STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	**10/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DOUGLAS CARE CENTER LLC	**1108 BIRCH STREET DOUGLAS, WY 82633**

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 -** 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** Based on observation, staff interview, and review of the Centers for Disease Control (CDC) guidelines, the facility failed to ensure residents utilized appropriate personal protective equipment and followed social distancing in 2 of 3 resident care areas (100 unit, 300 unit) to prevent the spread of COVID-19. The findings were: 1. Observation on 10/9/20 at 11:38 AM showed resident #13 exited his/her room in a wheelchair and did not have a face mask applied. The resident carried a face mask in his/her right hand. The resident traveled from his/her room to room [ROOM NUMBER] and interacted with the resident in the doorway of the room. The resident in room [ROOM NUMBER] was wearing a mask; however, during the interaction the residents' wheelchairs were touching and 6 feet of social distancing was not maintained. Continued observation showed 2 unidentified staff members walked past and did not remind the resident to apply the face mask. 2. Observation on 10/9/20 at 11:45 AM showed the dining room had 3 recliners near the wall by the entrance. The dining tables were arranged in 2 sets of 3 square tables that were pushed together, 1 single square table, and 1 round table. Continued observation showed 11 residents were in the dining room at that time. The following concerns were identified. a. Observation on 10/9/20 at 11:45 AM showed the recliners were occupied by residents and were within arm's reach of one another. None of the residents in the recliners were wearing masks. b. Observation on 10/9/20 at 11:45 AM showed there were 3 residents seated at the round table. Resident #11 was seated at the 2 o'clock position, resident #9 was seated at the 7 o'clock position, and resident #10 was seated at the 10 o'clock position. The residents were within arm's reach of one another and none of the residents were wearing a face mask. c. Observation on 10/9/20 at 11:45 AM showed the set of 3 tables near the windows had 2 residents seated on the same end across from each other. Resident #6 was positioned at the 12 o'clock position and resident #7 was positioned at the 6 o'clock position and neither resident was wearing a face mask. d. Observation on 10/9/20 at 11:54 AM showed resident #2 was assisted to the table at the 9 o'clock position of the first table, in the set of 3 tables closest to the recliners. Resident #4 was seated at the 3 o'clock position of the 2nd table in the set of 3 tables. Observation on 10/9/20 at 12:05 PM showed resident #1 was assisted to the at the 3 o'clock position across from resident #2 and next to resident #4. Resident #1 was positioned with arm's reach of resident #2 and resident #4 and none of the residents were wearing face masks. e. Interview with the administrator on 10/9/20 at 11:53 AM revealed the square tables were between 36 inches (3 feet) and 48 inches (4 feet) across. 3. Interview with the facility administrator on 10/13/20 at 8:33 AM revealed her expectation was for staff to attempt to keep residents separated to ensure social distancing and attempt to have residents wear personal protective equipment. Further interview revealed staff should remind residents to wear face masks when they are outside of their rooms. 4. Review of the CDC guidance titled Preparing for COVID-19 in Nursing Homes last updated 6/25/20 showed .Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance .Remind residents to practice social distancing, wear a cloth face covering (if tolerated), and perform hand hygiene .Considerations when restrictions are being relaxed include: Allowing communal dining and group activities for residents without COVID-19, including those who have fully recovered while maintaining social distancing, source control measures, and limiting the numbers of residents who participate .

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