STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	08/22/2024

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

(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 8/19/24 to 8/22/24. The following common abbreviations are used throughout this document: ADL: Activities of Daily Living ADON: Assistant Director of Nursing CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse RN: Registered Nurse MDS: Minimum Data Sheet BIMS: Brief Interview for Mental Status Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		9/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/12/2024

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 656	Continued From page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure care plans were developed and implemented for 1 of 2 sample residents (#34) observed during personal care. The findings were: 1. Review of the quarterly MDS assessment dated 5/29/24 showed resident #34 had a BIMS	F 656	1. Resident #34 was identified as being affected and both were reviewed with no recent infections noted. This resident□s care plan was updated to include interventions on positioning and handling of foley catheter bags. 2. All residents who have foley catheters were reviewed to ensure their care plans	

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F 656	Continued From page 2 score of 7 out 15, which indicated severe cognitive impairment, and diagnoses which included renal insufficiency, neurogenic bladder, hypertensive chronic kidney disease, history of traumatic brain injury, and benign prostatic hyperplasia with lower urinary tract symptoms. Further review showed the resident had an indwelling catheter and was dependent on staff for toileting hygiene, personal hygiene, and chair/bed-to-chair transfer. Review of the enhanced barrier precautions care plan initiated on 4/23/24 showed interventions which included "...Staff will perform proper donning and doffing of PPE guidelines..." The following concerns were identified: a. Observation on 8/21/24 at 10:27 AM showed the resident was seated in his/her wheelchair, in common area, watching television. CNA #2 obtained mechanical lift and attached the lift sling, which was positioned behind the resident, to the lift. The CNA obtained the resident's catheter drainage bag from under the resident's chair, without applying gloves, and attached it to the mechanical lift. After handling the drainage bag, the CNA touched the controls of the mechanical lift, lifted the resident, and positioned him/her over a recliner. The CNA lowered the resident into the recliner and, without applying gloves, removed the catheter drainage bag from the mechanical lift. In addition, the CNA held the drainage bag above the resident's bladder, where urine visible in the tubing flowed toward the resident's bladder, walked it around to the side of the recliner, and placed the drainage bag on the floor next to the recliner. Further observation showed the CNA obtained a blanket and covered the resident, raised the resident's feet, obtained gloves from a box in hanging near the common area and applied them, and wiped	F 656	were updated as needed to include interventions on handling catheters and proper incontinent care as it relates to preventing infections and cross contamination. 3. Direct care staff were re-educated to ensure care plan interventions related to appropriate catheter positioning and handling. The care plan team was re-educated about ensuring that care plans for residents who have foley catheters contain interventions on proper foley catheter positioning and handling. 4. The DON or designee will conduct weekly audits for the next 60 days of all care plans for residents who have foley catheters to ensure the care plans include interventions on proper foley catheter positioning and handling. 5. The DON or designee will report results of audits to the QAPI committee monthly for the next 60 days. Additional training and/or audits will be completed as appropriate to ensure ongoing compliance.	

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F 656	Continued From page 3 down the mechanical lift with sanitizing wipes. b. Review of the indwelling foley catheter care plan last revised on 6/18/24 showed interventions which included "Catheter: Position catheter bag and tubing below the level of the bladder..." There was no indication the catheter drainage bag should not be positioned on the floor. b. Interview with the DON on 8/21/24 at 3:12 PM revealed the staff member should have donned gloves prior to handling the catheter drainage bag and should not have positioned the bag above the resident's bladder or on the floor. 3. Interview with the DON on 8/22/24 10:13 AM revealed care information should be included on the care plan so staff can know how to provide resident care and staff should follow the care plan.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident record review, staff interview, professional standard review, and policy and procedure review, the facility failed to ensure administered resident medications were taken in the presence of nursing staff for 1 of 2 resident units (200 unit). The census was 58. The findings were: 1. Observation on 8/19/24 at 5:22 PM showed resident #30 had a medication cup, with	F 658	1. Resident #□s 30 and 47 were identified as being affected. Both residents were immediately re-approached and observed taking their medications. 2. All residents who are administered medications were immediately reviewed upon notification of this deficient practice to verify no other meds had been left at resident□s bedside or table.	9/10/24

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F 658	Continued From page 4 medications in it, on the table in front of the resident. Further, observation showed no nurse was present. The resident revealed LPN #1 had dropped it off. 2. Observation on 8/19/24 at 5:55 PM showed resident #47 had a medication cup, with medications in it, sitting in front of resident in dining room. Further, observation showed RN #1 reminded the resident, at 6 PM, to take medication. The RN stated she thought the resident took the medication. 3. Interview with the DON on 8/21/24 at 9:30 AM revealed neither resident was assessed for self-administration of medication and they were not to self-administrator medications. 4. Review of the policy and procedure titled "Medication Processing and Administration" provided by the facility on 8/21/24 at 10:45 AM by the DON showed "...m. a) Process for Administration of Medication...x. The resident is always observed by the licensed nurse during administration to ensure that the dose was completely ingested..." 5. Review of the National Library of Medicine's "Summary of Safe Medication Administration Guidelines," found at "https://www.ncbi.nlm.nih.gov/books/NBK593214/table/ch18adminprntlmeds.T.summary_of_safe_med/" on 9/5/24 showed "...Follow a standardized procedure when administering medication for every patient..."	F 658	3. All licensed nurses, including LPN #1 and RN #1, were re-educated on policies related to medication administration, including not leaving medications with a resident unless they have been approved to self-administer. 4. The DON or designee will conduct 1 weekly observation of a med pass on each floor for the next 60 days to ensure compliance with the medication administration policy. 5. The DON or designee will report results of audits to the QAPI committee monthly for the next 60 days. Additional training and/or audits will be completed as appropriate to ensure ongoing compliance.	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		9/10/24

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F 755	Continued From page 5 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, resident record review, staff interview, and policy and procedure review, the facility failed to ensure nursing staff dispensed resident medications according to facility policy and procedure for 1 of 2 resident units (200 unit). The census was 58. The findings	F 755	1. Resident #□s 30 and 47 were identified as being affected. Both residents were immediately re-approached and observed taking their medications. 2. All residents who are administered	

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F 755	Continued From page 6 were: 1. Observation on 8/19/24 at 5:22 PM showed resident #30 had a medication cup, with medications in it, on the table in front of the resident. Further, observation showed no nurse was present. The resident revealed LPN #1 had dropped it off. 2. Observation on 8/19/24 at 5:55 PM showed resident #47 had a medication cup, with medications in it, sitting in front of resident in dining room. Further, observation showed RN #1 reminded the resident, at 6 PM, to take medication. The RN stated she thought the resident took the medication. 3. Interview with the DON on 8/21/24 at 9:30 AM revealed neither resident was assessed for self-administration of medication and they were not to self-administrator medications. 4. Review of the policy and procedure titled "Medication Processing and Administration" provided by the facility on 8/21/24 at 10:45 AM by the DON showed "...m. a) Process for Administration of Medication...x. The resident is always observed by the licensed nurse during administration to ensure that the dose was completely ingested..."	F 755	medications were immediately reviewed upon notification of this deficient practice to verify no other meds had been left at resident□s bedside or table. 3. All licensed nurses, including LPN #1 and RN #1, were re-educated on policies related to medication administration, including not leaving medications with a resident unless they have been approved to self-administer. 4. The DON or designee will conduct 1 weekly observation of a med pass on each floor for the next 60 days to ensure compliance with the medication administration policy. 5. The DON or designee will report results of audits to the QAPI committee monthly for the next 60 days. Additional training and/or audits will be completed as appropriate to ensure ongoing compliance.	
F 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	F 880		9/10/24

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F 880	Continued From page 7	F 880		

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:

§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.

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F 880	Continued From page 8 (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 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 and procedure review, the facility failed to ensure infection prevention practices were implemented for 2 of 2 sample residents (#18, #34) observed during personal care. The findings were: 1. Review of the quarterly MDS assessment dated 5/21/24 showed resident #18 had a BIMS score of 11 out 15, which indicated moderate cognitive impairment, and diagnoses which included hemiplegia or hemiparesis, non-Alzheimer's dementia, and weakness. Further review showed the resident was dependent on staff for toileting hygiene, dressing, and personal hygiene. Review of the ADL self-care performance deficit care plan last	F 880	1. Resident #'s 18 and 34 were identified as being affected. Both residents were reviewed and neither have evidence of any recent infections related to improper incontinent care or foley catheter handling. 2. All residents have the potential to be affected. Infection tracking review was conducted to verify no other residents were affected. 3. Direct care staff, including CNA's #1 and 2, were re-educated on appropriate foley catheter handling as well as incontinent care procedures to include proper hand hygiene and PPE usage to prevent infection cross contamination. 4. The DON or designee will conduct	

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F 880	Continued From page 9 revised on 6/12/24 showed interventions which included "... [resident name] requires total assist with a full lift for toileting and incontinence care. [s/he] wears a full brief..." and "... [resident name] is totally dependence [sic] by 1 staff with personal hygiene..." The following concerns were identified: a. Observation on 8/21/24 at 10:14 AM showed CNA #1 assisted the resident to his/her room, obtained a mechanical lift, and left the room. At 10:18 AM CNA #1 and CNA #2 returned to the room, attached the lift sling, which was positioned behind the resident, to the mechanical lift, and assisted the resident out of the chair and into bed. The CNAs removed the residents lift sling from the lift, assisted the resident to position side to side, and removed the sling from under the resident. The CNAs removed the resident's pants and brief and CNA #1 performed perineal care due to urinary incontinence. Without removing her contaminated gloves, CNA #1 placed a clean brief under the resident, pulled up the resident's pants, and held the resident's hands. Interview with CNA #1 on 8/21/24 at 10:39 AM confirmed the resident had been incontinent of urine. b. Interview with the DON and ADON on 8/21/24 at 3:18 PM revealed gloves should be removed and hand hygiene performed when they are contaminated and after resident care. They revealed clean items should not be touched or applied with the dirty gloves. Further interview confirmed the CNA should have removed her gloves after performing perineal care and everything she touched with contaminated gloves would be contaminated. 2. Review of the quarterly MDS assessment dated 5/29/24 showed resident #34 had a BIMS	F 880	weekly observations of incontinent care on each floor. The observations on each floor will consist of 2 different staff performing incontinent care and 2 staff members on each floor handling a catheter for the next 60 days. 5. The DON or designee will report results of audits to the QAPI committee monthly for the next 60 days. Additional training and/or audits will be completed as appropriate to ensure ongoing compliance.	

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F 880	Continued From page 10	F 880		

score of 7 out 15, which indicated sever cognitive impairment, and diagnoses which included renal insufficiency, neurogenic bladder, hypertensive chronic kidney disease, history of traumatic brain injury, and benign prostatic hyperplasia with lower urinary tract symptoms. Further review showed the resident had an indwelling catheter and was dependent on staff for toileting hygiene, personal hygiene, and chair/bed-to-chair transfer. Review of the enhanced barrier precautions care plan initiated on 4/23/24 showed interventions which included "...Staff will perform proper donning and doffing of PPE guidelines..." Review of the indwelling foley catheter care plan last revised on 6/18/24 showed interventions which included "Catheter: Position catheter bag and tubing below the level of the bladder..." The following concerns were identified:

a. Observation on 8/21/24 at 10:27 AM showed the resident was seated in his/her wheelchair, in common area, watching television. CNA #2 obtained mechanical lift and attached the lift sling, which was positioned behind the resident, to the lift. The CNA obtained the resident's catheter drainage bag from under the resident's chair, without applying gloves, and attached it to the mechanical lift. After handling the drainage bag, the CNA touched the controls of the mechanical lift, lifted the resident, and positioned him/her over a recliner. The CNA lowered the resident into the recliner and, without applying gloves, removed the catheter drainage bag from the mechanical lift. In addition, the CNA held the drainage bag above the resident's bladder, where urine visible in the tubing flowed toward the resident's bladder, walked it around to the side of the recliner, and placed the drainage bag on the floor next to the recliner. Further observation showed the CNA obtained a blanket

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F 880	Continued From page 11 and covered the resident, raised the resident's feet, obtained gloves from a box in hanging near the common area and applied them, and wiped down the mechanical lift with sanitizing wipes. b. Interview with the DON on 8/21/24 at 3:12 PM revealed the staff member should have donned gloves prior to handling the catheter drainage bag and should not have positioned the bag above the resident's bladder or on the floor. 3. Review of the policy titled "IFC: Standard Precaution" provided by the facility on 8/22/24 showed "...D. PPE: Always follow hand hygiene protocol before donning and doffing. a. Gloves: 1. Gloves are to be worn when contact with blood, body fluids, secretions, excretions, or contaminated items are anticipated...3. Gloves are to be changed between tasks and procedures on the same patient after contact with material that may contain high concentration of microorganisms. 4. Gloves are to be removed promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another patient..."	F 880		