MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	48AM	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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M 000	Initial Comments The State Agency (SA) determined during an annual licensure survey, conducted from 10/16/23 to 10/19/23 that the facility was not in compliance with the Mississippi Regulations for Minimum Standards of Operation for Institutions for the Aged or Infirm with deficiencies cited at M 500, M 610, M 815, M1010 and M 1570. Census at the time of the survey was 104 and the facility has beds for 152 residents.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his	M 500		11/18/23

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M 500	Continued From page 1	M 500		

medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the

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M 500	Continued From page 2 facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail	M 500		

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M 500	Continued From page 3 unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on resident and staff interviews and facility policy review the facility failed to ensure a resident's preferences was honored for one (1) of 20 sampled residents. Resident #70	M 500	1. Resident #70 was informed on 10/18/2023 that his coffee would be served daily. Upon assessment by the Administrator on 10/18/2023 it was learned the resident has received his coffee routinely with this being an isolated	

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M 500	Continued From page 4 Findings include: A record review of the facility policy titled, "Resident Rights & Quality of Life with a revision date of March 13, 2020, revealed that it is the policy that all residents and patients have the right to a dignified existence, self-determination, and communication with access to people and services inside and outside the center. An interview on 10/16/23 at 11:00 AM with Resident #70 revealed he didn't have coffee on his tray one morning a couple of weeks ago and he asked about it, he revealed one of the Certified Nursing Assistants (CNAs) stated, "Well they didn't put it on your breakfast tray, and I'll have to walk all the way back to the kitchen to get it." He revealed I didn't get any coffee that morning. An interview on 10/18/23 at 11:40 AM with Resident #70 revealed he did not get coffee again this morning for breakfast. He revealed, I told them that I wanted a cup of coffee, but I never got it. Resident #70 stated, "That's what I miss about being at home, getting coffee whenever I want it, at least for breakfast." An interview on 10/18/23 at 12:01 PM with the Administrator (ADM) confirmed Resident #70 should not have to go without his coffee that is his choice, and he should have had it, and she would take care of this issue right now. An interview on 10/18/23 at 12:10 PM CNA #5 revealed she is assigned to the resident, and he is a big coffee drinker. She revealed the food comes out to the hallways and we pass out the trays and then we go back to the dining room to	M 500	occasion. No negative outcome was revealed during the assessment. The Nurse assure that Resident #70 received his coffee on 10/18/23 after the resident brought it to the attention of the surveyor. Dietary Manager was instructed by the Administrator on 10/18/23 to send coffee out in carafe with cups prior to serving trays so that CNA's could pass coffee prior to meals. 2. All residents who have the wish to have coffee have the potential to be affected by this deficient practice. 3. On 10/20/23 the Assistant Director of Nursing provided an in-service for staff on resident rights, including notice of meeting preferences related to coffee. Dietary staff were in-serviced by Dietary Manager on 10/20/23 that coffee is to served prior to trays being served. Dietary Manager was instructed by Administrator on 10/18/23 to send coffee out in carafe with cups prior to serving trays so that CNA's could pass coffee prior to meals. 4. The Administrator of Director of Nursing will conduct weekly audits of a minimum of 5 resident's who prefer to drink coffee beginning on October 23, 2023 for three months. The Administrator will report the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for three months and as deemed necessary beginning with the November Quality Assurance and Performance Improvement Committee meeting on November 17,2023.	

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M 500	Continued From page 5 the coffee bar and get them coffee. She revealed this morning she passed breakfast trays and then fed two residents and then helped pass out coffee. She revealed I thought the resident got coffee but I'm not totally sure. An interview on 10/18/23 at 12:36 PM with CNA #6 revealed I passed the breakfast tray to Resident #70 this morning and before I left the room, he said he wanted some coffee. She revealed his assigned aide was out in the hall and I let her know that he wanted coffee. She stated I think she got it for him but I'm not totally sure. Record review of Resident #70's Admission Record revealed the resident was admitted to the facility on 11/17/2022 with diagnoses that include Type 2 Diabetes Mellitus with Diabetic Polyneuropathy, Heart failure, and Chronic Obstructive Pulmonary Disease. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 08/10/23, revealed Resident #70 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident is cognitively intact.	M 500		
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;	M 610		11/18/23

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M 610	Continued From page 6 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observations, staff interview, record review and facility policy review, the facility failed to provide activities of daily living (ADLs) for a resident dependent on staff for shaving and oral hygiene for one (1) of 20 residents sampled. Resident #21. Findings include: Record review of the facility policy titled "Activities of Daily Living (ADLs)" undated, revealed, "Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care...Policy Explanation and Compliance Guidelines...2. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene ..." During an observation on the Dementia Care Unit on 10/16/23 at 11:01 AM, Resident # 21 was sitting in a chair and noted a buildup of a thick white substance on her lower teeth. Observed gray facial hair to her entire chin area measuring approximately one-fourth (1/4) inch in length and a thin layer of gray hair over the top lip measuring three-eight (3/8) inch.	M 610	1. Resident #21 was immediately assessed by Director of Nursing on 10/17/23. Resident #21 was shaved and mouthcare was provided by the Memory Care Unit Director on 10/17/23. On 10/17/23 1:1 education was provided to Certified Nursing Assistant's who failed to follow the care plan regarding facial hair and oral care by the Memory Care Unit Director concerning Activities of Daily Living care. On 10/17/23 Director of Nursing updated Resident #21's care plan to include need for shaving and oral hygiene. Nurses responsible for assuring theses residents were shaved and oral care given were educated by the Memory Care Director beginning on 10/25/23 concerning Activities of Daily Living care. 2. All residents requiring Activities of Daily Living assistance on the Memory Care Unit have the potential to be affected by this deficient practice. 3. On 10/25/23, the Memory Care Director provided assessments of all residents in the Memory Care Unit to determine whether there was anyone else who had not been shaved or given oral care. No additional residents were found. Beginning on 10/20/23, Activities of Daily living rounds will be completed weekly by the Director of Nursing or designee so that all residents will be rounded on during the month to verify Activity of Daily Living needs are being met. Beginning on 10/20/23, Director of Nursing, Assistant	

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M 610	Continued From page 7 An observation and interview on 10/17/23 at 1:00 PM, with Certified Nurse Aide (CNA) #3 revealed she was assigned to Resident # 21 today. She confirmed that the resident's teeth needed brushing, and she was the person responsible for providing oral hygiene. She revealed that oral hygiene had not been done today, and it should be done after meals. She stated that the resident should have gotten the facial hair shaved on her bath day, which was yesterday, and confirmed that the aides were responsible for shaving facial hair and this care was included as part of bathing. An observation and interview with Licensed Practical Nurse (LPN) # 2 on 10/17/23 at 1:06 PM, confirmed that Resident # 21 had a white substance on her lower teeth. She stated, "It looks like gingivitis." She revealed that the aides should be brushing her teeth three times a day after meals. Not only that, but she confirmed that poor oral hygiene could cause infection, decay or could cause the resident to lose teeth. She confirmed that the resident should have facial hair shaved as part of bathing routine or whenever needed. An observation and interview on 10/17/23 at 1:25 PM, with the Administrator (ADM) confirmed that Resident # 21 had white buildup on her lower teeth, which could lead to an infection. She revealed the resident should have oral hygiene three times daily and as needed. An interview with the Director of Nursing (DON) on 10/18/23 at 12:08 PM, revealed that female residents should have facial hair removed. She confirmed that shaving should be done on bath days or whenever needed as part of the grooming routine and care provided, and that Resident # 21 should have oral hygiene done after meals. She	M 610	Director of Nursing will review all new admissions withing 24 hours of admit to verify that all team members are aware of Activity of Daily Living needs for each admission. Education will be provided to Certified Nurses Assistant's and Nursing beginning on 10/25/23 by the Assistant Director of Nursing or designee regarding assisting residents with Activities of Daily Living. 4. Audits will be completed by Director of Nursing or Assistant Director of Nursing on 5 residents in the Memory Care Unit weekly for 3 months to ensure that the Activities of Daily Living care plans are being followed beginning on 10/20/2023. Findings of audits will be addressed in the Quality Assurance Performance Improvement Committee meeting for a minimum of three months for review and interventions as necessary beginning with the November Quality Assurance Performance Improvement meeting on November 17,2023.	

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M 610	Continued From page 8 confirmed that the lack of oral hygiene could lead to loss of teeth, decay, infection, and pain. Record review of the "Admission Record" for Resident # 21 revealed an admission date of 10/07/19 and medical diagnoses that included Unspecified Dementia, Hypothyroidism, Type 2 Diabetes Mellitus with Hyperglycemia and Mild Intellectual Disabilities. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/11/23 revealed, under Section C, a Brief Interview for Mental Status (BIMS) score of 10, which indicated Resident # 21 is moderately cognitively impaired. Also revealed under Section G, the resident required one (1) person physical assist with personal hygiene.	M 610		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation, staff interview and facility policy review the facility failed to ensure that opened food items stored in the refrigerator were dated and labeled for two (2) of four (4) kitchen tours. Findings include:	M 815	1. On October 16, 2023, the Dietary Manger dated and labeled, lemon juice, peanut butter and jelly, and bologna. Pudding was disposed of in the trash. On October 17, 2023 a bag of turkey was labeled and dated. The Dietary Manager educated Dietary Staff #2 on October 17, 2023 regarding the need to date and label all foods before placing them back in the cooler or freezer after opening the package. On October 17, 2023, the	11/18/23

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M 815	Continued From page 9 Record review of the facility policy revised 9/2017 and titled, "Food: Preparation" documented under "Procedures" the following, "...17. All TCS (Time/Temperature Controlled for Safety) foods that are to be held for more than 24 hours at a temperature of 41 degrees F (Fahrenheit) or less, will be labeled and dated with a 'prepared date' (Day 1) and a 'use by date' (Day 7). On 10/16/23 at 10:10 AM, a brief tour of the kitchen revealed an opened 32-ounce bottle of lemon juice which was approximately three-fourths full with no labeled date on the bottle. There was also approximately 2 cups of brownish purple substance observed in a clear covered bowl which the Dietary Manager (DM) identified as peanut butter and jelly and there was no label or date on the container. There was also a gallon zip lock bag with light colored meat inside undated and unlabeled. This meat was identified by the DM as bologna which had just been opened during the preparation of breakfast that morning on 10/16/23. There was also observed approximately a gallon of a thick yellow substance in a covered bowl with no label and no date noted. The DM revealed that this yellow substance was pudding and she confirmed that everything should be labeled and dated when opened and prior to storage in the refrigerator. On 10/17/23 at 1:20 PM, a follow up tour of the kitchen revealed an unlabeled and undated zip lock bag about one-half full of white meat inside which was identified by the DM as turkey. The DM revealed that the meat should have been dated and labeled as soon as it was opened. On 10/17/23 at 1:30 PM, an observation and interview with Dietary #1 revealed that they (dietary staff) were responsible for dating and	M 815	dietary staff looked at all foods in the kitchen, coolers and freezers to determine if any other food might be opened without a date or label. No additional food was noted. 2. All residents have the potential to be affected by this deficient practice. 3. Dietary Manager and or Cook will monitor cooler and freezer daily for three months to assure all opened foods are dated and labeled beginning on 10/20/23. The dietary manager completed education regarding labeling and dating open foods with dietary staff on October 19.2023. 4. Audits will be conducted by the Dietician/Dietary Manager weekly for three months beginning on October 20, 2023. Findings of audits will be addressed in Quality Assurance and Performance Improvement Committee for a minimum of three months by the Dietician/Dietary manager for review and interventions as necessary beginning with November Quality Assurance Performance Improvement Meeting on November 17, 2023.	

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M 815	Continued From page 10 labeling everything as soon as it was opened. On 10/17/23 at 1:35 PM, an interview with the Healthcare Services District Manager, confirmed unlabeled and undated white meat in a gallon zip lock bag. On 10/17/23 at 1:40 PM, an interview with the Healthcare Services District Manager, revealed that all employees should be labeling and dating foods/items as they go. She revealed that as the staff opened and put things up, they should be labeled and dated right then. She also revealed that not labeling and dating opened food items could cause many different problems including cross contamination, a risk of sickness, and a risk of residents with allergies receiving the wrong thing if not labeled properly. On 10/17/23 at 1:50 PM, an interview with Dietary Staff #2 revealed that she had opened the turkey up before lunch and failed to date and label it. She revealed that she tried to always put a date and label on everything she opened, but failed to this morning because she was in a hurry.	M 815		
M1010	45.35.1 Housekeeping Facilities and Services Housekeeping Facilities and Services. 1. The physical plant shall be kept in good repair, neat, and attractive. The safety and comfort of the resident shall be the first consideration. 2. Janitor closets shall be provided with a mop-cleaning sink and be large enough in area to store house cleaning supplies and equipment. A separate janitor closet area and equipment should be provided for the food service area.	M1010		11/18/23

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M1010	Continued From page 11 This Statute is not met as evidenced by: Level II Based on observation, staff interviews, and facility policy review, the facility failed to ensure a clean environment as evidenced by multiple areas of a circular black substance on two ceiling air vents for two (2) of four (4) survey days. Findings include: Review of the facility policy titled "5-Step Daily Room Cleaning" undated, revealed, "PURPOSE: To teach Environmental Services employees the proper cleaning method to sanitize a patient room or any area in a healthcare facility ...2. Horizontal Surfaces- disinfected ... Use your high duster to dust hard to reach areas, such as the tops of closets, high lights, and ceilings areas as needed..." An observation on 10/16/23 at 12:42 PM, of the Dementia Care Unit, revealed two (2) square ceiling air vents with multiple areas of a circular black substance. The air vents had a total of 10 to 17 areas in total and ranged in different sizes of one-half (1/2) inch to two (2) inches. An observation and interview with Licensed Practical Nurse (LPN) #2 on 10/17/23 at 1:08 PM, revealed the air vents on the ceiling were an environmental concern related to moisture. She described the color of the substance adhering to the air vents as "dark black." She confirmed that the substance could be a health concern and could cause breathing issues. An observation and interview on 10/17/23 at 1:11	M1010	1. The two ceiling vents on the Memory Care Unit were cleaned by maintenance on October 17, 2023. 2. All residents in the memory care unit have the potential to be affected by this deficient practice. 3. The Housekeeping Account Manager in-serviced housekeeping staff on 5 step daily room cleaning and 7 step daily washroom cleaning beginning on November 2, 2023 and completed the training on 11/3/2023. Cleaning of ceiling vents will be monitored weekly completed by the Housekeeping Account Manager and turned in weekly to the Administrator beginning on November 1, 2023. 4. Ceiling Vent audits Will be completed weekly starting 10/23/2023 and reported to Administrator, District Manager, Director of Operations every week for three months to ensure that ceiling vents are cleaned. Findings of audits will be addressed in Quality Assurance and Performance Improvement Committee for a minimum of three months by the Housekeeping Account Manager for review and interventions as necessary beginning with November Quality Assurance Performance Improvement Meeting on November 17,2023.	

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	48AM	A. BUILDING: _____ B. WING _____	10/19/2023

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M1010	Continued From page 12 PM, with Certified Nurse Aide (CNA) #2 revealed the black substance on the air vents, "Looks like mold." She revealed this could cause breathing problems for the staff and residents. An observation and interview on 10/17/23 at 1:15 PM, with Housekeeping Staff #1 confirmed the black substance on the ceiling air vents. She revealed the memory care unit has a housekeeper assigned daily to look for these issues. She revealed that the substance could cause breathing issues. An interview on 10/17/23 at 1:18 PM, with the Regional Environmental/Housekeeping Director #2 revealed the black substance on the ceiling air vents was from moisture. He revealed that housekeeping or maintenance was responsible for cleaning the vents. An observation and interview with the Administrator (ADM) on 10/17/23 at 1:20 PM, revealed the black substance on the air vents was "dust" and they've had this issue before.	M1010		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 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,	M1570		11/18/23

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M1570	Continued From page 13 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: Based on observation, staff interview, record review and facility policy review, the facility failed to prevent the likelihood of the spread of infection as evidenced by a nebulizer and tubing not properly stored, hand hygiene not performed with incontinent care, and an isolation cart being transported in and out of a transmission-based precautions room for two (2) of 20 sampled residents reviewed. Resident #39 and Resident #83 Findings include: A review of the facility policy titled "Nebulizer Therapy", undated, revealed, "Policy: It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions ...Care of the Equipment: ... 7. Once completely dry, store the nebulizer cup and mouthpiece in a zip lock bag. 8. Change nebulizer tubing every seventy-two hours or per facility policy. 9. Periodically disinfect unit per manufacturer's recommendations ..."	M1570	1. 1:1 education provided by the Assistant Director of Nursing to CNA #2 on 10/18/23 who failed to adhere to transmission based precautions guidelines concerning contact precautions, handwashing with return demonstration, peri-care checkoff, and isolation cart position. The Director of Nursing assessed resident #83 on 10/18/23 and identified there was no negative outcome for resident #83. The Director of Nursing assessed resident #39 on 10/18/2023 with no negative outcomes related to nebulizer storage. In-service by Assistant Director of Nursing to staff with return demonstration check off handwashing beginning on October 23, 2023. In-service by Assistant Director of Nursing to Certified Nurses Assistants with return demonstration of peri-care beginning on 10/23/23. In-services by Assistant Director of Nursing beginning on 10/20/23 to staff on transmission based precautions. In-service by Assistant Director of Nursing beginning on 10/20/23	

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M1570	Continued From page 14 Record review of the facility policy titled "Transmission-Based (Isolation) Precautions" undated, revealed, " ...Policy Explanation and Compliance Guidelines: 1. Facility staff will apply Transmission-Based Precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission ... 8. Initiation of Transmission-based Precautions ("Isolation Precautions")- ... f. The facility will have PPE (Personal Protective Equipment) readily available near the entrance of the resident's room and will don appropriate PPE before or upon entry into the environment of a resident on transmission-based precautions. g. ... If sharing noncritical equipment between residents, the equipment will be cleaned and disinfected following manufacturer's instructions with an EPA-registered disinfectant after use ..." Record review of the facility Infection Control Guide Dated 2022 revealed, " ...Standard precautions include: 1. Hand hygiene before and after patient/resident contact-including after gloves are removed ..." Record review of the facility policy titled "Perineal Care" undated, revealed, "Policy: It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown ..." Resident #39 An observation, on 10/16/23 at 10:45 AM, revealed Resident #39's nebulizer machine was lying in the corner of the room on the floor at the	M1570	to nurses on nebulizer storage. 2. All residents in the facility have the potential to be affected by this deficient practice. 3. On 10/20/23, Director of Nursing conducted assessments of all residents currently on transmission based precaution to determine whether there was anyone else who staff failed to adhere transmission based precautions. No additional residents found. Isolation rounds will be completed weekly by the Director of Nursing, Assistant Director of Nursing, or Unit Managers so that all residents will be rounded on during the month to verify isolation needs are being met beginning on 10/20/2023. All residents with nebulizers were checked on 10/20/2023 to verify proper storage. The Director of Nursing or Assistant Director of Nursing will conduct a review of all residents with new diagnosis requiring transmission based precautions within 24 hours to verify that all team members are aware of isolation needs for each new diagnosis. Education will be provided by Assistant Director of Nursing to Certified Nurses Assistants, Nurses and staff beginning on 10/20/23 regarding following Infection Control guidelines in reference to handwashing, peri-care, transmission based precautions, isolation carts, and nebulizer storage. 4. Audits will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Managers on 5 residents weekly for 3 months beginning on 10/20/23 to ensure that the transmission based precaution guidelines are being followed. Audits will be completed by Director of	

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M1570	Continued From page 15 head of bed. The nebulizer mask was attached to the machine and lying flat on the floor next to the machine and was not covered or bagged. An interview on 10/16/23 at 2:30 PM, with Certified Nursing Assistant (CNA) #1 confirmed that Resident #39's nebulizer machine was sitting on the floor in the corner of resident's room and that the mask was laying on the floor beside it and was not covered. CNA #1 confirmed that it should not be sitting on the floor and that the mask should be in a bag. CNA #1 confirmed that with the mask lying on the floor it could become contaminated with germs. An interview on 10/16/23 at 2:35 PM, with the Assistant Director of Nursing (ADON) confirmed that Resident #39 had nebulizer treatments and that the nebulizer that is sitting on the floor in the corner of the room with the mask lying on the floor beside it belongs to Resident #39. The ADON confirmed that it is an infection control issue and that it could spread germs. She confirmed that the machine should be sitting on a table beside the bed and that the mask should be in a plastic bag when not in use. An interview, on 10/18/23 at 3:00 PM, with the Director of Nursing (DON) confirmed that no nebulizer should be on the floor and that the mask should be bagged when not in use. The DON confirmed it is an infection control issue. Record review of the Order Review Report for Resident #39 revealed an order effective 10/17/23 for Albuterol Sulfate Inhalation Nebulization Solution 0.083% 3 (three) ml (milliliters) inhale orally via (by) nebulizer every 6 hours for cough and congestion for 5 (five) days.	M1570	Nursing, Assistant Director of Nursing or Unit Managers on all nebulizer storage weekly for 3 months beginning on 10/20/2023. Findings of audits will be addressed in Quality Assurance Performance Improvement Committee for a minimum of 3 months by the Director of Nursing or the Assistant Director of Nursing for review and interventions as necessary beginning with November Quality Assurance Performance Improvement Meeting on November 17, 2023.	

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M1570	Continued From page 16 A review of the Admission Record for Resident #39 revealed that he was admitted to the facility on 08/14/23 with diagnoses including Type 2 Diabetes Mellitus with Hyperglycemia and Hypertensive Chronic Kidney Disease. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/12/23 revealed a Brief Interview for Mental Status (BIMS) score of 11 which indicated Resident #39 was mildly cognitively impaired. Resident #83 An observation on 10/17/23 at 10:30 AM, of Resident # 83's door revealed a sign on the door that read, "Contact isolation." There were two (2) red biohazard barrels observed inside the resident's room. Record review of Resident # 83's urine culture results dated 10/13/23 revealed findings, "Greater than 100,000 colonies per ML (milliliter) of Escherichia Coli confirmatory ESBL (Extended Spectrum Beta-Lactamase) POS (positive)" An observation of incontinent care for Resident # 83 on 10/18/23 at 10:58 AM, with Certified Nursing Assistant (CNA) # 2 revealed she applied a gown outside the resident's room and then pushed a 3-compartment rolling isolation cart inside the room and left it beside the bathroom doorway. She applied gloves that she gathered from the isolation cart and did not perform hand hygiene. CNA # 2 provided incontinent care for Resident #83 and when done, she removed her gloves and reached inside the isolation cart to get a new pair of gloves. She applied the gloves and removed the resident's soiled pull up brief from	M1570		

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around the resident's lower legs. She applied a clean pull up brief and completed the care after disposing of the linen and trash inside the biohazard containers in the room. She removed her gloves and pushed the isolation cart back into the hallway.

An interview with CNA #2 on 10/18/23 at 11:15 AM, confirmed that she did not perform hand hygiene upon entering the room, after changing gloves and following the incontinent care. She revealed that not performing appropriate hand hygiene was an infection control issue. She stated that she "should have" washed her hands to prevent the spread of infection. CNA #2 also confirmed that she took the isolation cart into the room with her and that it should be left outside of the door and that she could see how that would spread infection by taking something into the room and bringing it back out.

An interview with the Infection Preventionist on 10/18/23 at 3:10 PM, confirmed that lack of hand hygiene while performing incontinent care could cause the spread of infection. She revealed the aides have check offs for incontinent care and were inserviced on the importance of handwashing. She revealed that the isolation cart should never be pushed inside the resident's room due to cross contamination and should remain on the unit.

An interview with the Director of Nursing (DON) on 10/18/23 at 4:06 PM, revealed that staff has been educated on handwashing, and they know that taking an isolation cart in and out of a resident's room was cross contamination and could increase the spread of infection.

A record review of the facility "In-Service Training

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M1570	Continued From page 18 Record" revealed an in-service was conducted on 10/12/23 for the topics of Hand Hygiene and Peri care and CNA #2 signed as attended. Record review of the Admission Record for Resident # 83 revealed an admission date of 9/09/21 and medical diagnoses that included Unspecified Dementia, ESBL Resistance, Urinary Tract Infection, and Type 2 Diabetes Mellitus. Record review of the MDS with an ARD of 9/13/23 revealed under Section C, a BIMS score of 10, indicating Resident # 83 has moderate cognitive impairment. Section H indicated the resident is frequently incontinent of bladder and Section G revealed she requires one-person physical assist with toileting.	M1570		