STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	C 05/09/2024

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CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	**713 OAK STREET SUNDANCE, WY 82729**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 5/6/24 through 5/9/24. Also reviewed in the course of the survey was complaint intake WY000003731. The following abbreviations were used throughout the document: ADL: Activities of Daily Living ADON: Assistant Director of Nursing BIMS: Brief Interview for Mental Status MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure MDS assessment information was an accurate reflection of resident status for 1 of 12 sample residents (#8) reviewed. The findings were: 1. Review of the 3/6/24 quarterly MDS assessment for resident #8 showed the resident was admitted to the facility on 8/24/23 and had a diagnosis of atrial fibrillation. Review of the November 2023, December 2023, January 2024,	F 641	The facility will ensure MDS assessment information reflects accurate resident status. This will be accomplished by: 1. Resident #8 MDS assessment was corrected and submitted with accurate information. 2. The facility will audit each resident's past quarterly or annual assessment to ensure accuracy. If errors are found, a correction MDS will be submitted. 3. The current MDS coordinator, or designee, will complete MDS training to	7/3/24

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

Electronically Signed | 05/24/2024

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F 641	Continued From page 1 February 2024, and March 2024 medication administration records showed the resident was administered 5 milligrams of Eliquis (an anticoagulant) every 12 hours. The findings were: a. Review of the 12/6/23 and 3/6/24 quarterly MDS assessments showed the resident was not coded as receiving an anticoagulant during the 7-day look-back period. b. Interview with the ADON on 5/9/24 at 9:57 AM confirmed the MDS assessments had been coded incorrectly. 2. According to the MDS 3.0 RAI Manual version 1.18.11 page 483 "N0415E1. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days)."	F 641	help facilitate the accuracy of assessments. Each assessment will be double checked by DON, or designee, for accuracy before submission of the MDS. 4. The results of the audit will be presented to the QAPI committee for a minimum of 3 months or until QAPI committee is satisfied that the facility is in compliance with F641. - -	
F 657 SS=D	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	F 657		7/3/24

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F 657	Continued From page 2 medical record if the participation of the resident 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 medical record review and staff interview, the facility failed to ensure the comprehensive care plan was revised as needed to reflect the resident's current needs for 2 of 12 sample residents (#8, #9). The findings were: 1. Review of the 3/20/24 quarterly MDS assessment showed resident #9 was admitted on 9/7/22 with diagnoses which included a primary medical condition of moderate dementia without psychotic disturbance, heart failure, and depression. Review of an 3/19/24 "Office Clinic Note Physician" report showed the resident had been recently placed on comfort cares as his/her "dementia seems to be progressing and [s/he] is no longer eating well and is losing weight. A discussion was had with the POA and a mutual decision was made to discontinue medications with the exception of liquid Tylenol." The following concerns were identified: a. Review of the care plan, last reviewed 3/20/24, failed to show revisions related to comfort care. b. Interview with the ADON on 5/9/24 at 9:54 AM confirmed the care plan had not been revised to reflect the resident's comfort care status.	F 657	The facility will ensure comprehensive care plans are revised as needed to reflect the resident's current needs. This will be accomplished by: 1. Resident #9 care plan was updated to reflect current resident needs for comfort care status. 2. Resident #8 care plan was updated to reflect pain management. 3. The DON, or designee, will audit all care plans to ensure resident’s needs are care planned appropriately. 4. The DON, or designee, will provide education to staff on care plan documentation. 5. The DON, or designee, will audit care plans weekly to ensure that any resident needs are care planned appropriately and make changes as needed. 6. Audits will be brought to QAPI for 3 months or until the QAPI committe deems this issue to be resolved.	

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F 657	Continued From page 3 2. Review of the 9/6/23 admission MDS assessment showed resident #8 was prescribed scheduled and as needed pain medication, and had mild pain almost constantly which did not interfere with sleep or activities. The following concerns were identified: a. Review of the 12/6/23 quarterly MDS assessment showed the resident had pain almost constantly at an intensity level of 10 out of 10 which affected both sleep and interfered with activities. b. Review of the 3/6/24 quarterly MDS assessment showed the resident had pain almost constantly at an intensity level of 10 out of 10 which frequently affected his/her sleep, interfered with therapy activities almost constantly, and occasionally interfered with day-to-day activities. c. Review of the resident's current physician orders showed the resident was prescribed acetaminophen 325 milligrams and tramadol (an opioid) 50 milligrams every 12 hours. d. Review of the resident's care plan, last reviewed 3/6/24, failed to show the care plan had been revised to include goals and interventions related to pain. e. Interview with the ADON on 5/9/24 at 9:50 AM confirmed the care plan should have been revised to include pain management.	F 657		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.	F 732		7/3/24

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F 732	Continued From page 4 (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on daily staff posting review and staff interview, the facility failed to ensure the data requirements were included on the the daily staff postings. The findings were: The census was 20.	F 732	The facility will ensure data requirements are included on the daily staffing posting. This will be accomplished by: 1. The daily staffing sheet is updated to reflect the facility's name 2. Educating the nurses, or responsible	

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F 732	Continued From page 5 1. Review of 2 weeks look back of the daily staff postings showed the facility failed to include the facility's name. 2. Interview with the ADON on 5/8/24 at 11:37 AM revealed she was unaware the facility's name needed to on the daily staff postings, and confirmed the facility name was not on the daily staff postings.	F 732	party, of the regulation to ensure all aspects are included daily. 3. The DON, or designee, will perform a daily audit of the daily staff posting with the exception of weekends and/or holidays. The audit will be conducted for weekends and/or holidays on the following business day. 4. The results of the audit will be presented to the QAPI committee for a minimum of 3 months or until the QAPI committee is satisfied that the facility is in compliance with F732.	
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, 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	F 812	The facility will ensure a sanitary kitchen	7/3/24

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F 812	Continued From page 6 the dishwasher and refrigerator/freezer temperature log sheets, manufacturer's instructions, and the 2022 FDA Food Code, the facility failed to ensure a sanitary environment in 1 of 1 kitchen. The census was 20. The findings were: 1. Observation on 5/6/24 at 2:39 PM showed the facility used a Jackson chemical sanitizing dishwashing machine. The temperature of the water and the concentration of the chlorine sanitizer solution were to be monitored at breakfast, lunch and dinner. Review of the Jackson dishwashing machine manufacturer's instructions showed the minimum temperature of the wash and rinse water was 120 degrees Fahrenheit (F), with a recommended temperature of 140 degrees F. The concentration of the chlorine sanitizer should be between 50 and 100 parts per million (ppm). The following concerns were identified: a. Review of the March 2024 dish machine log sheet showed the required concentration of the sanitizer and temperature of the wash and rinse water was not documented on the form 32 out of 93 opportunities. Review of the April 2024 dish machine log sheet showed the required concentration of the sanitizer and temperature of the wash and rinse water was not documented on the form 23 out of 90 opportunities. b. The dinner wash cycle, rinse cycle and sanitizer concentration were missing on 3/1, 3/3, 3/4, 3/5, 3/6, 3/8, 3/13, 3/15, 3/18, 3/21, 3/22, 3/25, 3/27, 3/31, 4/1, 4/2, 4/3, 4/6, 4/8, 4/9, 4/15, 4/16, 4/18, 4/19, 4/25, 4/29, and 4/30. c. The breakfast, lunch, and dinner wash cycle, rinse cycle and sanitizer concentration were missing on 3/2, 3/30, 4/7, and 4/13. d. The breakfast and lunch wash cycle, rinse	F 812	environment. This will be accomplished by: 1. All kitchen staff will be educated on appropriate wash and rinse temperatures per manufacturer's instruction and appropriate concentration of the chlorine sanitizer. 2. The kitchen staff, or designee, will adjust wash and rinse temperatures to the appropriate temperature per manufacturer instructions and the 2022 FDA Food Code. 3. Kitchen staff will be educated on documentation of wash and rinse temperatures and concentration of chlorine sanitizer for breakfast, lunch, and dinner cycles. 4. Kitchen staff will be educated on appropriate documentation of the Walk-In Cooler for both morning and afternoon shift. The logs will be updated to reflect the expected ranges of appropriate refrigerator temperatures. 5. Kitchen staff will be educated on appropriate documentation of the Walk-In Freezer for both morning and afternoon shift. The logs will be updated to reflect the expected ranges of appropriate freezer temperatures. 6. Kitchen staff will be educated on appropriate documentation of the Reach-In Cooler for both morning and afternoon shift. The logs will be updated to reflect the expected ranges of appropriate temperatures. 7. Kitchen supervisor, or designee, will audit logs daily to ensure compliance with F812.	

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F 812	Continued From page 7 cycle and sanitizer concentration were missing on 3/9, 3/10, and 3/23. e. The breakfast sanitizer concentration was missing on 3/16. f. The lunch and dinner wash cycle, rinse cycle and sanitizer concentration were missing on 3/16, 3/17, 3/24, and 4/21. g. The dinner sanitizer concentration was missing on 4/17. h. The lunch wash cycle, rinse cycle and sanitizer concentration was missing on 4/28. 2. Review of the March and April 2024 Walk-In Cooler Temperature Log showed the temperature was to be documented on both the morning and afternoon shifts. The expected ranges of the refrigerator were not posted on the log sheet. The following concerns were identified: a. The morning and afternoon shift temperatures were missing on 3/1, 3/2, 3/3, 3/4, 3/5, 3/30, and 3/31. b. The afternoon shift temperature was missing on 3/18, 4/15, 4/23, and 4/30. c. The morning shift temperatures were missing on 3/28, 3/29, 4/11, 4/14, 4/15, 4/16, 4/20, 4/21, 4/22, 4/24, and 4/26. d. On the afternoon shift of 4/7 the temperature was recorded as minus 10 degrees F. e. On the afternoon shift of 4/8 the temperature was recorded as minus 12 degrees F. f. On the afternoon shift of 4/9 the temperature was recorded as 0 degrees F. g. On the afternoon shift of 4/10 the temperature was recorded as minus 8 degrees F. 3. Review of the March and April 2024 Walk-in Freezer temperature log showed the temperature	F 812	8. The kitchen supervisor, or designee, will present the results of the audit to the QAPI committee to ensure continued compliance for a minimum of 3 months or until QAPI committee is satisfied that the facility is in compliance with F880.	

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F 812	Continued From page 8	F 812		

was to be documented on both the morning and afternoon shifts. The expected ranges of the freezer were not posted on the log sheet. The following concerns were identified:

a. The morning and afternoon shift temperatures were missing on 3/1, 3/2, 3/3, 3/4, 3/5, 3/30, 3/31, 4/11, 4/14, 4/15, 4/16, 4/20, 4/21, 4/22, 4/24, and 4/26.

b. The afternoon shift temperature was missing on 3/18, 4/12, 4/19, and 4/30.

c. The morning shift temperatures were missing on 3/28, 3/29, 4/10, 4/11, 4/16, 4/17, 4/20, 4/22, and 4/26.

4. Review of the February 2024 and May 2024 Reach-In Cooler Temperature Log showed the temperature was to be documented on both the morning and afternoon shifts. The expected ranges of the refrigerator were not posted on the log sheet. The following concerns were identified:

a. The morning and afternoon shift temperatures were missing on 2/1, 2/2, 2/3, and 2/4.

b. The afternoon shift temperature was missing on 2/18.

c. The morning shift temperatures were missing on 2/19, 2/28, and 2/29, 5/1, 5/2, 5/3, and 5/4.

5. Interview with the administrator on 5/9/24 at 9:09 AM confirmed the temperature log and dish machine sheets were incomplete.

6. Review of the undated "Dishwasher Temperature" policy provided by the administrator on 5/8/24 showed "...2. The wash temperature of the spray dishwasher will be at 150 degrees or above. 3. The rinse temperature of the dishwasher will be at 160 or above. 4. The final

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rinse temperature will be at 180 degrees or above. 5. Temperatures below 180 degrees require corrective actions." 6. Water temperatures will be measured prior to each meal and/or after the dishwasher has been emptied or re-filled for cleaning purposes and recorded on the Dishwasher Temperature Chart. "

7. Review of the undated "Monitoring of Cooler/Freezer Temperature" policy provided by the administrator on 5/8/24 showed "...1. Logs for recording temperatures for each refrigerator or freezer will be posted in a visible location outside the freezer or refrigerator unit. Temperatures will be checked and logged at least twice per day by designated personnel. Logs will be changed out and filed each month. 2. Thermometers shall be placed inside each cooler/freezer and calibrated at least once per week. Calibration between the inside thermometer and the outside gauge of the unit will be checked as well. 3. All refrigerated storage must be maintained at or below 41 degrees F, unless otherwise specified by law. 4. All frozen storage must be maintained at or -4 degrees F, unless otherwise specified by law. 5. If temperatures are above 41 degrees for coolers or 10 F for freezer, the supervisor will be notified immediately for corrective action."

8. According to the 2022 FDA Food Code "4-703.11 Hot Water and Chemical. Efficacious sanitization depends on warewashing being conducted within certain parameters. Time is a parameter applicable to both chemical and hot water sanitization. The time hot water or chemicals contact utensils or food-contact surfaces must be sufficient to destroy pathogens that may remain on surfaces after cleaning. Other parameters, such as rinse pressure, temperature,

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F 812	Continued From page 10 and chemical concentration are used in combination with time to achieve sanitization. When surface temperatures of utensils passing through warewashing machines using hot water for sanitizing do not reach the required 71oC (160oF), it is important to understand the factors affecting the decreased surface temperature. A comparison should be made between the machine manufacturer's operating instructions and the machine's actual wash and rinse temperatures and final rinse pressure. The actual temperatures and rinse pressure should be consistent with the machine manufacturer's operating instructions and within limits specified in §§ 4-501.112 and 4-501.113. If either the temperature or pressure of the final rinse spray is higher than the specified upper limit, spray droplets may disperse and begin to vaporize resulting in less heat delivery to utensil surfaces. Temperatures below the specified limit will not convey the needed heat to surfaces. Pressures below the specified limit will result in incomplete coverage of the heat-conveying sanitizing rinse across utensil surfaces."	F 812		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.	F 851		7/3/24

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F 851	Continued From page 11 §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format.	F 851		

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	535029	A. BUILDING _____ B. WING _____	C 05/09/2024

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F 851	Continued From page 12 The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on Payroll Base Journal (PBJ) review and staff interview, the facility failed to ensure direct care staffing information was submitted on schedule specified by CMS for 2 of 4 quarterly periods (1st quarter, 10/2023-12/2023, 3rd quarter, 4/2023-6/2023). The findings were: 1. Review of the Casper Payroll Base Journal showed the facility failed to submit data for quarter 1 (10/2023- 12/2023) and quarter 3 (4/2023-6/2023). 2. Interview with payroll management on 5/8/24 at 2:42 PM revealed the facility had missed the deadlines for submission of the data on both quarters. 3. Interview with the administrator on 5/9/24 at 10 AM confirmed the facility had missed the deadlines for submission to the PBJ on the 2 quarters.	F 851	How corrective action will be accomplished for those residents found to have been effected by the deficient practice: Administrator and DON and/or PBJ Submission Designee will together review the deadlines for each PBJ reporting period and verify that appropriate filing reminders are in place. The Administrator will also review the current process for compiling, formatting, and submitting an PBJ direct patient care information and make adjustments as needed to create a more efficient and accurate process. Address how the facility will identify other residents having the potential to be affected by the same deficient practice The Administrator has determined that all residents are affected by the failure to provide direct care staffing information by the required deadline as required by Section 486.70(q)(5). Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

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F 851	Continued From page 13	F 851	The DON or Designee will provide the Administrator with copy(s) of the CMS Payroll Based Journal Upload Data File report for all PBJ files no later than 1 week before each PBJ reporting period deadline to verify the timely filing of direct care staffing information. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Administrator and/or DON will design an internal audit procedure and complete it quarterly to ensure all direct care staffing information has been submitted by the reporting period deadline. The results of the audit will be presented to QAPI, to ensure continued compliance for a minimum of 6 months or until the QAPI committee is satisfied that the facility is in compliance with F851.	
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. §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:	F 880		7/3/24

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F 880	Continued From page 14 §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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 15 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 professional standards review, the facility failed to ensure infection prevention techniques were followed during 1 of 1 wound care observation(#8). The findings were: 1. Observation of wound care for resident #8 on 5/8/24 at 11:27 AM showed RN #1 donned gloves, placed a barrier under the resident's legs, and set unopened supplies on the table. She removed an old dressing from the right leg. She cleaned the wound with gauze and wound cleaner. Doffing her gloves, she fanned the wound with a dressing packet. She performed hand hygiene, donned gloves and opened the packet and placed the calcium alginate. She then opened the abd pad packet and placed it over the calcium alginate and then opened the kerlix gauze packet and wrapped the right lower leg. The nurse then moved to the left lower leg, doffing, hand hygiene, donning gloves. She removed the old dressing, cleaned the wound with wound cleaner and gauze, and fanned the wound with an unopened dressing packet. She offed her gloves, performed hand hygiene, and donned new gloves. She then opened the	F 880	The facility will ensure proper infection prevention and control techniques are utilized to prevent the spread of infectious diseases. This will be accomplished by: 1. All nurse/aides will receive education at the next staff meeting on donning/doffing PPE for clean and dirty processes. 2. The DON or designee will provide proper wound care education to those staff performing wound care and said staff will redemonstrate proper wound care process to the DON or designee. 3. Resident #8 wound care was performed using a clean procedure. Gloves were changed between clean and dirty processes and this was observed by the DON. 4. An audit will be performed by DON, or designee, to ensure those who can change dressings have recieved appropriate education and demonstrated proper technique. 5. The DON, or designee, will present the results of the audit to the QAPI committee to ensure continued compliance for a	

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F 880	Continued From page 16 calcium alginate packet and placed the dressing to the wound. She opened the abd pad packet and placed it over the calcium alginate, then opened the kerlix gauze package and wrapped the dressing around the lower leg. 2. Interview with RN #1 at the end of the dressing change revealed she was not wound care certified. She confirmed that was how she normally did the wound dressing change. She stated she fanned the wounds because the resident liked it. She confirmed that outer packets were dirty and were opened when she was in the clean process. 3. Interview with the ADON on 5/8/24 at 12:20 PM revealed it was the expectation for staff during wound care to keep clean procedures clean, change gloves between dirty and clean, and do not fan a wound. 4. Review of website "https://www.ncbi.nlm.nih.gov/books/NBK593201/ " on 5/17/24 showed "... A break in the skin allows bacteria to enter and begin to multiply. ...Step 1. Gather supplies: 2. Perform safety steps: Perform hand hygiene, Check the room for transmission-based precautions, ...Be organized and systematic... Perform hand hygiene immediately prior to arranging the supplies at the bedside. ... 6. Place a clean, dry, barrier on the bedside table. Create a sterile field if indicated by agency policy. 7. Pour sterile normal saline into opened sterile gauze packaging to moisten the gauze. Normal saline containers must be used for only one patient and must be dated and discarded within at least 24 hours of being opened. Commercial wound cleanser may also be used.	F 880	minimum of 3 months or until QAPI committee is satisfied that the facility is in compliance with F880.	

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F 880	Continued From page 17 8. Expose the dressing. 9. Perform hand hygiene and apply nonsterile gloves. 10. Remove the outer dressing. 11. Remove the inner dressing. Use transfer forceps, if necessary, to avoid contaminating the wound bed. 12. Remove gloves, perform hand hygiene, and put on new gloves. Wrap the old inner dressing inside the glove as you remove it, if feasible, to prevent contaminating the environment. 13. Assess the wound. 14. Drape the patient with a water-resistant underpad, if indicated, to protect the patient's clothing and linen. 15. Apply gloves and other PPE as indicated. Goggles, face shield, and/or mask may be indicated. 16. Cleanse the wound based on agency policy, using moistened gauze, commercial cleanser, or sterile irrigant. When using moistened gauze, use one moistened 2" x 2" sterile gauze per stroke. Work in straight lines, moving away from the wound with each stroke. Strokes should move from a clean area to a dirty area and from top to bottom. Note: A suture line is considered the "least contaminated" area and should be cleansed first. ... 18. Remove gloves, perform hand hygiene, and apply new gloves. 19. Apply sterile dressing (4" x 4" sterile gauze), using nontouch technique so that the dressing touching the wound remains sterile. 20. Apply outer dressing if required. Secure the dressing with tape as needed. 21. Remove gloves and perform hand hygiene."	F 880		