STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80TC	A. BUILDING: _____ B. WING _____	09/14/2023

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LOUISVILLE HEALTHCARE LLC	543 EAST MAIN STREET LOUISVILLE, MS 39339

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 9/12/23-9/14/23. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm at M610, M615 and M1570. The census at the time of the survey was 48 and the facility is licensed for 60.	M 000		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, record review and facility policy review, the facility failed to provide nail care to a resident for 1 (one) of 48 residents reviewed for activities of daily living (ADL) care. Resident #8 Findings include: Review of the facility policy titled, "Fingernails/Toenails, Care of", undated, revealed, "Policy The purposes of this policy is to	M 610	Louisville Healthcare acknowledges receipt of the statement of deficiencies and proposes this plan of correction as required by federal and state regulations and statues applicable to long term care providers. This plan does to constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute an agreement by the facility that the surveyors findings or conclusions are accurate, that the findings	10/30/23

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/25/23

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M 610	Continued From page 1 clean the nail bed, to keep nails trimmed, and to prevent infections. Procedure ...4. Nails can be partially cleaned during the bath ...6. Nail care includes daily cleaning and regular trimming. 7. Proper nail care can aid in the prevention of skin problems around the nail bed. 8. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin ..." On 09/12/23 at 10:07 AM, an observation and interview revealed Resident #8's fingernails were long and dirty and the nails on both hands had brownish material under them. Resident #8 confirmed that he had already had his bath this morning and he would have liked his nails cut. On 09/13/23 at 8:37 AM and 3:40 PM, an observation and interview revealed the resident stated his fingernails have not been cut and are still dirty. He stated his nails had not been cut in about a month. On 09/13/23 at 3:45 PM, during an observation and interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) confirmed the resident's fingernails were long and dirty. The ADON stated that she cut the residents fingernails on Saturday week before last. He was in the hospital last Saturday so they would be due for a cut this Saturday. The ADON stated that dirty nails could cause possible infection issues. The DON confirmed the resident's fingernails were dirty and review of the bath schedule confirmed he got bath on Tuesday. She stated that she would think the resident's nails should not be dirty if he got a bath on Tuesday. An interview on 09/14/23 at 10:10 AM, with the lead Certified Nursing Assistant (CNA) #2	M 610	constitute a deficiency or the scope of severity regarding any of the deficiencies cited are correctly applied. F677 An observation of resident #8's finger nails was completed by Director of Nursing and Assisted Director of Nursing on 09/13/2023. Nail care was provided by Assistant Director of Nursing on 09/13/2023. Residents requiring staff assisted nail care have the potential to be affected by this deficient practice. Nail care will be completed on Resident's bath days, also when observed by management team rounds. This will then be reported to the charge nurse for follow up care. Director of Nursing and Assistant Director of Nursing will be responsible for follow up care. Audit of all residents finger nails was completed on 09/25/2023. In-service on Nail care was completed by Assistant Director of Nursing on 09/25/23 Observations of resident nail care will be completed by the Director of Nursing or Assistant Director of Nursing on a daily basis x 2 weeks beginning 09/25/2023, then 10 nail audits weekly x 3 months. Findings of these observations will be presented to qapi meeting on 10/29/2023 x 3 months	

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M 610	Continued From page 2 revealed that personal care for diabetic residents concerning nail care is that the nurse cuts the nails, but the CNAs should wash the residents hands with a bath cloth or soak them during bathing and get dirt out from under the nails. Review of the Admission Record resident information sheet revealed Resident #8 was admitted to the facility on 9/29/20 with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting left dominate hand, Acquired Absence of right and left leg above knee, Type 2 Diabetes Mellitus, Heart Failure. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/21/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #8 was cognitively intact.	M 610	Completion date: 10/30/2023	
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level II Based on observations, staff interviews, record review and facility policy review, the facility failed to clean a residents wound as prescribed by the physician for one (1) of four (4) residents observed for wound care. Resident # 28	M 615	Louisville Healthcare acknowledges receipt of the statement of deficiencies and proposes this plan of correction as required by federal and state regulations and statues applicable to long term care providers. This plan does to constitute an admission of liability on the part of the	10/30/23

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M 615	Continued From page 3 Findings include: Review of the facility policy titled Wound Care updated 1/2015 revealed under, "Policy: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing." Also revealed under, "Procedure: ... After cleaning wound as ordered, clean the tissue around the wound that is usually covered by the dressing, tape or gauze with normal saline and pat dry." ... Record review of the "Order Listing Report" revealed an order dated 8/10/23, "Clean stage 2 sacral pressure ulcer with normal saline, pat dry, apply resinol to entire wound bed & (and) cover with foam dressing. Change daily and PRN (as needed) for soiled or dislodged dressing." An observation and interview with the Wound Care Nurse of sacral wound care for Resident # 28 on 9/13/23 at 11:00 AM, revealed the resident did not have a wound dressing intact at the beginning of wound care. The Wound Nurse stated, "I'm not going to clean the wound because she just had a bath." Observed that the Wound Nurse did not clean the wound before she applied the resinol to the wound and covered it with a foam dressing. An interview with the Wound Nurse on 9/13/23 at 11:10 AM, confirmed that she did not clean the wound for Resident # 28 as ordered by the physician. She stated, "No, I didn't because she had just got a bath and the area was clean." She acknowledged that she did not follow the physician's order for treatment of the wound and acknowledged that she should have but was nervous and "messed up." She confirmed that failure to clean the wound as ordered by the	M 615	facility, and such liability is hereby specifically denied. The submission of this plan does not constitute an agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency or the scope of severity regarding any of the deficiencies cited are correctly applied. F686 An observation of sacral wound care for resident #28 revealed the treatment nurse did not clean the wound before applying resinol to the wound and covering it with a foam dressing on 09/13/2023 Director of Nursing did assessment of wound 09/13/2023 to ensure there were no negative findings from this incident Residents with MD orders for wound care have the potential to be affected by this deficient practice. The Director of Nursing and Assistant Director of Nursing in-serviced the treatment nurse on 09/13/2023 about Following Doctor orders for all treatments provided. On 09/25/2023, Nursing staff was in-serviced on following current MD orders for treatments provided. Ongoing wound education will be provided during monthly in-services by Assistant Director of Nursing on 10/09/2023. Director of Nursing or Assistant Director of Nursing will observe 2 treatments weekly beginning 09/25/2023 with treatment	

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M 615	Continued From page 4 physician could affect the healing status of the wound. An interview with the Director of Nursing (DON) on 9/13/23 at 2:20 PM, confirmed that the Wound Nurse should have cleaned the wound for Resident # 28 per the physician's order. She acknowledged that failure to clean the wound according to the physician's order could influence wound healing. An interview with the Administrator (ADM) on 9/14/23 at 10:15 AM, revealed the Wound Nurse should have cleaned Resident # 28's wound according to the physician's order. She stated, "Anything could come in contact with the wound between the time of bathing and the wound care." Record review of the Admission Record revealed Resident # 28 was admitted to the facility on 12/18/19 with diagnoses that included Diffuse Traumatic Brain Injury, Paraplegia, Type 2 Diabetes Mellitus and Pressure Ulcer of Sacral Region, Stage 2. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/08/23 revealed under "Section C" a Brief Interview for Mental Status (BIMS) score of 08, which indicated Resident # 28 is moderately cognitively impaired. Also revealed under "Section M," the resident has one (1) stage 2 pressure ulcer that was present upon admission/entry or reentry to the facility.	M 615	nurse x 3 months and report to QAPI on 10/29/2023. The results of the weekly treatment observations will be reviewed weekly during Quality Assurance meetings and Quarterly during Quality Assurance Performance Improvement meetings x 3 months. Completion date: 10/30/2023	
M1570	48.58.1 Infection Control The following infection control standards shall be met:	M1570		10/30/23

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M1570	Continued From page 5 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observations, staff interviews, record review and facility policy review the facility failed to prevent the possibility of the spread of infection as evidence by not removing a mask after exiting a COVID-19 isolation room (Resident #2) and failed to clean a wound during wound care (Resident # 28) for two (2) of seven (7) resident care observations. Resident #2 and Resident #28 Findings Include Review of the facility policy titled "Standard Precautions Infection Control" with no revision	M1570	Louisville Healthcare acknowledges receipt of the statement of deficiencies and proposes this plan of correction as required by federal and state regulations and statues applicable to long term care providers. This plan does to constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute an agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency or the scope of severity regarding any of the deficiencies	

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M1570	Continued From page 6 date revealed under, "Policy Explanation and Compliance Guidelines:.. #2. Using Personal Protective Equipment (PPE) ...c. Before leaving the patient's room or cubicle, remove and discard PPE into the appropriate receptable". Review of the facility policy titled, "Infection Prevention and Control Program" with no revision date revealed under "Policy ...This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines". This review was revealed under, "Policy Explanation and Compliance Guidelines: ..#2 All staff are responsible for following all policies and procedures related to the program". Review of the facility policy titled, "Hand Sanitizing Procedure" with a revision date of 4/2015 revealed under the "Procedure for Handwashing ...#2 Apply one squirt of soap. Using friction, rub hands together, cleaning under nails and between fingers thoroughly. Wash up to your wrist as well. Do this for at least 10 seconds". Resident #2 An interview on 9/12/23 at 9:18AM, with the Administrator confirmed the facility was in a COVID19 outbreak that began on 9/11/23 and that they currently have two nurses and two resident's that are positive. An observation on 09/12/23 at 9:32 AM, of the hall outside Resident #2's room revealed a red barrel and a yellow barrel sitting outside the	M1570	cited are correctly applied. 1570 On 09/12/2023, CNA #1 was in-serviced about putting on and taking off personal protective equipment by Assistant Director of Nursing. On 9/12/2023, red and yellow barrels were moved inside Resident #2's room. Residents who are on isolation have the potential to be affected by this deficient practice. All Nursing staff was in-serviced on 09/13/2023 regarding red and yellow barrels remaining inside isolation rooms by Assistant Director of Nursing. Nursing staff was in-serviced on 09/13/2023 about putting on and taking off personal protective equipment by Assistant Director of Nursing. Current employees will receive a skills competency checkoff for putting on and removing personal protective equipment on 10/18/2023 by the Infection Control Nurse or Assistant Director of Nursing. Observations of putting on and taking off personal protective equipment and locations of red/yellow barrels will be completed daily by Director of Nursing, Assistant Director of Nursing, Administrator or Charge nurse daily while isolation precautions are present in facility x 3 months beginning 09/25/2023. Observations will be reported to Quality	

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M1570	Continued From page 7 resident's room door. An observation on 9/12/23 at 10:00 AM, revealed Certified Nurse Assistant (CNA) #1 exit Resident #2's room with her PPE on which included gown, hair net, shoe covers and N95 mask. This observation revealed that CNA #1 removed all her PPE except her N95 mask, she put the removed PPE in the red barrel in the hallway outside the resident's room door, walked to the nurse's station with the N95 mask on and began a conversation with other staff members. An interview on 9/12/23 at 10:15AM, with CNA #1 revealed that she must put a gown, shoe covers, hair net and mask on when she goes into the COVID-19 positive resident rooms, remove it when she leaves the resident's room and put it in the red barrel outside the resident's room door. She stated that the PPE goes into the red barrel and the dirty linen goes into the yellow barrel. She confirmed that she did not remove her mask when she left Resident #2's room but should have. She stated that she knows better than that. An interview on 9/12/23 at 10:55AM, with the Administrator and the Director of Nurses (DON) confirmed that the staff caring for the positive COVID-19 residents should remove all PPE when they leave the residents room, hand sanitize and put on a new mask. The DON confirmed that the barrels for PPE and dirty linen should be inside the resident's room so that the PPE can be removed and disposed of before leaving the resident's room and this should be done to prevent the possible spread of infection. An observation and interview on 9/12/23 at 1:35 PM with Resident #2 confirmed there were no barrels inside the resident's room for disposal of	M1570	Assurance Performance Improvement meeting on 10/29/2023 Completion Date: 10/30/2023	

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M1570	Continued From page 8 PPE or dirty linens. An interview on 9/13/23 at 3:40 PM with CNA #1 confirmed that she should have removed the mask when she left Resident #2's room, performed hand hygiene, and put on a clean mask to prevent the spread of infection. An interview on 9/13/23 at 3:50 PM with Licensed Practical Nurse (LPN) confirmed that when a resident is in isolation for COVID-19 then you have to put your gown, N95 mask, shoe covers, hair cover and gloves on before entering the resident's room, remove it all before you leave their room, hand sanitize and put on a clean mask after leaving their room. Record review of the facilities in-services revealed the following: In-service training 10/31/22 with PPE handout attended by nursing staff that included CNA #1. In-service training 2/6/23 regarding donning and doffing of PPE was attended by nursing staff that included CNA #1. In-service training 6/26/23 regarding don/doff PPE attended by nursing staff. Record review of testing for the facilities current COVID-19 outbreak revealed the following: Resident #2-tested positive 9/11/23. Record review of Resident #2's "Physician's Orders" revealed the following: Order dated 9/11/23; Airborne isolation for COVID-19 x 5 days. Record review of Resident #2's "Admission Record" revealed the resident was admitted to the facility on 7/12/20 with medical diagnoses that include Unspecified Hypothyroidism.	M1570		

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M1570	Continued From page 9 Record review of Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/28/23 revealed in "Section C" a Brief Interview for Mental Status (BIMS) score of 08, which indicated the resident was moderately cognitively impaired. Resident #28 Record review of the "Order Listing Report" revealed an order dated 8/10/23, "Clean stage 2 sacral pressure ulcer with normal saline, pat dry, apply resinol to entire wound bed & (and) cover with foam dressing. Change daily and PRN (as needed) for soiled or dislodged dressing." An observation and interview during wound care for Resident #28 on 9/13/23 at 11:00 AM, with the Wound Care Nurse, observed the resident did not have a wound dressing intact at the beginning of wound care. The Wound Nurse stated, "I'm not going to clean the wound because she just had a bath." Observed that the Wound Nurse did not clean the wound before she applied the resinol to the wound. In an interview with the Wound Nurse on 9/13/23 at 11:10 AM, confirmed that she did not clean the wound for Resident # 28. She stated, "No, I didn't because she had just got a bath and the area was clean." She acknowledged that she should have but was nervous and "messed up." During an interview with the Director of Nursing (DON) on 9/13/23 at 2:20 PM, confirmed that the Wound Nurse should have cleaned the wound for Resident # 28 according to the physician's order regardless that the resident had just received a bath to prevent the spread of infection.	M1570		

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M1570	Continued From page 10 An interview with the Administrator on 9/14/23 at 10:15 AM, revealed that Resident # 28's wound should have been cleaned according to the physician's order because anything could have happened between getting a bath and the provided wound care. Record review of the "Admission Record" revealed Resident # 28 was admitted to the facility on 12/18/19 with diagnoses that include Diffuse Traumatic Brain Injury, Paraplegia, Type 2 Diabetes Mellitus and Pressure Ulcer of Sacral Region, Stage 2. Record review of the MDS with an ARD of 8/08/23 revealed under "Section C" a BIMS score of 08, which indicated Resident #28 is moderately cognitively impaired. Also revealed under "Section M," the resident has one (1) stage 2 pressure ulcer that was present upon admission/entry or reentry to the facility.	M1570		