STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. Building B. Wing	02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Rehabilitation and Wellness	60 Magnolia Casper, WY 82604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38149 Based on observation, review of facility infection control documentation, staff interview, review of policy and procedures, and CDC guidelines, the facility failed to ensure transmission-based precautions were followed consistently and correctly to prevent the spread of communicable disease. This failure resulted in an unacceptable risk to resident health and a determination of immediate jeopardy. In addition the facility failed to ensure acceptable infection control practices were followed related to hand hygiene during 1 observation of meal service. The census was 140. The findings were: 1. Observation on 2/9/22 at 11:53 AM showed an isolation cart located between rooms [ROOM NUMBERS] and one droplet precaution sign on the wall between the 2 resident name plates for room [ROOM NUMBER] and the 2 resident nameplates for room [ROOM NUMBER]. It was not clear which room was on precautions. The drawers of the isolation cart contained yellow gowns, gloves and goggles. The doors to both rooms were open and resident #1 was seated in a wheelchair in the hallway outside room [ROOM NUMBER]. The resident was not wearing a mask. The following concerns were identified: a. Review of the facility infection control documentation provided by the facility on 2/9/22 showed the facility was in outbreak status with 10 residents positive for COVID-19. Resident #1 was listed as positive for COVID-19. b. Observation of the meal service on 2/9/22 from 12 PM to 12:10 PM showed nutrition services aide (NSA) #1 was wearing a KN95 mask and goggles while assisting with setting up meal trays. He entered the room for resident #1 without performing hand hygiene, or donning a gown and gloves, or changing his mask to a N95 mask, and delivered the lunch tray. He exited the resident's room without changing his mask, performing hand hygiene or disinfecting his goggles. He walked into the communal dining room, retrieved some juice and brought the juice back to resident #1. When he entered the resident's room he again failed to don a gown, gloves, and N95 mask, and failed to perform hand hygiene. When he exited the resident's room he failed to change the KN95 mask, disinfect the goggles, or perform hand hygiene. He then returned to the communal dining room and assisted with the meal trays. NSA #1 returned to the resident's room for a third time to provide additional assistance, and donned an isolation gown that was hanging in the room. When he finished assisting the resident, he removed the isolation gown, hung it back up on the door, and failed to perform hand hygiene, change the mask or disinfect the goggles. (continued on next page)

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	h. Education will be provided by the staff development coordinator or designee annually, and upon hire for staff regarding PPE, hand hygiene, infection control practices, and isolation room guidelines. i. DON to ensure new admissions that are in isolation and/or new COVID-19 diagnosed residents have appropriated PPE protocols in place. j. Random audits will be conducted daily on isolation rooms, isolation carts, hand hygiene for 4 weeks, then reassessed during the quality assurance meeting. Random audits of staff will be conducted daily with questioning of appropriate PPE use for 45 weeks, then reassessed in the quality assurance meeting. The action plan was accepted on 2/10/22 at 10:30 AM. The implementation of the action plan was verified and immediacy was removed on 2/10/22 at 11:08 AM; however, deficient practice remained at a scope and severity level of E. Concerns related to hand hygiene during meal service: 1. Observation on 2/9/22 from 11:53 AM to 12:10 PM of the meal service on the East nursing unit showed the following concerns: a. CNA #2 entered rooms [ROOM NUMBER] without performing hand hygiene, delivered lunch trays, assisted the residents and exited the rooms without performing hand hygiene. Further observation showed the CNA walked into the communal dining room, removed a resident's mask and no hand hygiene was performed prior to the CNA offering fluids to the resident. b. Interview on 2/9/22 at 12:10 AM with the CNA confirmed she was to perform hand hygiene upon entrance and exit of resident rooms and after providing resident care. She further stated the hand gel dispensers were not easily accessible and they were under pressure to get the meal trays to the residents. c. According to the CDC guidelines for Hand Hygiene in Healthcare Settings: hand hygiene should be performed immediately before touching a resident, and after touching a resident or the resident's immediate environment: retrieved 2/16/22 from https://www.cdc.gov/handhygiene/providers/index.html.