STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535057	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN HEALTHCARE COMMUNITY	**2009 LARAMIE STREET TORRINGTON, WY 82240**

(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 recertification survey was conducted by Healthcare Licensing and Surveys from 4/15/24 to 4/18/24. Also reviewed in the course of the survey were complaint intakes WY000003803 and WY000003864. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		5/17/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/13/2024

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 578	Continued From page 1 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the resident rights the facility failed to ensure resident advance directives were accurate for 1 of 18 sample residents (#46). The findings were: 1. Review of the WyoPOLST (Providers Orders for Life Sustaining Treatment) dated 9/6/23 showed resident #46 elected Cardiopulmonary Resuscitation (CPR). 2. Review of the physician orders dated 3/5/24 showed the resident was Do Not Resuscitate	F 578	Plan of Correction This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a	

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F 578	Continued From page 2 (DNR). 3. Interview with LPN #1 on 4/17/24 at 10:05 AM revealed "I would look at the orders and look for the code status." We do have a binder with the POLST in it. They must not have changed it since she came back." 4. Interview with health information coordinator on 4/17/24 at 10:10 AM confirmed the WyoPOLST and the physician orders were conflicting between the POLST and the orders. 5. Review of the Resident Rights showed "...Get proper medical care....To participate in the decisions that affect your care....To formulate advance directives, such as a living will or durable power of attorney for health care..."	F 578	deficiency or that the scope or severity regarding the deficiencies cited are correctly applied. The POLST form for resident #46 was revised by the family during the survey and now matches the physician's order for DNR. Medical records were reviewed to ensure that the current POLST forms are reflected in the physician's orders. POLST forms are completed at the time of admission, and reviewed quarterly and with change of condition thereafter. Physician orders are entered into the record to match the POLST form. Emergency care is performed based only on the POLST forms which are available at each nurse's station and audited weekly. Licensed nurses have been re-educated in this process. Ongoing education on this process also occurs throughout the year and at time of hire. The Director of Nursing is responsible for this system. The Health Information Manager audits POLST forms weekly. The Director of Nursing or designee will audit new admissions for orders matching the POLST form on an ongoing basis. Results of these audits will be brought to the QA committee for review x 3 months. Future concerns with this system will be brought to the QA committee for review and resolution.	

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F 578	Continued From page 3	F 578	Completion Date: 5/17/24	
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 observation, staff interview, and medical record review, the facility failed to ensure residents received oral care per the plan of care for 1 of 2 sample residents (#4), who were unable to independently carry out activities of daily living. The findings were: 1. Review of the annual MDS assessment dated 1/25/24 showed resident #4 had short-term and long-term memory impairment and diagnoses which included rheumatoid arthritis, non-Alzheimer's dementia, and weakness. Further review showed the resident required partial/moderate assistance to perform oral hygiene. Review of the ADL care plan last revised on 4/15/24 showed the resident had an ADL deficit related to Lewy-Body dementia and severely impaired cognition. Interventions included "...ORAL CARE: Provide oral care after each meal. 1-person assist. Encourage [resident name] to participate...ORAL CARE: Requires total assistance for completion. I do not wear dentures or partials..." The following concerns were identified: a. Review of a progress note dated 4/13/24 and timed 4:27 PM showed the facility contacted the resident's power of attorney related to oral care and a build of plaque on the resident's teeth.	F 677	Plan of Correction This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied. F677 Resident #4 is now receiving oral care after each meal. Residents in the facility were reviewed for their oral care needs and care plans and task assignments were revised accordingly.	5/17/24

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F 677	Continued From page 4 The facility communicated a "new plan" for oral care and the power of attorney "voiced understanding" and was "okay with the new plan." b. Observation on 4/17/24 at 2:42 PM showed CNA #1 and CNA #2 assisted the resident to the bathroom following the lunch meal. Continued observation showed the staff did not offer or perform oral hygiene. c. Observation on 4/18/24 from 8:05 AM through 10:26 AM showed the resident was assisted to the dining room table for the breakfast meal. Further observation showed the resident finished the meal at 8:35 AM and was assisted to a recliner in the TV area. The resident remained in the recliner until 10:26 AM and staff did not offer or perform oral hygiene during that time. d. Review of the oral care task documentation from 4/13/24 through 4/17/24 showed oral care was documented at 11:34 AM and 9:06 PM on 4/14/24, 2:34 PM on 4/14/24, 2:13 AM and 9:35 AM on 4/15/24, 9:11 AM and 9:15 PM on 4/16/24, and 1:42 PM on 4/17/24; however, there was no evidence the oral care was offered or provided after each meal. e. Interview with the infection preventionist and DON on 4/18/24 at 11:24 AM revealed the resident should receive oral care, within 30 minutes following the completion of each meal.	F 677	Nursing staff were educated on adherence to the care plan and proper oral care. The Director of Nursing is responsible for this system. The Director of Nursing or designee will perform regular and random audits of oral care provided to the residents per the care plan. Results of oral care audits and concerns with this system will be brought to the QA committee monthly x 3 months. Future concerns with this system will be brought to the QA committee for review and resolution. Completion Date: 5/17/24	
F 729 SS=E	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program	F 729		5/17/24

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F 729	Continued From page 5 approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on personnel record review, and staff interview, the facility failed to ensure the CNA abuse registry was verified for 1 of 3 sample CNAs (#1) prior to resident contact. The findings were: Review of the personnel record for CNA #1 showed she had quit on 5/3/23, and was rehired on 11/3/23, indicating 6 months between employment. The review showed the CNA abuse registry was checked on 1/19/23 prior to the	F 729	Plan of Correction This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that	

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F 729	Continued From page 6 CNAs initial employment; however, there was no evidence it was verified upon rehire. Interview with the business office manager and CEO on 4/16/24 at 3:52 PM confirmed the facility did not recheck the abuse registry when the CNA was rehired.	F 729	the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied. F729 The abuse registry for CNA #1 was checked on 1/19/24 and there were no issues. CNAs re-hired in the last 12 months were reviewed to ensure that the abuse registry was checked. No other problems were identified. The manager responsible for this action at time of hire and re-hire was re-educated on the process for checking the abuse registry for CNAs. The Administrator is responsible for oversight of hiring of employees in the facility. The Administrator was educated on the process for hiring CNAs and will sign off all new employee files using a checklist to ensure they are complete. A report of new hires and this process will be brought to the QA committee monthly x 3 months. Future concerns with this process will be brought to the QA committee for review and resolution. Completion Date: 5/17/24	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		5/17/24

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F 758	Continued From page 7 §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 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	F 758		

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F 758	Continued From page 8 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 policy and procedure review, the facility failed to ensure target symptoms were identified and monitoring of target symptoms was completed for 3 of 5 sample residents (#14, #20, #32) with psychotropic medication use. The findings were: 1. Review of the quarterly MDS assessment dated 2/14/24 showed the resident #14 had a brief interview for mental status score of 10 out of 15, which indicated moderate cognitive impairment, and diagnoses which included non-Alzheimer's dementia and depression. Review of the physician orders showed the resident received Abilify (antipsychotic) 5 milligrams (mg) by mouth daily for depression, buspirone (anti-anxiety) 10 mg by mouth three times daily for depression, and sertraline (antidepressant) 50 mg by mouth daily for depression. The following concerns were identified: a. Review of the care plan, last revised on 4/5/24 showed "...TARGETED BEHAVIORS: 1) anxiety 2) depressed or withdrawn 3) insomnia..." Further review showed no evidence of resident specific or medication specific target symptoms for the identified behaviors. b. Review of the medication administration	F 758	Plan of Correction This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied. F758 Residents #14, #20, and #32 now have identified resident-specific target behaviors for the medications they are receiving. Care plans were revised for these residents. Residents who are receiving psychotropic medications were reviewed for resident specific target behaviors. Care plans	

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F 758	Continued From page 9 record for January 2023 through April 2023 showed no evidence resident specific or medication specific target symptoms were identified or monitored for the effectiveness of psychotropic medications. 2. Review of the quarterly MDS assessment dated 1/23/24 showed resident #20 short-term and long-term memory impairment and diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, and adjustment disorder with mixed anxiety and depressed mood. Review of the physician orders showed the resident received citalopram (antidepressant) 20 mg by mouth daily for depression/agitation, divalproex sodium (anticonvulsant) 250 mg by mouth twice daily for psychotic disturbance, Seroquel 50 mg by mouth twice daily for dementia with aggression towards others, and Seroquel (antipsychotic) 75 mg by mouth daily at bedtime for dementia. The following concerns were identified: a. Review of the care plan, last revised on 1/16/24, showed "...TARGETED BEHAVIORS: 1) agitated 2) depressed withdrawn 3) restless..." Further review showed no evidence of resident specific or medication specific target symptoms for the identified behaviors. b. Review of the medication administration record for January 2023 through April 2023 showed no evidence resident specific or medication specific target symptoms were identified or monitored for the effectiveness of psychotropic medications. 3. Review of the annual MDS assessment dated 3/28/24 showed resident #32 had diagnoses which included non-Alzheimer's dementia, anxiety disorder, depression, and post-traumatic stress	F 758	were revised to reflect the new target behaviors. Nursing staff were educated on behavior tracking and behavior documentation to include recording of target behaviors identified for each resident. The Director of Nursing is responsible for monitoring behavior tracking and the identification of target behaviors. The Director of Nursing or designee will perform regular and monthly audits of target behavior tracking to justify psychotropic medications. Results of these audits will be brought to the QA committee monthly x 3 months. Future concerns with this system will be brought to the QA committee for review and resolution. Completion Date: 5/17/24	

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F 758	Continued From page 10	F 758		

disorder. Review of the physician orders showed the resident received buspirone (anti-anxiety) 5 mg by mouth twice per day for anxiety disorder and depression, Celexa (antidepressant) 20 mg by mouth once daily for depression, and clonazepam (anticonvulsant) 0.5 mg by mouth twice per day for anxiety.

a. Review of the care plan, last revised on 4/4/24, showed no evidence target symptoms were identified for the use of each psychotropic medication.

b. Review of the medication administration record for January 2023 through April 2023 showed no evidence resident specific or medication specific target symptoms were identified or monitored for the effectiveness of psychotropic medications.

4. Interview with the DON on 4/18/24 at 11:24 AM confirmed target symptoms were not identified or monitored with the use of psychotropic medication.

5. Review of the policy titled "Psychotropic Medication Use" last revised on 11/28/16 showed "...1.1 The facility should not use psychotropic medications to address behaviors without first determining if there is a medical, physical, functional, psychological, social or environmental cause of the resident's behaviors...4. Psychotropic medications to treat behaviors will be used appropriately to address specific underlying medical or psychiatric causes of behavioral symptoms...7. All medications used to treat behaviors must have a clinical indication and be used in the lowest possible dose to achieve the desired therapeutic effect. All resident's receiving medications used to treat behaviors should be monitored for: 7.1 efficacy, 7.2 Risks,

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F 758	Continued From page 11 7.3 Benefits, and 7.4 Harm or adverse consequences..."	F 758		
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, and 2022 U.S. Public Health Food Code review, the facility failed to ensure a sanitary equipment and failed to ensure food was stored under safe conditions in 1 of 2 food storage, preparation, and service areas (main kitchen). The census was 62. The findings were: 1. Observation on 4/15/24 at 2:14 PM showed the ice machine had a plastic piece which was not secured to the machine and a white powdery substance was built-up around the exterior above	F 812	Plan of Correction This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors findings or conclusions	5/17/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN HEALTHCARE COMMUNITY	2009 LARAMIE STREET TORRINGTON, WY 82240

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F 812	Continued From page 12 the door. Further observation showed the white powdery substance moved when the ice machine door was opened and closed and could fall into the ice. 2. Observation of the walk-in refrigerator on 4/15/24 at 2:17 PM showed a container of tomatoes with no date, a container labeled bell peppers with a use by date of 4/12, three containers labeled beef base dated with an expiration date of 10/1/23 and a use by date of 1/2/24, two containers labeled chicken base with and expiration date of 10/1/23 and a use by date of 4/5/24, a bag labeled chili with use by date of 4/1, a container labeled hardboiled eggs with a use by date of 4/10/24. 3. Observation on 4/17/24 at 10:56 AM showed the ice machine remained with a white powdery substance on the exterior above the door. 4. Observation of the walk-in refrigerator on 4/17/24 at 10:58 AM showed the bell peppers, beef base, and chicken base remained. 5. Interview with the dietary manager on 4/17/24 at 11:35 AM revealed expired items or items past use by date should be discarded and the ice machine was cleaned by maintenance; however, she was unsure of the cleaning schedule. She revealed the facility was aware of the damaged part of the ice machine and confirmed the powdered build-up could fall in the machine. Further she confirmed all items in the walk-in refrigerator were available for resident consumption. 6. According to Food Code 22, U.S. Public Health Service: 4-601.11 " ...(A) EQUIPMENT	F 812	are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied. F812 Outdated/expired food Items cited in the survey were removed prior to the end of the survey. The ice machine was unplugged and was not used until it was cleaned, disinfected, and descaled. The plastic piece was repaired. All food storage areas were inspected for outdated/expired food items. All items were discarded. There are no other ice machines of this type in the facility. Dietary staff were educated on expiration and use by dates for food items. Dietary and Maintenance staff were educated on the maintenance and cleaning of the ice machine. A cleaning schedule was developed for the ice machine in which the maintenance department periodically descales the machine and dietary regularly cleans the machine. Food storage areas are now assigned to daily kitchen staff to review and discard any expired items. The Dietary Manager is responsible for proper food storage and cleanliness of kitchen equipment. The Dietary Manager or designee will complete regular and frequent audits of food storage areas for outdated/expired food and the ice machine for cleanliness. Food storage	

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F 812	Continued From page 13 FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris ..." 7. According to Food Code 22, U.S. Public Health Service: "...3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1..."	F 812	areas will be audited twice weekly x 3 months for appropriate storage and adherence to use by and expiration dates. Results of these audits will be brought to the QA committee monthly x 3 months. Future problems with this system will be brought to the QA committee for review and resolution. Completion Date: 5/17/24	
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		5/17/24

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F 880	Continued From page 14 §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 disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 15 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 control techniques were implemented to prevent cross contamination during 2 of 4 observations of perineal care. The census was 62. The findings were: 1. Review of the annual MDS assessment dated 3/27/24 showed resident #15 had short-term and long-term memory impairment and diagnoses which included Alzheimer's dementia, seizure disorder, traumatic brain injury, anxiety disorder, and depression. Further review showed the resident was totally dependent on staff for toileting and personal hygiene. Review of the ADL care plan last revised on 2/7/24 showed the resident required assistance with ADLs related to early onset Alzheimer's dementia and interventions included "...INCONTINENT: Check and change q [every] 2-3 hours and prn [as	F 880	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied. Residents #15 and #4 were assessed for adverse outcomes from the incorrect procedure. No adverse outcomes were found. Incontinent residents requiring personal	

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F 880	Continued From page 16 needed]. Toilet upon awakening, before and after meals, and at bedtime and PRN with goal to be as dry as possible during waking hours..." The following concerns were identified: a. Observation on 4/17/24 at 2:26 PM showed the resident was assisted by 2 staff members his/her room and transferred into bed. CNA #2 and CNA #1 applied gloves, obtained supplies, and removed the resident's pants and brief. CNA #2 provided perineal care, then without removing her gloves, CNA #2 used her contaminated gloved hand to apply a clean brief, pull up the resident's pants, and touched the resident's shirt. 2. Review of the annual MDS assessment dated 1/25/24 showed resident #4 had short-term and long-term memory impairment and diagnoses which included rheumatoid arthritis, non-Alzheimer's dementia, and weakness. Further review showed the resident required substantial/maximal assistance with toileting and personal hygiene. Review of the ADL care plan last revised on 4/15/24 showed the resident had an ADL deficit related Lewy-Body dementia and severely impaired cognition. Interventions included "...TOILETING: Total dependence with toileting, wears briefs. Frequently incontinent. The following concerns were identified: a. Observation on 4/17/24 02:42 PM showed CNA #1 and CNA #2 assisted the resident out of a chair and ambulated the resident to his/her room. CNA #1 explained to resident she was going to assist her to the bathroom. The staff member applied gloves, removed the resident's pants, and assisted the resident to sit on the toilet. When the resident was finished going to the bathroom, the CNA assisted the resident to stand a performed perineal care; however, without	F 880	hygiene to be performed by staff after incontinence are potentially at risk. Nursing staff were re-educated on the proper procedure for perineal care after incontinence. Return demonstrations were conducted. The Director of Nursing and Infection Preventionist are responsible for this process. The DON or designee will perform regular audits x 3 months of staff performing perineal care of residents. Results of these audits will be brought to the QA committee monthly x 3 months. Future problems with this process will be brought to the QA committee for review and resolution. Completion Date: 5/17/24	

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F 880	Continued From page 17	F 880		

removing her gloves, the CNA used the contaminated gloved hand to reach into the wipe container and obtain additional wipes. CNA #2 stood near the sink while care was provided. CNA #1 began performing care to the resident's buttocks to remove feces from a bowel movement and wiped the resident front to back, clean to dirty; however, during the care, CNA #1 continued to use her contaminated gloved hand to removes wipes from the container and touched the outside of the perineal spray to spray the resident's skin with the solution. During the care, CNA #1 passed the contaminated bottle of perineal spray from one hand to the other, contaminating her clean gloved hand. In addition, CNA #1 placed each of her contaminated gloved hands on the resident's shirt while performing perineal care with the opposite hand. Further observation showed, upon completion of the perineal care and without removing the contaminated gloves, CNA #1 touched the outside of resident's clean brief, the resident's shirt, and the resident's pants.

3. Interview with the infection preventionist and DON on 4/18/24 at 11:24 AM revealed staff should wash their hands before resident care, apply gloves prior to performing perineal care, and change gloves before touching clean areas when they were contaminated. They confirmed gloves should be removed before touching resident clothing.

4. Review of the policy titled "Perineal Care" last revised February 2023 showed "...14. Remove gloves and discard into designated container. Perform hand hygiene. 15. If changing brief or dressing/undressing resident, apply clean gloves before proceeding with these items..."

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