

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  535042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/10/2022
NAME OF PROVIDER OR SUPPLIER  Shepherd of the Valley Rehabilitation and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38149</b></p> <p>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:</p> <p>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:</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>c. Interview on 2/9/22 at 12:10 PM with NSA #1 confirmed resident #1 (room [ROOM NUMBER]) was on droplet precautions and the door should be kept closed. He also confirmed he donned an isolation gown that was hanging in the room because it was there. He revealed there were 2 gowns hanging in the room, which were for the CNAs.</p> <p>2. Observation on 2/9/22 at 12:10 PM of the Rapid Recovery Unit showed CNA #1 was in room [ROOM NUMBER] providing resident care. A sign indicating the room required droplet precautions was posted, however the door was open. The CNA wore a KN95 mask and goggles. The following concerns were identified:</p> <p>a. Observation showed the CNA was not wearing gloves or an isolation gown.</p> <p>b. The CNA provided resident care by adjusting a cooling pad on the resident's leg that had an external fixator (orthopedic device). The CNA noticed the medical device that delivered ice water to the cooling pad needed to be refilled. She brought the medical device out of the room, did not disinfect the device, and did not perform hand hygiene, don a clean mask, or disinfect her goggles upon exit.</p> <p>c. The CNA poured the contents of the medical device into a sink at the nurse's station. The CNA then took the medical device, that had not been disinfected despite being taken from a room that was on droplet precaution, to the ice machine located in the communal dining room. She placed the medical device on the edge of the ice machine, used an ice scoop to dispense ice into the medical device multiple times and touched the inside of the medical device with the scoop. When she finished she placed the scoop back in the holder on the side of the ice machine.</p> <p>d. The CNA obtained the resident's lunch tray and returned to the resident's room with the tray and the medical device. She donned a yellow isolation gown and glove and assisted the resident with the meal tray, and the medical device. She doffed the isolation gown and gloves upon exit. However, she failed to dispose of her mask and don a clean mask, perform hand hygiene or disinfect her goggles.</p> <p>e. Meal service observation on 2/9/22 from 11 AM to 12:30PM showed staff utilized the ice machines in the dining rooms to fill meal tray cups and bedside cups.</p> <p>3. Observation on 2/9/22 at 12:21 PM of the East Unit and Rapid Recovery Unit showed 4 out of 6 rooms with posted transmission-based precaution signage had open doors.</p> <p>4. Interview on 2/9/22 at 6:05 PM with the DON and ADON confirmed when staff exit an isolation room they were to doff the gown and gloves and dispose of them in the garbage. They further stated hand hygiene should be performed and goggles/face shields should be disinfected. They also stated they had never thought about changing masks when they entered and exited the isolation rooms. The DON confirmed there was a policy and she needed to review it.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>i. DON to ensure new admissions that are in isolation and/or new COVID-19 diagnosed residents have appropriated PPE protocols in place.</p> <p>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.</p> <p>The action plan was accepted on 2/10/22 at 10:30 AM.</p> <p>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.</p> <p>Concerns related to hand hygiene during meal service:</p> <p>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:</p> <p>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.</p> <p>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.</p> <p>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 <a href="https://www.cdc.gov/handhygiene/providers/index.html">https://www.cdc.gov/handhygiene/providers/index.html</a>.</p>		