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

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 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 [DATE] showed resident #34 had a BIMS 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 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. (continued on next page)

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 37603 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 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 .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37603 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 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 .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 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 [DATE] 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 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 [DATE] showed resident #34 had a BIMS 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: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 .