STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255096	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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F 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 Medicare and Medicaid requirements of participation and cited F644, F656, F677, F686 and F880. The census at the time of survey was 48 and the facility is licensed for 60.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to obtain a	F 644	Louisville Healthcare acknowledges receipt of the statement of deficiencies	10/30/23

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

Electronically Signed | 09/25/2023

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F 644	Continued From page 1 Level II Preadmission Screening and Resident Review (PASARR) for a resident with a new mental health diagnosis for one (1) of four (4) PASARRs reviewed. Resident #23. Findings Include: A review of the facility policy title, PASARR (Pre-admission Screening and Resident Review) dated 6/27/2023 revealed, " ...Procedure (2) The nursing facility must submit a Change in Status Request whenever a Significant Change in Condition occurs for an individual with a PASARR identified condition (i.e. Serious Mental Illness (SMI), Intellectual and/or Developmental Disability (ID/DD) and/or Related Condition (RC) This includes residents previously identified by PASARR to have a mental illness, intellectual disability or a condition related to an intellectual disability who: *Demonstrate increased behavioral, psychiatric, or mood-related symptoms ..." Record review of Resident #23's Admission Record revealed that she was admitted to the facility on 02/18/2020 with diagnoses that included Multiple Sclerosis, Major Depressive Disorder, and Insomnia. Record review of Resident #23's Medical Diagnosis revealed diagnoses of Auditory Hallucinations/other Hallucinations dated 3/12/2023 and Schizophrenia dated 4/17/2023 were added to the list of diagnoses. An interview on 09/13/23 at 8:45 AM, the Social Services Director revealed she was responsible for submitting the PASARR and was aware that with any new mental illness diagnoses she was	F 644	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 cited are correctly applied. F644 Review of Resident #23 admission records revealed a diagnosis of auditory hallucinations/other hallucinations dated 3/12/2023 and Schizophrenia dated 04/17/2023. On 09/13/2023, Resident's physician rescinded the diagnosis of Schizophrenia extracting the need for a LEVEL 11 Preadmission Screening and Resident Review. (PASSR) All residents in the facility have the potential to be affected by this deficiency. On 09/25/2023, Administrator and Director of nursing in-serviced all Department Heads on importance of notifying Director of Nursing and Social Services of any new diagnosis that requires a change in status form for a Level 11 PASSR.	

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F 644	Continued From page 2 required to submit a new change of status form for a Level 2 PASSR. She confirmed that she did not do that because she wasn't aware of the new diagnoses for Resident #23. An interview on 09/13/23 at 8:55 AM, with the Director of Nurses (DON) revealed Resident #23 started having some issues and received a new diagnosis for hallucinations and schizophrenia. She revealed we usually discuss changes during our weekly Utilization Review meeting and morning meetings, but I'm not sure if we didn't meet that week or what, but it obviously got missed. The DON confirmed the resident should have had a change in status done for her Level 2 evaluation. An interview on 09/13/23 at 2:23 PM, with the Administrator (ADM) revealed the purpose of the Level 2 evaluation is to make sure the resident gets the proper psychiatric care that they may need. She revealed she was unaware of a new mental health diagnosis for Resident #23 and that a Level II change in status had not been completed. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date of 08/02/2023 revealed Resident #23 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident is cognitively intact.	F 644	On 09/19/2023, Louisville Healthcare has introduced a new DAILY Nursing Morning Standup Form that reviews all new orders, diagnosis, and any new behaviors. The Director of Nursing will go over the form every morning beginning 09/19/2023 (Monday through Friday) and ongoing indefinitely with all department heads, In her absence, the Assistant Director Of Nursing or Administrator will complete the form. Daily Nursing Morning standup forms will be discussed in Quality Assurance weekly beginning 10/02/2023 x 3 months. Social Services will audit 5 charts weekly x 3 months beginning 10/02/2023 and brought to Quality Assurance beginning 10/29/2023 to check for diagnosis that prompt a PASSR to be completed. Completion Date: 10/30/2023	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		10/30/23

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F 656	Continued From page 3	F 656		

resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive

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F 656	Continued From page 4 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, record review and facility policy review the facility failed to implement a comprehensive care plan related to nail care (Resident 8) and wound care (Resident 28) for 2 (two) of 13 care plans reviewed. Findings include: Review of the facility care plan policy titled, "Care Plans - Comprehensive", dated 10/2016, revealed, "Policy Statement An individualized (person centered) comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident. Policy interpretation and Implementation 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or resident representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. ...3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; ...f. Identify the professional services that are responsible for each element of care; g. Aid in preventing or reducing declines in the resident's functional status and /or functional level ..." Resident #8 Review of the care plan for Resident #8 revealed, "Focus: Resident requires assistance with his	F 656	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 cited are correctly applied. F656 Care Plan was implemented on 9/13/2023 for Resident #8 when resident's nail care was not provided. One on one in service was provided with Treatment nurse on 09/13/2023 by Director of Nursing. Residents requiring staff assisted nail care and wound care have the potential to be affected by this deficient practice. All resident's nails were audited on 09/13/2023 for nail care. In-service on Nail care with nursing staff was completed by Assistant Director of Nursing on	

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F 656	Continued From page 5 ADLs (Activity of Daily Living) related to bilateral above the knee amputations, hemiplegia, and bilateral upper extremity contractures ...Revision on: 10/05/2022 Goal: Resident's needs will be met every shift with assistance from staff through the next review date ... Interventions: ...Nail care as needed or scheduled by registered nurse only. Assist with ... personal hygiene ...daily & as needed or requested ..." An observation on 09/12/23 at 10:07 AM, revealed that Resident 8's fingernails were long and dirty and the nails on both hands had brownish material under them. He stated that his nails need to be cut and cleaned. Resident #8 confirmed that he had already had his bath this morning. An observation on 09/13/23 at 8:37 AM and 3:40 PM, revealed the resident stated his fingernails have not been cut and were still dirty. He stated his nails had not been cut in about a month. An observation and interview on 09/13/23 at 3:45 PM, with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) confirmed the resident's fingernails were long and dirty. An interview, on 09/14/23 at 11:00 AM with the DON confirmed Resident #8's care plan was not followed for cleaning his 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, and	F 656	09/25/2023. Inservice on following doctor orders for wound care was given on 09/25/2023 by Assistant Director of Nursing. 100% of all care plans were audited and reviewed by MDS nurse and Medical Records nurse. Ten Daily Observations of resident nail care will be completed by the Director of Nursing or Assistant Director of Nursing x 3 months starting on 09/25/2023. Findings of these observations will be presented to Quality Assurance Performance Improvement meeting x 3 months on 10/29/2023 Completion date: 10/30/2023	

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F 656	Continued From page 6	F 656		

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.

Resident #28

Record review of Resident # 28's care plan revealed, "Clean Stage 2 pressure injury to sacrum with normal saline, apply resinol to the entire area, and cover with foam border dressing; change daily and PRN (as needed)."

An observation of sacral wound care for Resident # 28 and interview with the Wound Care Nurse 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." The Wound Nurse did not clean the wound before applying resinol to the wound and covering it with a foam dressing.

On 9/13/23 at 11:10 AM, during an interview with the Wound Nurse confirmed that she did not clean the wound for Resident # 28. She stated, "No, I didn't because she had just gotten a bath and the area was clean." She acknowledged that she did not follow the physician's order for treatment or the care plan for treatment of the wound and acknowledged that she should have.

An interview on 9/14/23 at 8:35 AM, with Registered Nurse (RN) #2 revealed the purpose

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F 656	Continued From page 7 of the care plan was to identify the problems with the resident and to give the staff a guideline to provide the needed care. She confirmed that Resident #28's care plan was not followed related to wound care. An interview with the Director of Nursing (DON) on 9/14/23 at 9:55 AM, revealed the purpose of the care plan was to try to provide a guideline to provide individualized care for the resident. She confirmed that Resident #28's care plan was not followed for 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.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review and facility policy review,	F 677	Louisville Healthcare acknowledges receipt of the statement of deficiencies	10/30/23

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F 677	Continued From page 8 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 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	F 677	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 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	

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F 677	Continued From page 9 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 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.	F 677	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 Completion date: 10/30/2023	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		10/30/23

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F 686	Continued From page 10 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: 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 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	F 686	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 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	

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F 686	Continued From page 11 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 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	F 686	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 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	

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	255096	A. BUILDING _____ B. WING _____	09/14/2023

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F 686	Continued From page 12 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.	F 686		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		10/30/23

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F 880	Continued From page 13 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 14 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 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 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	F 880	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 cited are correctly applied. F880 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	

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F 880	Continued From page 15 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 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.	F 880	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 beginning 09/25/2023 x 3 months. Observations will be reported to Quality Assurance Performance Improvement meeting on 10/29/2023 Completion Date: 10/30/2023	

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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 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

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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.

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

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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.

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

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F 880	Continued From page 19 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.	F 880		