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	535043	A. BUILDING _____ B. WING _____	C 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	**503 S 18TH ST LARAMIE, WY 82070**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 10/7/24 to 10/10/24. Also reviewed in the course of the survey was complaint intake WY00003923. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse RN: Registered Nurse MDS: Minimum Data Sheet Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		11/24/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/01/2024

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F 584	Continued From page 1 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, the facility failed to ensure a clean environment for 1 of 3 sample residents (#5) reviewed for bowel and bladder incontinence and activities of daily living. The findings were: 1. Observation of resident #5's room on 10/7/24 at 2:28 PM showed the resident was in his/her room with a visitor and there was a strong urine odor present, which could be smelled in the hallway. 2. Observation of resident #5's room on 10/8/24 at 8:22 AM showed the room had a very strong urine odor and the floor was sticky.	F 584	F 584 HOMELIKE ENVIRONMENT Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of	

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F 584	Continued From page 2 3. Observation of resident #5's room on 10/9/24 at 10:24 AM showed a housekeeper #1 was cleaning the resident's room. Upon completion at 10:32 AM, the housekeeper #1 exited the room; however, the urine odor and sticky floors remained. Interview with the resident at that time revealed s/he could not smell the odors; however, s/he asked housekeeper #1 to mop again due to the floors remaining sticky. 4. Observation of resident #5's room on 10/10/24 at 9 AM showed the room smelled of urine, the bathroom ventilation was not working, and the resident's floor was sticky. 5. Interview with the housekeeping manager on 10/10/24 at 9:13 AM revealed the facility was aware of increased urination on the floor in resident #5's room and revealed they did not perform a "heavy mop" on the floor while the resident was in the room due to potential fall risk. She revealed nursing staff had a mop bucket available to clean if housekeeping was not available.	F 584	compliance in accordance with section 7305 of the state operations manual. CORRECTIVE ACTION On 10/8/2024 the Resident room with the STICKY FLOOR for Resident #5 was thoroughly cleaned and urine odors were eliminated. On 10/23/2024 the lower water temperatures were evaluated by the plumber and the low water temperature was fixed. IDENTIFICATION. Residents currently residing at the community are at a potential risk. On 10/10/2024 the Maintenance Director conducted room rounds throughout the community to identify other potential issues with low water temperature. On 10/30/2024 the Housekeeping Supervisor conducted room rounds throughout the community to identify other potential issues with urine odors and sticky floors. No other issues were identified. SYSTEMIC CHANGES The NHA/Designee in-serviced the Housekeeping and Maintenance Director on 10/14/2024 to ensure that the facility maintains a sanitary, orderly, and comfortable interior, specifically ensuring sticky floors, offensive urine odors, and low water temperatures are not present. Beginning at the time of survey and up to the date of compliance, the NHA/Designee in-serviced facility staff on communication of housekeeping concerns/issues including sticky floors, offensive urine odors, and/ or low water	

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F 584	Continued From page 3	F 584	temperatures. The housekeeping director, the maintenance director, and the facility management team will conduct ongoing room rounds to ensure compliance. NHA will provide oversight to ensure identified issues have been addressed. MONITORING The maintenance director, housekeeping director, and NHA/Designee will conduct weekly environmental rounds checking for sticky floors, urine odors, and low water temperatures for 4 weeks, then monthly rounds for 2 months then prn to identify outstanding issues Further monitoring through Resident Council, facility grievance process, ombudsman, and family feedback. Any issues identified will be addressed at that time and issues identified will be reported to the monthly QAPI committee meeting to ensure the corrections have been implemented, achieved, sustained, and evaluated for its effectiveness. DATE OF COMPLIANCE: 11/24/2024	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		11/24/24

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F 758	Continued From page 4 (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 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.	F 758		

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F 758	Continued From page 5 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 1 of 5 sample residents (#2) reviewed for unnecessary psychotropic medications. The findings were: 1. Review of the quarterly MDS assessment dated 8/21/24 showed resident #2 had diagnoses which included non-Alzheimer's dementia, anxiety disorder, and depression. Review of the physician orders showed the resident received Sertraline (antidepressant) 100 milligrams (mg) by mouth daily for anxiety with depression. The following concerns were identified: a. Review of the physician orders showed behaviors related to the use of Sertraline were to be monitored every shift; however, there were no medication or resident specific target symptoms identified; b. Review of the care plan, last revised on 10/7/24, showed no medication or resident specific target symptoms were identified related to the use of the Sertraline. c. Review of the medication administration record for October 2024 showed no evidence of medication or resident specific target symptoms were identified related to the use of the Sertraline. d. Review of the "Anti-Depressant Informed consent for medication" dated 8/23/24 showed the consent was for Sertraline; however, there was no medication or resident specific target symptoms were identified related to the medication use. e. Interview with the DON and regional nurse on 10/9/24 at 3:09 PM revealed target symptoms	F 758	F 758 Unnecessary Psychotropic Medication/PRN use Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. Corrective Action: For Resident # 2, she no longer resides at the community, she respectfully passed on 10/24/2024 Staff and IDT were educated on Unnecessary Medication policy to include policy and regulatory requirements behavior documentation for medication use. Nurses that were not working during the education will be educated 1:1 upon their return to work. Identification: Residents currently receiving a psychotropic may be subject to this deficiency A review of records for resident's receiving psychoactive medications will be conducted by the IDT Prior to the	

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F 758	Continued From page 6 should be on the care plan, medication administration record, or medication consent. f. Interview with the DON and regional nurse on 10/10/24 at 10:16 AM confirmed the resident did not have resident or medication specific target symptoms identified. 2. Review of the policy titled "Psychotropic Medication Use" dated July 2022 showed "...Resident Evaluations...3. When determining whether to initiate, modify, or discontinue medication therapy, the IDT conducts an evaluation of the resident. The evaluation will attempt to clarify whether:..b. signs and symptoms are clinically significant to warrant medication therapy..."	F 758	allegation of compliance to determine any Issues identified behavior tracking of the medication. Issues were corrected at that time. Systemic changes: For residents who are prescribed psychoactive medications, the clinical record documentation needs to be reviewed to ensure: 1). Nursing/Clinical documentation includes targeted behaviors, and interventions and behavior monitoring when indicated. 2). Target behaviors, interventions, outcome and medication side effects are monitored on the Medication administration record IDT and licensed nurses were educated on Unnecessary Medication policy to include policy and regulatory requirements for behavior documentation for psychotropic medication use. Nurses unable to attend the education will be educated 1:1 upon their return to work. An attendance sheet was utilized at the education and all new nurses will be educated upon hire as indicated. Monitoring: DON/Designee will audit records of residents with psychotropic medications monthly for 3 months then quarterly. Issues identified will be corrected at that time and on the spot, reeducation will be done. The issues identified will be tracked/ trended for review by the QAPI committee until compliance has been achieved.	

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F 758	Continued From page 7	F 758	Date of compliance: 11/24/2024	
F 761 SS=E	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 labeled with an open date or not expired in 2 of 5 medication storage areas (100 hall medication cart, 200 hall medication cart). The findings were:	F 761	F761 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the	11/24/24

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F 761	Continued From page 8 1. Observation of the 100 hall medication cart on 10/9/24 at 8:52 AM showed an Insulin Glargine 100 units/milliliter pen for resident #5 was not labeled with an open date and did not indicate when the medication should be discarded. The following concerns were identified: a. Interview with LPN #1 on 10/9/24 at 8:57 AM revealed the person who opened the insulin should label it with the date it was opened and with a 28-day expiration date. She confirmed she did not know if the insulin, which she administered to the resident, was within the useable timeframe or was expired. b. Interview with the DON on 10/9/24 at 10:39 AM confirmed insulin pens should be labeled with the open date. She revealed nurses should not administer the medication and should discard the pen if it was not labeled. 2. Observation of the 200 hall medication cart on 10/8/24 at 8:29 AM showed a multidose bottle of Aspirin 81 milligram (mg) tablets with a manufacturer's expiration date of "7/2024." Interview with RN #2 at that time revealed multidose medication bottles should not be used after the manufacturer's expiration date on the bottle. 3. Interview with the DON on 10/9/24 at 4:10 PM stated her expectation is that the nurse who dispensed the medication should check the expiration date prior to administration. 4. Review of the policy titled "Administering Medications", provided by the DON on 10/8/24, showed "...The expiration/beyond use date on the medication label is checked prior to administering..."	F 761	statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. Corrective Action: The undated insulin pen and expired aspirin were removed from the medication cart. The facility will label drugs and biologicals in accordance with currently accepted professional principles, and include the appropriate necessary and cautionary instructions, and the expiration date when applicable. Identification: There are currently 50 residents at the facility who can be impacted. The facility will audit 100% of medication carts to ensure that all drugs and biologicals are labeled, dated and stored in accordance with currently accepted professional standards, specifically insulin pens and removal of any expired meds. The DON conducted an initial audit of all medication carts on 10/30/2024 and no other issues were identified. Systemic Changes: The policy and procedure for drug storage has been reviewed. All licensed nurses received education related to the policy for drug storage on or before the allegation of compliance by the DON/ Designee. An attendance sheet will be kept, and those	

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F 761	Continued From page 9	F 761	unable to attend the reeducation will be provided with one-on-one in servicing Monitoring: The DON/Designee will audit 100% of med carts weekly, for one month. After one month, the DON/Designee will audit 100% of med carts bi-monthly, for two months. Audits will demonstrate compliance with the facility policy and procedure for drug storage. Audit results will be reviewed by the NHA/Designee and areas of non-compliance will be addressed at the time they are identified. Audit trends will be reported to the facility QAPI committee monthly, for review and further corrective action when negative trends are identified. The DON/Designee will be delegated responsibility for assuring compliance with this plan of correction for F761. Compliance Date: 11/24/2024	
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other	F 801		11/1/24

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F 801	Continued From page 10	F 801		

clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-
(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-

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F 801	Continued From page 11 (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to ensure the dietary manager met the required qualifications. The facility census was 48. The findings were: Interview with the dietary manager on 10/9/24 at 11:24 AM revealed the manager had "one more month" to complete the certified dietary manager coursework. Further interview with the dietary manager revealed the facility had two part time dietitians who were not on site.	F 801	F801 CORRECTIVE ACTION: Dietary Director will be Certified before 12/31/2024. Full time dietician services are being provided and will remain in place until a CDM is acquired. IDENTIFICATION All residents that reside at the facility have the potential to be affected. SYSTEMIC CHANGES Dietary Director with be Certified before	

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F 801	Continued From page 12 Interview with the administrator on 10/10/24 at 10:57 AM confirmed the facility did not have a qualified dietary manager or a full-time dietitian.	F 801	12/31/2024. Full time dietician services are being provided and will remain in place until a CDM is acquired. The Community employs staff with appropriate competencies and skills sets to carry out the functions of the food and nutrition services taking into consideration resident assessments, individual plans of care and the number, acuity and diagnosis of facility resident population in accordance with the facility assessment. On or before the allegation of compliance the regional nurse consultant/ designee will in service ED, on ensuring there is a CDM and an RD in place. MONITORING The ED/Designee will monitor weekly to ensure the Dietary directors progress ongoing progress on the CDM certificate. The ED/Designee will monitor monthly to ensure RD is in place no less than 8 hours per day. DATE OF COMPLIANCE 11/1/2024	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		11/8/24

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F 880	Continued From page 13 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 §483.71 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	F 880		

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F 880	Continued From page 14 (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, medical record review, staff interview, and policy review, the facility failed to ensure infection control procedures were implemented for 4 of 4 sample residents (#2, #14, #23, #41) who required enhanced barrier precautions. The findings were: 1. Observation on 10/9/24 at 9:56 AM showed CNA #1 and CNA #2 assisted resident #41 to transfer from the bed to the wheelchair. Prior to the transfer, CNA #1 applied gloves, disconnected the resident's wound vacuum, and placed the tubing over the bed. Following the transfer, the end of the tubing for the wound vacuum dropped on floor and CNA #1 picked it and reconnected the tubing, without disinfecting the open end of the tubing which was on the floor. Further observation showed neither CNA used enhanced barrier precautions during the care. Interview with the DON and regional nurse on 10/9/24 at 11:35 AM revealed open tubing dropped on the floor should not have been	F 880	F880 Enhanced Barrier Precautions Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for: Ensuring enhanced barrier precaution are in place per CDC guidelines Identification of Others All residents residing at Cottonwood Health and Rehab, The IP and DON, in conjunction with the applicable interdisciplinary team (IDT) members, will review the current Infection Control Program and current Enhanced Barrier	

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F 880	Continued From page 15 reconnected without disinfection of the tubing. 2. Observation on 10/9/24 at 3:51 PM showed CNA #3 and CNA #4 entered resident #2's room with a sit to stand lift, applied gloves, and positioned the lift sling behind the resident. The CNAs assisted the resident to stand and removed his/her pants. The resident had a dressing present on his/her coccyx which was not attached on bottom right side. CNA #4 performed perineal care and without removing her soiled gloves, touched a bottle of silicone cream, the outside of the resident's clean brief, and the resident's pants when she pulled them up. The CNA also touched the lift, the lift sling, a wipe container, and a bedside table without removing the gloves. Further observation showed no enhanced barrier precautions were used. Interview with the DON on 10/10/24 at 9:41 AM revealed gloves should be changed prior to touching clean surfaces. 3. Observation of catheter care performed on resident #14 on 10/9/24 at 9:44 AM showed the CNA #3 performed the catheter care while wearing only gloves. Observation of resident #14's room at that time showed no enhanced barrier precaution signage posted in the room or additional personal protective equipment (PPE), other than gloves, was available. Interview with the CNA on 10/9/24 at 9:52 AM revealed she was not aware of the need for enhanced barrier precautions when performing catheter care. 4. Observation of resident #23 on 10/7/24 at 2:08 PM, 10/8/24 at 9:43 AM, and 10/9/24 at 8:31 AM, showed the resident was in his/her wheelchair, his/her bilateral lower legs were wrapped with a dressing, and the resident's bare feet were on the floor. Observation of the resident's room on	F 880	precautions for nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. System Changes On or before 11/08/2024 the facility shall complete the following actions: (1) The DON, SDC, IP or suitable designee will ensure the following: a. Educate all staff whose normal duties include entering resident rooms on enhanced barrier precautions b. All staff will receive education on keeping hands clean between tasks, contacts with potentially contaminated surfaces and between residents. e. Educate all staff whose duties include perineal care procedures in the importance of hand hygiene between changing gloves. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: observation of staff to ensure precautions are being followed correctly and the appropriate postings and PPE supplies are in place. All monitoring will be reported to the quality assurance performance improvement (QAPI) committee as part of	

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F 880	Continued From page 16 10/8/24 at 8:31 AM showed no PPE, other than gloves, was available. Interview with LPN #1 on 10/9/24 at 10:40 AM revealed she was not aware of any interventions in place to prevent reinfection of the resident's legs, or keep his/her bare feet off of the floor. The LPN revealed there were no residents on enhanced barrier precautions on South or North Birch Halls, which was where the resident's room was located. Interview with the DON on 10/9/24 at 10:55 revealed she was unaware the resident did not have foot pedals on his/her wheelchair or that his/her bare feet were on the floor. 5. Interview with CNA #1 on 10/9/24 at 9:52 AM revealed she was not aware of enhanced barrier precautions until 10/9/24 when education was provided by the DON. 6. Interview with CNA #2 on 10/9/24 at 9:52 AM revealed she was not aware of enhanced barrier precautions until 10/9/24 when education was provided by the DON. 7. Review of policy titled Enhanced Barrier Precautions, provided by the DON on 10/9/24, showed "...Enhanced barrier precautions are used as an infection prevention and control intervention to reduce the spread of multidrug resistant organisms (MDRO) to residents. EBP's employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. EBP's are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization..." 8. Review of the policy titled "Briefs/Underpads"	F 880	QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. Date of Compliance: 11/08/2024	

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F 880	Continued From page 17 dated 2001 showed "...12. Perform perineal care the resident's back side...14. Remove gloves, sanitize hands and replace with clean gloves..."	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on staff interview and policy and procedure review, the facility failed to ensure a qualified individual was designated as the facility infection preventionist. The facility Census was 48. The findings were: Interview with the DON on 10/10/24 at 9:41 AM revealed she had been covering the infection control program since May and she had not completed any specialized training in infection prevention.	F 882	F882 CORRECTIVE ACTION: The Director of Nursing and the ADON both will have Specialized Training in Infection Prevention and Control (IPC) training. with time necessary to properly assess, develop, implement, monitor, and manage the IPCP for the community, address training requirements, and participate in required committees such as QAPI. The DON has initiated training for IPC.	11/24/24

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F 882	Continued From page 18 Review of the facility policy titled "Infection Preventionist" last revised September 2022 showed "...Specialized Training...1. The infection preventionist has obtained specialized IPC beyond initial professional training or education prior to assuming the role...2. Evidence of training is provided through a certificate(s) of completion or equivalent documentation..."	F 882	IDENTIFICATION Residents that currently reside at Cottonwood may be affected. SYSTEMIC CHANGES The IP will have the time necessary to properly assess, develop, implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees such as QAPI. The IP will physically work onsite in the facility. The IPC will have Specialized Training in Infection Prevention and Control (IPC) training. MONITORING: The ED/designee will monitor weekly to ensure progress of the DON□s completion of the IPC course. The DON/designees will monitor quarterly to validate IPC certification. COMPLIANCE DATE: 11/24/2024	
F 923 SS=E	Ventilation CFR(s): 483.90(i)(2) §483.90(i)(2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure ventilation was working in 7 of 10 resident rooms observed. The census was 48. The findings were: 1. Observation of room 103 on 10/10/24 at 8:16 AM showed the ventilation in the room was not working. Observation of room 103 with the	F 923	F923 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed	11/24/24

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F 923	Continued From page 19 maintenance director on 10/10/24 at 8:58 AM confirmed the ventilation in the room was not working. 2. Observation of room 110 on 10/10/24 at 8:20 AM showed the ventilation in the room was not working. Observation of room 110 with the maintenance director on 10/10/24 at 8:54 AM confirmed the ventilation in the room was not working. 3. Observation of room 114 on 10/10/24 at 8:24 AM showed the ventilation in the room was not working. 4. Observation of room 115 on 10/10/24 at 8:26 AM showed the ventilation in the room was not working. 5. Observation of room 345 with the maintenance director on 10/10/24 at 8:32 AM showed the ventilation in the room was not working. 6. Observation of room 336 with the maintenance director on 10/10/24 at 8:38 AM showed the ventilation in the room was not working. 7. Observation of room 119 with the maintenance director on 10/10/24 at 9 AM showed the ventilation in the room was not working, the floor was sticky, and the room smelled of urine. Interview with the maintenance director at that time confirmed the ventilation system was not working in some of the resident rooms.	F 923	solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. Corrective Action The ventilation for room #110, #103, #114, #115, #345, #336, and #`119 was repaired by Fremont Electric on 10/16/2024. Identification: On or before the date of compliance the Environmental Service Director will Conduct an immediate assessment of all ventilation systems within the facility to identify areas of concern. Identified issues will be addressed at that time. This may include repairing or replacing filters, fans, and ducts. Systemic Changes On or before the allegation of compliance the NHA/ designee will Provide training for facility staff on the importance of proper ventilation and how to identify potential issues. On or before the allegation of compliance the Environmental Service Director/ designee will Educate staff on reporting procedures for maintenance needs related to ventilation. Monitoring and Evaluation: Weekly for 12 weeks the Maintenance Director will inspect and service ventilation	

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F 923	Continued From page 20	F 923	systems then monthly and prn. Results from these inspections will be reviewed monthly in QAPT to ensure the plan is implemented, sustained, and evaluated for its effectiveness. Date of compliance 11/24/2024	