STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	C 07/13/2023

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 7/11/23 to 7/13/23. Also reviewed in the course of the survey was complaint intake WY00003629. The following common abbreviations are used throughout this document: ADL: Activities of Daily Living CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 677 SS=D	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, staff interview, and policy and procedure review, the facility failed to ensure baths or showers were provided routinely for 1 of 6 sample residents (#109) who required assistance with ADLs. The findings were: 1. Review of the admission MDS assessment dated 4/5/23 showed resident #109 admitted to the facility on 3/30/23, had a brief interview for mental status score of 13 out 15 (which indicated	F 677	F 677 1. Resident #109 was identified as being affected. Resident #109 discharged from the facility 4/21/23. 2. All residents who receive assistance with ADL's were reviewed to determine if any other residents were missing baths. 3. Direct care staff were in-serviced on ensuring baths are given per resident preferences and to document in the	8/4/23

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

Electronically Signed | 08/03/2023

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F 677	Continued From page 1 the resident was cognitively intact), and diagnoses which included atrial fibrillation, coronary artery disease, heart failure, hypertension, arthritis and osteoporosis. The following concerns were identified: a. Review of the ADL self-care performance care plan last revised on 4/19/23 showed the resident required limited assistance by 1 staff person with bathing/showering as necessary. Further review showed no indication of the resident's bathing preferences related to the frequency of bathing. b. Review of the progress notes showed the resident discharged from the facility on 4/21/23 c. Review of the bathing record from 3/30/23 through 4/30/23 showed the resident received bathing on 3/31/23 and 4/4/23. The resident refused bathing on 4/21/23. There was no other evidence of bathing or refusals for 17 days between 4/4/23 and 4/21/23. d. Interview with the DON on 7/13/23 at 4:27 PM revealed residents should have bathing 2 to 3 times per week and staff should follow the resident preferences. e. Interview with the DON on 7/13/23 at 4:56 PM revealed she checked the bathing lists and found the resident was not on the list during his/her stay. The DON revealed she asked staff about the resident, and to their knowledge, the resident was self-care. She revealed staff gave him/her the supplies and s/he performed the bathing him/herself. Further interview confirmed the facility had no evidence the resident received or refused bathing during his/her stay except on the days documented in the electronic health record (EHR). f. Review of the policy titled "Bathing Residents" provided by the facility on 7/13/23 showed "...2. The Bath Aide will schedule	F 677	electronic health record and bath logs when baths are given or refused by the resident. Bath logs and PCC (electronic health record) bathing tasks are being reviewed in IDT meetings 3 x weekly to ensure all residents are being bathed per preferences. 4. The DON or designee will conduct weekly audits for the next 60 days of PCC bathing tasks and bath logs to ensure all residents receive at least 2 baths per week unless they refuse and this is documented. 5. The DON or designee will report results of audits to the QAPI committee monthly for the next 60 days. Additional training and/or audits will be completed as appropriate to ensure ongoing compliance.	

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F 677	Continued From page 2 residents for two baths per week. If a resident requests more or less than two baths, the Bath Aide will notify supervisory staff, and this information will be reflected on the resident's care plan. Resident will be given the choice of a bath or shower...14. The Bath Aide is to document all care provided in the eHR...16. The Bath Aide will keep supervisory staff informed on a regular basis of issues that arise, i.e., resident refusal to bath, schedule changes, concerns or complaints..."	F 677		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 756		8/4/23

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F 756	Continued From page 3 irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on review of medical records, staff interview and policy review, the facility failed to ensure a monthly medication regimen review was performed by a licensed pharmacist at least once monthly for 1 of 5 sample residents (#8) reviewed for unnecessary medications. The findings were: 1. Review of the electronic health records for resident #8 showed there was no evidence a monthly medication regimen review was performed for the months of April 2023 and June 2023. 2. Interview with the director of pharmacy on 7/13/23 at 8:29 confirmed the monthly medication regimen review was not completed for resident #8 during April 2023 or June 2023 and the medication regimen review should be completed monthly. 3. Review of the policy and procedure titled "Medication Regimen Review (MRR) Pharmacy" provided by the facility on 7/13/23 showed "...A pharmacist will perform a medication regime	F 756	F 756 1. Resident #8 was identified as being affected. A Medication Regimen Review (MRR) was completed on Resident #8 on 7/16/23. 2. All other residents were reviewed see if there were any other missed MRR's. All resident MRR assessment tasks were reviewed and set to trigger every 30 days for completion. 3. The nurse managers and pharmacists were in-serviced on the requirement for monthly MRR's for each resident. 4. The DON or designee will conduct weekly audits for the next 60 days to ensure all residents receive a monthly MRR. 5. The DON or designee will report results of audits to the QAPI committee monthly for the next 60 days. Additional training and/or audits will be completed as appropriate to ensure ongoing compliance.	

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F 756	Continued From page 4 review and clinical review on each Long Term Care resident at the time of the resident's admission to the facility, at least monthly, and when requested by facility staff or attending/consulting provider..."	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure medications were properly labeled to include	F 761	F 761 1. Resident #52 was identified as being	8/4/23

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F 761	Continued From page 5 expiration dates for 1 of 2 medication storage areas (second floor medication cart). The findings were: 1. Observation on 7/12/23 at 2:26 PM showed a bottle of Carbidopa/levodopa (decarboxylase inhibitor) 25-100 milligrams (mg) capsules and a bottle of hydrochlorothiazide (diuretic) 25 mg tablets for resident #52 did not have expiration dates. Interview with LPN #1 and RN #1 at that time confirmed neither bottle had an expiration date and revealed both medications were being administered to the resident from the bottles. 2. Interview with the administrator on 7/13/23 at 4:06 PM revealed the facility expected the admitting nurse and pharmacist to verify the medication bottles, brought to the facility by residents had proper labels before the medications were administered. 3. Review of the policy titled "Medication Processing and Administration," provided by the facility on 7/13/2023, showed "...c) Labeling requirements for medication for LTCC residents...b. All medications will be labeled with the following information...i. innovator brand or non-innovator...iv. Expiration date...c. improperly or inaccurately labeled medications are rejected and returned to the dispensing pharmacy..."	F 761	affected. The medications identified were removed and replaced by facility's contracted pharmacy. 2. All other medications brought from home were audited to ensure all had proper labelling with expiration dates. 3. Licensed nurses were in-serviced on the policy that any medication brought from home must include all required labelling information per policy, including expiration dates. The licensed nurse will verify that any medications brought from home are labelled appropriately before accepting the medication. 4. The DON or designee will conduct weekly audits of resident medication carts for the next 60 days to ensure any new medications from home have expiration dates. 5. The DON or designee will report results of audits to the QAPI committee monthly for the next 60 days. Additional training and/or audits will be completed as appropriate to ensure ongoing compliance.	
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		8/4/23

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F 812	Continued From page 6 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, review of the US Food Code, and policy and procedure review, the facility failed to ensure the food storage equipment was maintained in a clean and sanitary manner in 1 of 1 kitchens. The census was 52. The findings were: 1. Observation on 7/11/23 at 7:04 AM showed the top of the "Blodgett" oven, "Rational Self-Cooking Center", and the "Metro c5 1 series" proofing cabinet were soiled with dark discolored dust and grime. Further observation showed extra racks were stored on top of the rational self-cooking center and a cookie sheet was stored on top of the "Blodgett" oven, and had discolored dust and grime on them. 2. Observation on 7/13/23 at 10:53 AM showed the top of the "Blodgett" oven, "Rational Self-Cooking Center", and the "Metro c5 1 series" proofing cabinet remained soiled with dark discolored dust and grime. Further observation showed the extra racks remained on top of the	F 812	F 812 1. No residents were identified as being affected. 2. All residents have the potential to be affected. Reviews of infection tracking did not indicate any issues with food related illnesses in the facility. The ovens top surfaces were cleaned immediately. 3. Nutrition Services staff were in-serviced on cleaning the tops of the ovens per weekly schedule and ensure they are kept free of dust/debris. 4. The Nutrition Services Director or designee will conduct weekly audits of kitchen for the next 60 days to ensure oven top surfaces are kept clean and free of dust/debris. 5. The Nutrition Services Director or designee will report results of audits to the QAPI committee monthly for the next 60 days. Additional training and/or audits will be completed as appropriate to ensure	

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F 812	Continued From page 7 rational self-cooking center and a cookie sheet remained on top of the "Blodgett" oven, and continued to have discolored dust and grime on them. 3. Interview with the executive chef on 7/13/23 at 11:19 AM revealed the equipment was scheduled to be cleaned last Sunday; however, he was unable to get them cleaned and put them on the cleaning list for the following Sunday. He confirmed he was the individual who cleaned the ovens; however, he did not clean the top of them. Further interview confirmed the discolored dust and debris were present and could be transferred to food items. 4. Review of policy titled "Food Safety and Sanitation" provided by the facility on 7/13/23 showed "...7. Work surfaced [sic] and equipment should be thoroughly cleaned after each use..." 5. 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... (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 812	ongoing compliance.	
F 880 SS=D	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.	F 880		8/4/23

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F 880	Continued From page 8 §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 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	F 880		

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F 880	Continued From page 9 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, staff interview, and policy and procedure review, the facility failed to ensure appropriate infection prevention practices during observations of care for 1 of 8 sample residents (#35). The findings were: 1. Observation on 7/12/23 at 3:12 PM showed LPN #1 and RN #1 entered the room of resident #35. At 3:13 PM, LPN #1 exited the room wearing gloves and holding her hands at shoulder height. The LPN walked down the hallway to the nurse's station, without touching items in the hall, and encountered a CNA. The CNA obtained a measuring tool from the nurse's station and walked with the LPN to the resident's room. Upon reentry to the resident's room, RN #1 assisted the resident to roll to his/her right side and the LPN lowered the resident's brief. The LPN used the measuring tool to measure a small open area	F 880	F 880 1. Resident #35 was identified as being affected. Review of Resident #35's record indicated no signs or symptoms of infection. 2. All residents have the potential to be affected. Residents were reviewed and none were identified with signs or symptoms of infection. 3. Staff were in-serviced on proper hand washing/hygiene and glove use when providing direct care to residents. 4. The DON or designee will conduct weekly observations for the next 60 days of at least 3 different staff members providing care to residents to ensure compliance with proper hand washing/hygiene and glove use.	

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F 880	Continued From page 10 near the resident's coccyx. At that time, the LPN touched the resident's skin with her gloved hands and manipulated the measuring device and the resident's skin, to obtain wound measurements. When she finished measuring the area and without changing gloves, the LPN touched the outside of the resident's brief to pull it to the proper position, and touched the exterior of the resident's pants to pull them up. 2. Interview with the infection preventionist on 7/13/23 at 2:30 PM revealed staff should remove gloves before exiting a room and should not touch clean items after contact with potentially contaminated surfaces. Further interview confirmed the nurse should have removed her gloves before going into the hallway and she should not have touched the resident's clothing with the gloves worn to measure the resident's wound. 3. Interview with the DON on 7/13/23 at 2:39 PM confirmed the nurse should have removed her gloves before exiting the resident room and should not have touched the resident's brief or clothing with potentially contaminated gloves. 4. Review of the policy titled "Hand Hygiene" provided by the facility on 7/13/23 showed "... Indications for Hand Hygiene...5. Hand Hygiene will be performed: Before and after patient contact. After contact with a patient's intact skin (e.g. when taking a pulse or blood pressure, and when lifting a patient). After contact with body fluids or excretions, mucous membranes, non-intact skin, or wound dressings. Before donning sterile gloves when doing an invasive procedure. After removing gloves. Gloves must be changed between patients or when moving	F 880	5. The DON or designee will report results of audits to the QAPI committee monthly for the next 60 days. Additional training and/or audits will be completed as appropriate to ensure ongoing compliance.	

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F 880	Continued From page 11 from a contaminated site to a clean site, or when moving from an area where gloves were applied..."	F 880		