on 9/28/22 at 4:30 PM showed oxygen tubing dated 9/13/22 was connected to an inline wall-mounted oxygen regulator. The oxygen tubing was placed in a recliner in the resident's room, and was lying on top of a pair of shoes. The nasal cannula was in direct contact with the bottom of the shoe sole.

b. Observation on 9/28/22 at 6:57 PM showed the resident was in his/her room and the nasal cannula, dated 9/13/22, was inserted in the resident's nares.

c. Observation on 9/29/22 at 9:38 AM showed the resident was in his/her room seated in the recliner, and the nasal cannula which was dated 9/13/22, was inserted in the resident's nares.

2. Review of the quarterly MDS assessment dated 4/13/22 showed resident #8 had a BIMS score of 9 out of 15, which indicted moderate cognitive impairment, and had diagnoses which included COPD and respiratory failure. Further review showed the resident required limited physical assistance of 1 person for mobility and transfers and required oxygen therapy. Review of the resident's physician orders showed "maintain SAO2 [arterial oxygen saturation] greater than or equal to 90%." Further review showed the resident received DuoNeb solution (0.5-2.5 mg) via nebulizer four times per day and a Pulmicort flexhaler 1 inhalation two times per day. Review of the oxygen therapy care plan dated 7/21/21 showed interventions which included "oxygen via nasal cannula at 6 liters at night and as needed

and Medicaid Services (CMS).
For Residents #8 & #27:
(1) Staff will implement appropriate equipment and environmental cleaning procedures when cleaning the resident□s equipment and/or environment.
Identification of Others:
(1) Facility will review all residents who receive supplemental oxygen to ensure their equipment is protected from contamination.
(2) 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 10/28 the facility shall complete the following actions:
Related to PPE:
(1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: Failure to ensure face masks and face shields were worn appropriately.
Related to Environmental and Equipment cleaning:
(2) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address reasons for non-compliance related to:

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F 880	Continued From page 9 during the day." The following concerns were identified: a. Observation on 9/28/22 at 9:48 AM showed the resident used oxygen from an E cylinder attached to a wheelchair while out of the room and oxygen from a inline wall-mounted oxygen regulator while in the room. The oxygen tubing connected to the inline wall-mounted oxygen regulator was dated 9/28/22 and the nasal cannula was observed lying on the floor, under the wheelchair wheels. b. Observation on 9/29/22 at 8:19 AM showed the resident was in his/her room and the nasal cannula, dated 9/28/22, was inserted in the resident's nares. 3. Interview with CNA #1 on 9/29/22 at 9:48 AM revealed all oxygen tubing was changed out monthly unless it was dirty or fell on the floor. Further interview revealed when a staff member observed oxygen tubing which was stored incorrectly or dirty, the staff member should change the tubing. 4. Interview with the administrator on 9/29/22 at 9:50 AM confirmed oxygen tubing should be changed if it was dirty or not stored correctly. 5. Review of a "LTCC [long term care center] EOC/IFC Rounds Checklist" which was un-dated and provided by the facility on 9/29/22 showed "...VI A. O2 tubing is changed routinely by CP. O2 signs are posted appropriately. B. O2 tubing is placed in plastic bag when not in use..." 6. Observation on 9/26/22 at 5:55 PM showed LPN #1 arrived on the second floor wearing a cloth face mask. The LPN entered a door behind the nurses' station with another staff member.	F 880	a. Failure to ensure resident care equipment related to supplemental oxygen use was protected from contamination. The DON and IP will ensure education is provided for the following: 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 cleaning and Disinfecting: a. All staff are educated on the appropriate management of resident care equipment related to supplemental oxygen use. 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: Monitoring of approaches to ensure infection control and prevention are effective will include: (1) 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 the use of facemasks and face shields. (2) 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 the	

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F 880	Continued From page 10 Observation on 9/26/22 at 6:18 PM showed LPN #1 was standing at the nurses' cart and wore a cloth mask. Interview with the LPN at that time confirmed the face mask was cloth and revealed the face mask was not provided by the facility. 7. Observation on 9/26/22 at 6:09 PM showed dietitian #1 wore a cloth mask in the dining room during meal service. 8. Interview with the infection preventionist on 9/28/22 at 12:55 PM revealed anyone doing "frontline care" was required to wear a medical mask and cloth masks should not be used in resident care areas. Further interview revealed the facility was in COVID outbreak status and the community transmission rate was substantial at that time. 9. Review of the policy titled "COVID Response Plan" which was un-dated and provided by the facility on 9/29/22 showed "...Source Control...HCP [health care personnel] should use surgical masks when masks are required as per CDC Guidance, Community levels and outbreak..." 10. 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 9/23/22 showed "...Cloth mask: Textile (cloth) covers that are intended primarily for source control in the community. They are not personal protective equipment (PPE) appropriate for use by healthcare personnel..."	F 880	appropriate management of resident care equipment related to supplemental oxygen use. 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 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.	