STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255112	A. BUILDING _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT HILLS COM LIV CENTER	1600 RAYMOND RD JACKSON, MS 39204

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and two (2) Complaint Investigations (CI MS #22690 and CI MS #22934), at the facility from 09/25/23 through 09/29/23. The SA investigated CI MS #22690 and CI MS #22934 for facility staffing, and quality of care and cited F725. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F609, F610, F625, F656, F689, F727, and F880. The facility held a license for 120 beds, with a census of 81.	F 000		
F 609 SS=G	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 609		10/19/23

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

Electronically Signed | 10/20/2023

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F 609	Continued From page 1 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to report within two (2) hours to the State Agency (SA) an injury of unknown source that resulted in a resident experiencing an intracerebral hemorrhage (major head injury) for one (1) of nineteen (19) sampled residents. Resident # 38 Findings include: Review of the facility's policy titled, "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating", with a reviewed date of 10/2022, revealed, "All reports of resident's abuse (including injuries of unknown origin) ...are reported to local, state, and federal agencies (as required by current regulations) ...Reporting Allegation to the Administrator and Authorities: ... 3. Immediately" is defined as: a. within two hours ...result in serious bodily injury ...Injury of unknown source" is defined as an injury that meets both of the following conditions: a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident, and b. The injury is suspicious because of: (1) the extent of the injury ..."	F 609	It was found by the State Agency (SA) that the facility was deficient in practice due to failure to report within two (2) hours of an incident regarding Resident #38. Resident #38 had a fall and was assessed by the Licensed Practical Nurse (LPN)#1 on 9/8/2023 at 7:35 PM and was sent to the hospital for further evaluation and treatment per doctor's order. Resident #38 returned from the hospital on 9/12/2023 at 7:18 PM and was placed in an electric bed, lowered to the floor to prevent further injuries, assessed by the Nurse on duty, and was found to be at standard baseline with no negative outcomes. The facility reported the incident to the SA on 10/19/2023 at 12:38 PM by the Administrator. All residents who reside in the facility have the potential to be affected by the deficient practice. Licensed Practical Nurse (LPN) #1, the Director of Nursing (DON) and the Administrator were in-serviced on 9/27/2023 by the Regional Nurse Consultant (RNC) on proper reporting	

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F 609	Continued From page 2 Record review of the facility policy "Accidents and Incidents", undated, revealed..."Accident/Incident Reporting and Investigating Guidelines...Level of Events-Quick Reference...Level 3 Results in and injury and ...Results in transfer to another level of care...Examples: Fall with injury...requiring transfer... is reportable to state agencies..Unusual Incidents: Reportable to State Agencies...Definition: An unusual incident is an unexpected occurrence or accident resulting in...serious physical injury to a resident..." On 9/25/23 in an interview at 10:00 AM, with the Nurse Practitioner (NP), she confirmed Resident #38 had a major injury to the head after being found on the floor on 9/8/23. The NP revealed she doesn't know how the resident got on the floor, as she had never seen the resident make any attempts to get out of bed without assistance. The NP stated she had reviewed the resident's hospital discharge instructions, and the resident has a follow up visit with the neurosurgeon with an magnetic resonance imaging (MRI), to see if the resident has further damage to her head. During an interview on 9/25/23 at 2:00 PM, with Licensed Practical Nurse (LPN) #1, she confirmed that she observed the resident on the floor on 9/8/23 at 07:35 PM. LPN #1 stated Resident #14, the roommate of Resident #38 at the time, came out into the hall and stated, Resident #38 was on the floor. The nurse said she "did not investigate" what caused the resident to be on the floor, because Resident #38 was confused and unable to tell her what happened. The nurse confirmed she also did not ask Resident #14 if she knew how Resident #38 ended up on the floor.	F 609	guidelines. All nursing staff were in serviced on fall policy and procedures and proper reporting guidelines on 9/27/2023 by the Director of Nursing (DON). The Quality Assurance Performance Improvement Team (QAPI) met on 9/29/2023 and discussed policy and procedure related to proper reporting guidelines with no revisions needed. Effective 10/1/2023 the Administrator or DON will be notified immediately of any incidents, if it is a reportable incident it will be reported to the correct authorities directed by the federal regulation, reporting of alleged violations. Effective 10/2/2023 and ongoing indefinitely, all reportable incidents will be reviewed in the daily stand-up meetings by the DON or Administrator; discussed with the Interdisciplinary Team and reviewed in the weekly Persons at Risk meeting to ensure proper procedures are followed. Any adverse findings will be addressed immediately and discussed in the QAPI committee meeting for review and recommendation this will be ongoing and indefinitely.	

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F 609	Continued From page 3	F 609		

During an interview on 9/28/23 at 10:00 AM, with the Director of Nursing (DON), she confirmed Resident #38 was observed on the floor in her room on 9/8/23. The DON also confirmed she did not know how the resident got on the floor. The DON also mentioned that she had never seen Resident #38 make any attempts to get out of bed. The DON stated Resident #38 was sent to the hospital for evaluation.

During an interview on 9/29/23 at 2:30 PM, with Certified Nursing Aide (CNA) #2, she revealed she was the CNA assigned to Resident #38 on 9/8/23, the night the resident was found on the floor. CNA #4 stated she was called by the nurse to come and help get Resident #38 off the floor.

During an interview on 9/29/23 at 2:38 PM, with the Administrator, he confirmed he was aware of the incident involving Resident #38 that occurred on 9/8/23. The Administrator said it was discussed the next morning in their stand-up meeting. The Administrator explained he did not feel the incident needed to be reported to the State Agency (SA), "because of the way her body was positioned on the floor in her room." He stated Resident #38 was sent to the Emergency Room at a local hospital for evaluation.

A record review of the "Admission Record" for Resident #38 revealed the facility admitted the resident on 2/13/19 with diagnoses that included Cognitive Communication Deficit and Abnormalities of Gait and Mobility.

A record review of Resident #38's Discharge Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/8/23, revealed the resident was sent to an Acute Hospital. Section G

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F 609	Continued From page 4 revealed that Resident #38 needed extensive assistance for bed mobility.	F 609		
F 610 SS=G	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review the facility, the facility failed to thoroughly investigate an injury of unknown source that resulted in an intracerebral hemorrhage (major head injury) for one (1) of nineteen sampled residents. Resident # 38 Findings include: Review of the facility's policy titles, "Abuse, Neglect, Exploitation or Misappropriation -Reporting and investigating policy," reviewed on 10/2022, revealed, "All reports of resident's abuse	F 610	It was found by the State Agency (SA) that the facility was deficient in practice by failing to thoroughly investigate a fall with injury for resident #38. Resident #38 was observed on the floor by Licensed Practical Nurse (LPN) on 9/8/2023 at 7:35 PM. Resident #38 was assessed and sent to the hospital for further evaluation and treatment by LPN #1 per doctor's orders. LPN #1 filled out an incident report and the incident was discussed on 9/9/2023 in the daily stand-up meeting. Resident #38 returned from the hospital on 9/12/2023 at	10/19/23

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F 610	Continued From page 5 (including injuries of unknown origin), ...thoroughly investigated by facility management. Findings of all investigations are documented ...Investigating Resident Injuries ... All Resident injuries are investigated ... 1. The director of nursing services or a designee assesses all resident injuries and documents findings in the medical record ... 7. If nursing and medical assessment determines an "injury of unknown source" the investigation will follow the protocols set forth in our facility's established abuse investigation guidelines ... 8. "Injury of unknown source" is defined as an injury that meets both of the following conditions: a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident, and b. The injury is suspicious because of: (1) the extent of the injury ..." Record review of the facility policy "Accidents and Incidents", undated, revealed..."Accident/Incident Reporting and Investigating Guidelines...Investigations: Investigations should begin when the incident is identified. The nurse in charge should identify...who may have knowledge of the occurrence individuals should be interviewed and asked to provide a statement...Interviews of witnesses or caregiver for the past 24 hours...An attempt to determine the root cause...is made..." Record review of the facility's, "Incident Report" dated 9/8/23 at 7:35 PM, by Licensed Practical Nurse (LPN) #1, revealed Resident #38 was observed on the floor in her room. The nurse was unable to determine how Resident #38 ended up on the floor. Resident #38 was noted with a hematoma to the back of her head. The resident was sent to the local Emergency Room in an	F 610	7:18 PM and was placed in an electric bed, lowered to the floor to prevent further injuries, assessed by the Nurse on duty, and was found to be at standard baseline with no negative outcomes. The facility reported the incident to the SA on 10/19/2023 at 12:38 PM by the Administrator. All residents who reside in the facility have the potential to be affected by the deficient practice. Licensed Practical Nurse (LPN) #1, the Director of Nursing (DON) and the Administrator were in-serviced on 9/27/2023 by the Regional Nurse Consultant (RNC) on proper reporting guidelines and investigation. All nursing staff were in serviced on fall policy and procedures, proper reporting guidelines and investigation on 9/27/2023 by the Director of Nursing (DON). The Quality Assurance Performance Improvement Team (QAPI) met on 9/29/2023 and discussed policy and procedure related to proper reporting and investigation with no revisions needed. Effective 10/1/2023 the Administrator or DON will be notified immediately of any incidents, and it will be reported to the correct authorities directed by the federal regulation, investigate/prevent/correct alleged violation. Effective 10/2/2023 and ongoing indefinitely, all incidents and investigations will be reviewed in the daily stand-up meetings by the DON or Administrator an audit checklist tool will	

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F 610	Continued From page 6 Acute Care Hospital, for evaluation. Review of the Acute Care Hospital discharge instructions dated 9/12/23, revealed Resident #38 was diagnosed with an Intracerebral Hemorrhage with instructions for follow-up with neurosurgeon for an MRI (magnetic resonance imaging) scheduled for 10/23/23. In an interview on 9/28/23 at 10:00 AM, with the Director of Nurses (DON), she confirmed Resident #38 was observed on the floor in her room on 9/8/23. The DON also confirmed she did not know how the resident ended up on the floor, as she had never seen the resident attempt to get out of the bed. The DON confirmed she had not done a thorough investigation. She reported that she did not have any statements from the staff or other residents regarding Resident #38's fall. The DON revealed that the "only thing that was done (regarding the incident) was an incident report was filled out and the resident was sent to the emergency room at (proper name of local hospital) for evaluation and it was discussed in the stand-up meeting the next morning." On 9/29/23 at 2:38 PM, during an interview , the Administrator confirmed he was aware of the incident involving Resident #38, that occurred on 9/8/23. The Administrator said it was discussed in stand-up the next morning. The Administrator explained he did not feel the incident needed to be investigated "because of the way Resident #38's body was positioned on the floor in her room." The Administrator said he determined the resident fell out of the bed, by the way her body was positioned. A record review of the "Admission Record" for	F 610	be used to monitor the incident for accuracy of investigation; discussed with the Interdisciplinary Team and reviewed in the weekly Persons at Risk meeting to ensure proper procedures are followed. The auditing tool will be brought before the monthly QAPI committee for review and recommendation any adverse findings will be addressed immediately; these efforts will be ongoing and continue indefinitely.	

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F 610	Continued From page 7 Resident #38 revealed the facility admitted the resident on 2/13/19 with diagnoses that included Cognitive Communication Deficit and Abnormalities of Gait and Mobility. A record review of Resident #38's Discharge Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/8/23, revealed the resident was sent to an Acute Hospital. Section G revealed the resident needed extensive assistance for bed mobility.	F 610		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing	F 625		10/19/23

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F 625	Continued From page 8 facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide the Resident, or the Resident Representative (RR), written notification of the bed hold policy at the time of transfer for two (2) of 19 sampled residents. Residents #4 and 39 Findings include: A review of the facility's policy, "Bed-Holds and Returns", reviewed 04/10/2023, revealed, "1...All residents/representatives are provided written information regarding the facility bed-hold policies .... b. at the time of transfer (or, if the transfer was an emergency, within 24 hours) ....3. The written information regarding bed-holds provided to the resident/representatives explains in detail: a. the duration of the stated bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; b. the reserve bed payment policy as indicated by the state plan (for Medicaid residents); c. the facility policies regarding bed-hold periods: d. the facility per diem rate required to hold a bed (for non-Medicaid residents), or to hold a bed beyond the state bed-hold period (for Medicaid residents); and e. the return policy ...." Resident # 4 Record review of the "Admission Record" revealed the facility admitted Resident #4 on 7/28/2017.	F 625	An audit of all residents who transferred within the last six months was completed on 9/28/2023 by the Business Office Manager. On 9/28/2023 the missing written notifications of the bed hold policies were mailed out to Resident #4 and #39 Resident Representatives. All residents that transfer out of the facility have the potential to be affected by the deficient practice. On 9/28/2023 the Business Office Manager, the Administrator in training and the Administrator were in-serviced by the Regional Director of Operations on policy and procedure related to notification of bed hold and transfer. The Quality Assurance Performance Improvement Team (QAPI) met on 9/29/2023 and discussed policy and procedure related to bed hold policy with no revisions needed. Beginning on 9/29/2023, all residents or their representatives will be notified in writing of the facilities bed hold policy upon transfer by the Business Office Manager and documented. If the Business Office Manager is unavailable, the Social Services Director or Administrator will be responsible for notifying the resident or representative. Effective 10/2/2023 the	

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F 625	Continued From page 9 Record review of the facility's "Progress Notes" for Resident #4 revealed a "Social Services" note, dated 9/21/23, " ...Family was informed that resident has left the facility and was given the phone number to the senior care unit ..." which indicated he was transferred from the facility to a behavioral health facility. A review of the medical record revealed there was no written notification of the bed hold policy at the time of Resident #4's transfer from the facility. Resident #39 Record review of the "Admission Record" revealed the facility admitted Resident #39 on 11/08/2021. Record review of the Significant Change in Status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/15/23, revealed Resident #39 was transferred to an acute hospital. A review of the medical record revealed there was no written notification of the bed hold policy at the time of Resident #39's transfer from the facility. On 09/28/23 at 10:10 AM, in an interview and record review with the Business Office Manager (BOM), she explained that she called the family at the time of transfer and mailed a notification letter to the Resident, or the RR, that she referred to as the "bed hold letter". The BOM presented a copy of the bed hold letters she mailed to Resident #4 and Resident #39 RRs, which indicated the	F 625	Business office Manager will review the census line daily and discuss in the daily stand-up meeting all residents who transfer out of the facility, to ensure that they receive a bed hold policy and transfer form. The Administrator will audit the written notification of bed hold policy and supporting documentation tool weekly times six (6) weeks beginning 10/2/2023 ending 11/13/2023 then monthly and ongoing indefinitely thereafter during the QAPI committee monthly meetings for review and recommendation.	

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F 625	Continued From page 10 resident's name, RR's name, date of transfer, place of transfer, and reason for transfer. The documents did not include any information related to the facility's bed hold policy. On 09/28/23 at 10:53 AM, in an interview with the Administrator, he confirmed the facility did not provide written notification of the bed hold policy at the time of the resident's transfer and acknowledged the facility did not follow their policy.	F 625		
F 656 SS=G	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 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	F 656		10/19/23

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F 656	Continued From page 11 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 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review the facility failed to implement the comprehensive care plan for two (2) of nineteen care plans reviewed. Residents #38 and #55 Findings include: A record review of the facility's policy, "Using the Care Plan," dated 12/5/16, revealed, "It is the policy of the facility that the care plan be used in...the resident's daily care routines ...." Resident #38 Record review of comprehensive Care Plan for Resident #38 initiated 3/21/19 revealed "Focus I	F 656	A record review of the comprehensive care plans for resident #38 and Resident #55 were reviewed and updated on 9/28/2023 by the Minimum Data Set Nurse (MDS) to reflect person centered care was addressed. All residents who reside in the facility have the potential to be affected by this deficient practice. On 9/28/2023, the MDS Nurse audited all resident's care plans to reflect proper interventions were in place for falls and Activities of Daily Living (ADL) with no adverse findings. On 9/28/2023 Licensed Practical Nurse (LPN) #1 and Registered	

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F 656	Continued From page 12 am at risk for falls r/t (related to) decreased mobility, side effects from medications, impaired cognition, and impaired safety awareness ...I will not sustain any undetected injuries through the review date 10/19/23... Interventions ...Bed will be kept in lowest position while in bed ...This intervention was initiated on 7/27/23. During an interview on 9/25/23 at 2:00 PM, with Licensed Practical Nurse (LPN) #1 she confirmed she observed Resident #38 on the floor on 9/8/23 at 7:35 PM. The nurse revealed Resident #38 was moved into different room, because she had COVID-19. LPN #1 also explained that Certified Nurse Aide (CNA) #2 reported to her that Resident #38's bed would not go down in low position after the resident had fallen. The nurse stated she put information about the problem with the resident's bed in the maintenance book. During an interview on 9/26/23 at 10:00 AM, with maintenance staff, he confirmed there had been a work order on his maintenance book on 9/9/23, revealing a problem with Resident #38's bed not being able to be lowered to the lowest position. The maintenance man stated he replaced that bed with a new electric bed and mattress, as the bed was an old crank bed and needed to be discarded. During an interview on 9/29/23 at 2:30 PM, with CNA #2, she said she was the CNA on 9/8/23, the night Resident #38 fell. CNA #2 said the nurse had called her for assistance to get Resident #38 off the floor. CNA #2 revealed the resident's bed was in high position and would not go down. The CNA said she told LPN #1 and they put the information in the maintenance book. CNA #2 also stated that the dayshift CNA reported to her	F 656	Nurse (RN) #1 were in-serviced by the Director of Nursing (DON) on policy and procedure of following care plans. Beginning 9/29/2023 ending 10/19/2023 all nursing staff were in-serviced by the DON on policy and procedures related to following care plans. The Quality Assurance Performance Improvement Team (QAPI) met on 9/29/2023 and discussed policy and procedure related to following care plans with no revisions needed. Effective 10/2/2023 the Care plan Nurse will review any incidents during the daily stand-up meeting to ensure the accuracy of care plans are updated, and ongoing indefinitely thereafter. The CarePlan Nurse will review two (2) care plans per week beginning 10/2/2023 and ongoing indefinitely thereafter during the Persons at Risk meeting to ensure that person-centered care is achieved. Any adverse findings will be addressed immediately and discussed in the QAPI committee meeting for review and recommendation these efforts will be ongoing and indefinitely.	

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that Resident # 38's bed wouldn't lower to the lowest position.

A record review of the "Admission Record" for Resident #38 revealed the facility admitted the resident on 2/13/19 with diagnoses that included Cognitive Communication Deficit and Abnormalities of Gait and Mobility.

Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/7/23 revealed in Section C that Resident # 38 had been unable to participate in a Brief Interview for Mental Status (BIMS), which indicated she was cognitively impaired. Review of Section G also revealed Resident #38 needs extensive assistance with bed mobility.

Resident #55

On 09/25/23 at 11:01 AM, an observation revealed Resident #55 sitting in her wheelchair in her room with the door closed. The resident was dry shaving her face with a blue razor, using her left hand. Resident #55 did not have any soap or shaving cream on her face.

Record review of the comprehensive Care Plan for Resident #55, with a revision date of 9/26/23, revealed "I have an ADL (activities of daily living) deficit ...I prefer to shave my face with a razor with staff supervision ...Interventions ...Staff will observe me while shaving to ensure safety. Staff will provide me with razors and shaving cream ..." Review of the care plan "Focus: I am at risk for bleeding r/t (related to) receiving Clopidogrel Bisulfate (a blood thinner) ...Interventions ...Observe for s/sx (signs/symptoms) of bleeding ...Use care when providing assistance with ADL's

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to prevent injury that may cause bleeding ..."

On 09/25/23 at 03:16 PM, in an interview with Registered Nurse (RN) #1 confirmed the resident should not have had a razor shaving herself without supervision. RN #1 confirmed the resident could have cut herself with the razor, which could have caused bleeding problems, as the resident is on a blood thinner.

On 09/25/23 at 03:22 PM, in an interview with CNA #1, she stated she did not know that Resident #55 had the razor. CNA #1 revealed none of the residents are allowed to shave themselves unsupervised.

On 09/29/23 at 09:25 AM, in an interview with Licensed Practical Nurse LPN #3/Care Plan Nurse revealed she is responsible for writing the resident care plans. She stated it is a personalized care plan to be used by all staff rendering care. LPN #3 confirmed that Resident #38 had a care plan with interventions that addressed falls and should have been followed. She stated that allowing Resident #55 to shave herself without CNAs in the room, was not following the care plan. She explained that "this was a safety issue" as Resident #55 could have cut herself shaving without assistance. She stated she expects all staff to follow the care plan.

A record review of the "Admission Record" for Resident #55 revealed the facility admitted the resident on 6/11/2020, with diagnoses that included Cerebral Infarction, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, and Seizures.

A record review of Quarterly Minimum Data Set

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F 656	Continued From page 15 (MDS) for Resident #55, with Assessment Reference Date (ARD) of 6/29/23, revealed a Brief Interview for Mental Status (BIMS) score of two (2), which indicated Resident #55 had severe cognitive impairment. Section G for Personal Hygiene revealed the resident required extensive assistance with personal hygiene.	F 656		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to adequately supervise and implement interventions for dependent residents to prevent one (1) resident from ending up on the floor with a major head injury and one (1) resident from dry shaving herself in her room with the door closed for two (2) of four (4) residents reviewed for accidents. Residents #38 and #55 Findings include: Review of the facility's policy titled, "Accidents and Incidents," revealed "It is the policy of this facility that the resident environment remains as free of accidents and hazards as possible and those residents receive supervision and assistance devices to prevent accidents	F 689	Resident #38 had a fall on 9/8/2023 at 7:35 PM and was assessed by the Licensed Practical Nurse (LPN)#1 then sent to the hospital for further evaluation and treatment per doctor's order. Resident #38 returned from the hospital on 9/12/2023 at 7:18 PM and was placed in an electric bed, lowered to the floor to prevent further injuries, assessed by the Nurse on duty and was found to be at standard baseline with no negative outcomes. The facility reported the incident to the SA on 10/19/2023 at 12:38 PM by the Administrator. Resident #55 razor was removed by the Assistant Director of Nursing (ADON) and the resident was educated on the risk of shaving without assistance on 9/25/2023.	10/19/23

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whenever possible. This is accomplished through the identification and evaluation of environmental hazards and individual risk factors, implementing interventions to reduce hazards and risks that are identified, and monitoring for the effectiveness of the interventions ...Environmental risk may be identified through ...routine inspection of the physical plant ...These interventions may include repair, replacement ..."

Resident # 38

A record review of the "Progress Note," dated 9/13/23, revealed the Nurse Practitioner (NP) documented the hospital return of Resident #38 from a local Acute Care Hospital from 9/8/23 through 9/12/23, following hospitalization and treatment for an Intracerebral Hemorrhage.

During an interview on 9/25/23 at 10:00 AM with the NP, she confirmed the resident had a major injury to the head after a fall at the facility. The NP revealed she didn't know how the resident got on the floor, as she has never seen the resident make any attempts to get out of the bed without assistance.

A record review of Resident # 38's, "Fall Assessments" dated 9/8/23 revealed no history of falls within the last six (6) months.

Record review of the facility's, "Incident Report" dated 9/8/23 at 7:35 PM by Licensed Practical Nurse (LPN) #1, revealed Resident #14 came out of her room, stating her roommate, Resident #38 was on the floor. The nurse also documented the resident was unable to give a description of the incident, however, a body audit revealed that the resident had a hematoma to the back of her

The ADON made rounds on 9/25/2023 to ensure that no other razors were in the possession of residents that were not deemed safe to use them with no negative outcome from the search.

All residents have the potential to be affected by the deficient practice.

Licensed Practical Nurse (LPN) #1, the Director of Nursing (DON) and the Administrator were in-serviced on 9/27/2023 by the Regional Nurse Consultant (RNC) on proper reporting guidelines and investigation. All nursing staff were in serviced on fall policy and procedures, proper reporting guidelines and investigation on 9/27/2023 by the Director of Nursing (DON). On 9/28/2023 Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #1 were in-serviced by the Director of Nursing (DON) on policy and procedure of following care plans and Activities of Daily Living (ADL). Beginning 9/29/2023 ending 10/19/2023 all nursing staff were in-serviced by the DON on policy and procedures related to following care plans and ADLS.

The Quality Assurance Performance Improvement Team (QAPI) met on 9/29/2023 and discussed policy and procedure related to following care plans and ADLS with no revisions needed. Effective 10/1/2023 the Administrator or DON will be notified immediately of any incidents, and it will be reported to the correct authorities directed by the federal

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F 689	Continued From page 17 head. Further review LPN #1's documentation of the incident revealed that possible predisposing factors was the furniture, recent illness, and a room change. There was also documentation that no witnesses were found. During an interview on 9/25/23 at 2:00 PM, with LPN #1, she confirmed she observed Resident #38 on the floor on 9/8/23 at 7:35 PM. LPN #1 said Resident #14 came out into the hall and said Resident #38 was on the floor. LPN #1 confirmed she did not ask Resident #14, the residents' roommate, how the resident ended up on the floor. The nurse explained Resident #14 was upset about having a roommate and having to stay in the room because they both had COVID-19. LPN #1 explained that Resident #38 was moved into the room with Resident # 14 because she had COVID-19. LPN #1 also explained that CNA #2 reported to her that Resident #38's bed would not go down in low position after the resident had fallen. The nurse stated she put information about the problem with the resident's bed in the maintenance book. In an interview on 9/26/23 at 10:00 AM, with maintenance staff, he confirmed there had been a work order on his maintenance book on 9/9/23, revealing a problem with Resident #38's bed not being able to be lowered to the lowest position. The maintenance man stated he replaced that bed with a new electric bed and mattress, as the bed was an old crank bed and needed to be discarded. On 9/28/23 at 10:00 AM, in an interview, with the Director of Nurses (DON), she confirmed Resident #38 was observed on the floor in her room on 9/8/23. The DON also confirmed she did	F 689	regulation. Effective 10/2/2023 and ongoing indefinitely, all incidents will be reviewed in the daily stand-up meetings by the DON or Administrator; discussed with the Interdisciplinary Team and reviewed in the weekly Persons at Risk meeting to ensure proper procedures are followed. Effective 10/1/2023 the DON or ADON will perform room rounds twice weekly for four weeks, then two rooms per week will be checked as an ongoing effort to maintain a secure environment, these efforts will continue indefinitely. Any findings will be removed from the residents' area and discussed in the daily stand-up meeting with the Interdisciplinary Team (IDT). The CarePlan will be reviewed by the Minimum Data Set Nurse to ensure person-center interventions are in place during daily-stand-up meetings. Any adverse findings will be addressed immediately and discussed in the QAPI committee meeting for review and recommendation this will be ongoing and indefinitely.	

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not know how the resident ended up on the floor, as she had never seen the resident make any attempt to get out of her bed. The DON revealed they had moved the resident to another room and had sent the resident to the hospital for an evaluation.

During an interview on 9/28/23 at 10:15 AM, with Resident #14, she refused to discuss Resident #38's fall. Resident #14 said all she knows is the resident was on the floor and she was not discussing that situation anymore.

During an interview on 9/29/23 at 2:30 PM with CNA #2, she said she was the CNA on 9/8/23, the night Resident #38 fell. CNA #2 said the nurse had called her for assistance to get Resident #38 off the floor. CNA #2 revealed the resident's bed was in high position and would not go down. CNA#2 said she told LPN #1 and they put the information in the maintenance book. CNA #2 also stated that the dayshift CNA reported to her that Resident 38's bed wouldn't go down. CNA #2 revealed she had never seen Resident #38 attempt to get out the bed without assistance. CNA #2 also revealed that Resident #14 was upset and continued to stand by Resident #38's bed. CNA#2 said Resident #14 kept pressing Resident #38's call light. CNA #2 said she asked Resident #14 to leave Resident #38's call light alone and use her own call light if she needed assistance.

During an interview on 9/29/23 at 2:38 PM, with the Administrator, he confirmed he was aware of Resident #38's fall that occurred on 9/8/23. The Administrator said it was discussed in stand-up the next morning.

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A record review of the "Admission Record" for Resident #38 revealed the facility admitted Resident #38 on 2/13/19 with diagnoses that included Cognitive Communication Deficit and Abnormalities of Gait and Mobility.

Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/7/23 revealed Resident # 38 had been unable to participate in a Brief Interview for Mental Status (BIMS) review, which indicated she was cognitively impaired. Review of section G also revealed Resident #38 needs extensive assistance with bed mobility.

Record review of the "Admission Record" revealed the facility admitted Resident #14 on 8/20/17 with diagnoses that included Generalized Anxiety Disorder and Schizophrenia.

Record review of the Quarterly MDS, with an ARD of 7/5/23, revealed Resident #14 had a BIMS score of 15, which indicated she was cognitively intact. Section G indicated Resident #14 was independent with transfers and bed mobility.

Resident #55

On 9/25/23 at 11:01 AM, an observation of Resident #55, revealed the resident sitting in her wheelchair in her room with the door closed. Resident #55 was dry shaving her face with a blue razor using her left hand, without soap or shaving cream on her face. While being observed, Resident #55 attempted to put A&D ointment on her face to shave. Resident #55's speech was unclear; however, the resident could make simple needs known by pointing with her fingers and shaking her head yes and no

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answers. Resident #55 shook her head yes when asked if she shaved herself without staff present. The resident also shook her head yes when asked if the staff gave her the razor. No blood was noted on the resident's face and the hair over the resident's lip had been removed. Thick hair was noted under the resident's chin and neck. The Assistant Director of Nursing (ADON) entered the resident's room and asked the resident for the razor and finished shaving the resident.

During an interview on 09/25/23 at 03:16 PM, with the ADON, she confirmed Resident #55 "should not" have a razor shaving herself without supervision. The ADON also confirmed Resident #55 could have cut herself with the razor, which could have been a problem, as the resident is on a blood thinner.

During an interview on 09/25/23 at 03:22 PM, with CNA #1, she said she was told by the ADON that Resident #55 had a razor shaving herself in the room without supervision. CNA #1 said she didn't know the resident had the razor and explained the residents don't shave themselves at this facility.

During an interview on 09/28/23 at 3:57 PM, with the DON, she said the resident should not have been using a razor "unsupervised." The DON confirmed the resident could have cut herself and could have bled out with no staff in the room.

Record review of the "Admission Record" revealed the facility admitted Resident #55 on 6/11/20, with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominate Side, Seizures, and

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F 689	Continued From page 21 Cerebral Infarction. Record review of the Quarterly MDS, with an ARD of 6/29/23, revealed Resident # 55 had a BIMS score of 02, which indicated she was severely cognitively impaired. Review of section G revealed Resident #55 needs extensive assistance with personal hygiene.	F 689		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 725		10/19/23

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F 725	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to have staff to provide care to meet the needs of the residents for two (2) of 19 sampled residents. Resident #8 and Resident #41. Findings Include: The State Agency (SA) received a complaint, MS #22934, which alleged the facility did not have enough staff on the night shift to provide incontinent care for the residents. Review of the facility's policy, "Staffing", dated 10/2022, revealed, " ...Our facility provides sufficient numbers of staff ...to provide care and services for all residents in accordance with resident care plans and the facility assessment ..." A record review of the "Facility Assessment", undated, revealed " ...B.1. Acuity- Sufficiency Analysis Summary ...uses national benchmarks provided by national associations, clinical organizations, federal and state provided databases to establish baselines for organizational practices and goal setting ..." Resident #8 During an interview with Resident #8 on 9/29/23 at 11:00 AM, he confirmed the facility had two (2) Certified Nurse Aides (CNAs) on the 11-7 shift last night, no staff came into his room during the night to provide care, and he had to wait until the day shift came in to get assistance. Resident #8 stated the nurses do not help with turning and	F 725	A resident council meeting was held on 10/3/2023 by the Assistant Administrator to discuss complaints related to staffing needs and the plan to meet them, with no further complaints.The Assistant Administrator conducted interviews with resident #8 and #41 concerning their complaints and staffing needs on 10/16/2023. All residents have the potential to be affected by the lower staffing ratios. All staff were in serviced on 9/27/2023 by the Director of Nursing on Abuse, Neglect and Exploitation policy and procedures. All nursing staff were educated on whom to contact and when, related to staffing issues and sufficiency of staffing on 10/19/2023 by the Director of Nursing.The facility assessment was reviewed by the Assistant Adinistrator to ensure that it reflects the sufficiency of staff on 10/19/2023. The Quality Assurance Performance Improvement Team (QAPI) met on 9/29/2023 and discussed policy and procedure related to staffing ratios and facility assessment with no revisions needed. The Administrator implemented employee referral bonus, sign on bonuses and nurse contract pay effective 10/2/2023. Ads were placed on 10/2/2023 for certified nursing assistants to include referral bonuses, sign on bonuses and	

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F 725	Continued From page 23 repositioning. Record review of the "Admission Record" revealed the facility admitted Resident #8 on 5/09/2023 and he had diagnoses including Whipple's Disease, Paraplegia, and Neuromuscular Dysfunction of Bladder. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/01/23 revealed Resident # 8 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Section G revealed he required extensive assistance with hygiene, toileting, and bed mobility. Resident #41 During an interview on 9/29/23 at 10:30 AM, with Resident #41, he stated there were only two (2) CNAs on the North Hall to take care of 60 residents last night. He explained that he had to lay in his urine and bowel movement from 3:00 AM to 5:30 AM because there was not enough staff, and he was not able to clean himself. He stated that it was degrading to be laying in your own urine and feces. Record review of the "Admission Record" revealed the facility admitted Resident #41 on 5/26/23 with diagnoses including Hypertension and Diabetes Mellitus. Record review of the MDS, with an ARD of 8/30/23 revealed Resident #41 had a BIMS score of 15, which indicated he was cognitively intact. Section G revealed he required extensive assistance with hygiene and toileting.	F 725	contract nurse pay. The Ads will run continuously until all staffing needs are met. Effective 10/2/2023 the Staff Development Nurse will review all applications daily and make calls to set up interviews, this will be an ongoing daily continuous effort. Effective 10/2/2023 the Director of Nursing, the Assistant Director of Nursing and the Human Resources Director will notify the Staff Development Nurse of any new hires so they may be added to the direct care schedule accordingly. Effective 10/2/2023 the Staff Development Nurse will discuss the staffing openings in daily stand-up and address any issues with coverage, this will be ongoing efforts indefinitely thereafter. The on-call person will make great efforts to maintain the proper staffing ratio and make calls or texts to achieve this when a call-out has been placed by an employee effective 10/2/2023 and ongoing, if there is any issues with coverage the on- call person will notify the Director of Nursing and the Administrator for further guidance. Any adverse findings will be addressed immediately and discussed in the monthly QAPI committee meeting begining 10/2/2023 for review and recommendation and ongoing indefinitely therafter.	

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In an interview on 9/29/23 at 1:00 PM, Licensed Practical Nurse (LPN) #2 confirmed the facility had been attempting to bring in staff to meet the resident's needs and did not use contract CNAs. LPN #2 explained that it is difficult to retain staff because of the location of the facility. LPN #2 said that five (5) CNAs were scheduled and assigned to the North Hall the night of 9/28/23, but three (3) CNAs left because they were not happy with their assignments, which left two (2) CNA's working. LPN #2 confirmed the facility did not have a backup plan to replace the three CNA's that night. LPN #2 also confirmed several staff have worked 15 to 24 hour shifts to provide care for the residents and she did not think it was safe for the residents when the staff worked like that.

In an interview with the Director of Nursing (DON) on 9/29/23 at 1:30 PM, she confirmed the facility had attempted to hire staff through staffing agencies and by offering sign-on bonuses, but none of those measures had drawn staff to the facility. The DON said she thought the problem was the facility's location. The DON confirmed the facility had two (2) CNAs working on the 11-7 shift on 9/28/23 because three (3) CNAs had left because of their assignments. The DON explained that several staff members were picking up extra shifts and had worked 15 to 24 hour shifts,and that it was "not safe for the residents."

In an interview with the Administrator on 9/29/23 at 1:45 PM, he confirmed he was aware of the shortage of staff. He explained he was working with the DON and Staff Development Nurse to resolve the staffing problem by offering sign-on

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F 725	Continued From page 25 bonuses and utilizing contract staff. The Administrator said he was not aware that staff had been working 15 to 24 hour shifts.	F 725		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to have a Registered Nurse (RN) for eight (8) consecutive hours a day for eight (8) of 60 days reviewed. 5/6/23, 5/20/23, 5/21/23, 5/27/23, 5/28/23, 6/4/23, 6/10/23, 6/24/23, Findings include: Review of the facility's policy, "Staffing", dated June 1, 2000, revealed, "It is the policy for this facility to provide adequate staffing to meet the needs of the resident population ...1. This facility furnishes information from payroll records setting forth the average numbers and types of personnel ...on each shift as required ..."	F 727	The deficient practice found by the State Agency is that the facility failed to have a Registered Nurse (RN) for at least 8 consecutive hours a day for 7 out of 20 days. The days are as follows: 5/6/2023,5/20/2023,5/21/2023, 5/27/2023, 5/28/2023,6/4/2023,6/10/2023,6/24/2023. The Registered Nurse staffing coverage was reviewed for the current schedule on 10/2/2023 by the Staffing coordinator to ensure there was at least 8 consecutive hours a day for 7 days in coverage with no non-covered days. All residents who reside in the facility have the potential to be affected by the deficient	10/19/23

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F 727	Continued From page 26 Review of the facility's "Employee Time Cards" revealed the following: On 5/6/23 (Sunday), the RN was clocked in for 7.37 hours. On 5/20/23 (Saturday), the RN clocked in for 3.18 hours. On 5/21/23 (Sunday), the RN was clocked in for 2.35 hours. On 5/27/23 (Saturday), the RN was clocked in 7.6 hours. On 5/28/23 (Sunday), the RN was clocked in for 7.28 hours. On 6/4/23 (Sunday), the RN was clocked in for 3.38 hours. On 6/10/23 (Saturday), the RN was clocked in for 7.75 hours. On 6/24/23 (Saturday), the RN was clocked in for 7.57 hours. In an interview on 9/28/23 at 09:30 AM, with the Director of Nurses (DON), she confirmed there were days in which RNs did not work for eight (8) consecutive hours. The DON said she did not know RNs had to work for eight (8) consecutive hours. The DON reported that she works on the days in which they are unable to find RN coverage, but she checked on staff and residents and did not stay for more than three (3) to four (4) hours at the facility. In an interview on 9/28/23 at 01:00 PM, with Licensed Practical Nurse (LPN) #2, she confirmed there were several days identified that a RN did not work for eight (8) consecutive hours. She stated that she was unaware that RNs were required to work for 8 consecutive hours. LPN #2 reported that she notified the Director of Nursing (DON) and Assistant DON when she was unable to schedule an RN. In an interview on 9/29/23 at 10:00 AM, with the Administrator, he revealed he did not know RNs	F 727	practice. The Regional Nurse Consultant in-serviced the Director of Nursing on 9/29/2023 on the importance of an RN being in the facility 8 consecutive hours a day for 7 days a week and to ensure that they remain on the clock for the full 8 hours. The Director of Nurisng in serviced the Staff Development Nurse on 10/2/2023 on the importance of an RN being in the facility 8 consecutive hours a day for 7 days a week and to ensure that they remain on the clock for the full 8 hours. On 10/19/2023 all nursing staff were in serviced by the Director of Nursing that there must be an RN in the building for 8 consecutive hours a day for 7 days a week and to ensure that they remain on the clock for the full 8 hours. The Quality Assurance Performance Improvement Team (QAPI) met on 9/29/2023 and discussed policy and procedure related to staffing ratios and RN coverage with no revisions needed. Effective 10/2/2023 the Staff Development Nurse will review with the Director of Nurisng the RN coverage for the upcoming week and discuss any openings so that coverage can be found prior to the non-covered day(s), this will be an ongoing effort. Effective 10/2/2023 the Staff Development Nurse will discuss the staffing openings in daily stand-up and address any non-covered days, this will be ongoing efforts indefinitely thereafter. The on-call person will make great efforts to maintain the proper RN coverage and	

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F 727	Continued From page 27 were not working for 8 consecutive hours. The Administrator said he needed to check with the DON to make sure she did not work those days.	F 727	make calls or texts to achieve this when a call-out has been placed by an employee effective 10/2/2023 and ongoing, if there are any issues with coverage the on- call person will notify the Director of Nursing and the Administrator for further guidance. Effective 10/2/2023 any adverse findings will be addressed immediately and discussed in the monthly QAPI committee meeting for review and recommendation and continue indefinitely thereafter.	
F 880 SS=D	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; §483.80(a)(2) Written standards, policies, and	F 880		10/19/23

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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.
The facility will conduct an annual review of its

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F 880	Continued From page 29 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure infection control measures were consistently implemented to prevent the development and/or transmission of infection for two (2) of 19 sampled residents. Residents #180 and 181 Findings include: A record review of the facility's policy titled," Handwashing/Hand Hygiene," revised 8/2009, revealed, "Purpose: The purpose of this procedure is to provide guidelines for effective hand washing and hygiene techniques that will aid in the prevention of transmission of infections. Objective To prevent and control the spread of infectious diseases. General Guidelines 1 ... handwashing ... must be performed under the following conditions: a. Before and after direct contact with residents; ... d. After removing gloves; ... 3. The use of gloves does not replace handwashing ... 4. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use of alcohol-based hand rub for all the following situations: ... h. After handling used dressings, contaminated equipment, etc. i. After contact with inanimate objects (e.g., medical equipment) in the immediate vicinity of the resident; and/or j. After removing gloves ..." Resident #180 On 9/27/23 at 1:25 PM, an observation of Licensed Practical Nurse (LPN) #4 providing PEG	F 880	The facility failed to ensure proper infection control procedures were followed for residents #180 and #181. Residents #180 and #181 were assessed by the Director of Nursing on 9/28/2023 to determine if infection was transmitted during cross contamination of treatment; there was no negative outcome. All residents that require wound care or treatment have the potential to be affected by the deficient practice. The Infection Control Preventionist in-serviced Licensed Practical Nurse (LPN) #4 and Registered Nurse (RN) #2 on following infection control procedures related to hand hygiene and wound care procedures on 9/28/2023. The Infection Control Preventionist performed a competency check off for all nurses beginning 10/1/2023 ending 10/19/2023 to include proper hand washing techniques and standard infection control procedures related to wound care. The Quality Assurance Performance Improvement Team (QAPI) met on 9/29/2023 and discussed policy and procedure related to infection control procedures and wound care with no revisions needed. Beginning 10/1/2023 ending 11/12/2023 the Infection Control Preventionist will perform two (2) competency check offs per week for six (6) weeks to ensure effective	

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F 880	Continued From page 30 (percutaneous endoscopic gastrostomy) tube care on Resident #180, revealed LPN #4 used her gloved hands to adjust the bed with the remote control and to place the feeding pump on hold. She did not change gloves or wash hands. The LPN then used her gloved hands to remove the bed linen, abdominal binder, and PEG tube dressing. At this time, the nurse removed her gloves, washed hands and returned to the bedside and cleaned the PEG site. After she cleaned the PEG site, LPN #4 removed her gloves and applied clean gloves, but did not wash her hands prior to applying the clean dressing. After she applied the new dressing to the PEG site, LPN #4 pulled scissors out of her pocket to cut the tape for PEG dressing. She then placed the scissors on the bedside table. LPN #4 then removed her gloves, applied clean gloves, and secured the dressing with the tape. Prior to leaving the room, LPN #4 picked up the scissors and put them back in her pocket, removed her gloves and washed her hands. On 9/27/23 at 3:23 PM, in an interview with LPN #4, she revealed she did not think she needed to wash her hands after touching the feeding pump and bed remote, however, she stated that maybe she should have. LPN #4 confirmed that she should have washed or sanitized her hands between glove changes, as not washing her hands when removing soiled gloves "may cause residents to get an infection." On 9/27/23 at 4:10 PM, in an interview with Registered Nurse (RN) #1/ Infection Preventionist (IP), she confirmed the LPN #4 should have removed her gloves, washed, or sanitized her hands after touching the remote and feeding pump. She stated the feeding pump and bed	F 880	handwashing and wound care technique are being accomplished, then begining 12/1/2023 ending 6/30/2023 two (2) times per month the competency check offs will be completed. Any adverse findings will be addressed immediately and reviewed in the monthly QAPI committee meeting for review and recommendation begining 10/1/2023 and ending 6/30/2023.	

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remote are considered dirty. The IP stated LPN #4 should have washed her hands each time she changed her gloves, to prevent the spread of infection.

On 9/27/23 at 4:45 PM, in an interview with Director of Nursing (DON), she stated LPN#4 should have removed gloves after touching the remote and feeding pump and washed her hands. The DON confirmed that LPN #4 should washed or sanitized her hands each time she removed her gloves, as the LPN's actions could potentially cause the resident to develop an infection from cross contamination.

Record review of the Admission Record for Resident #180 revealed the facility admitted the resident on 9/22/23, with diagnoses that included Chronic Obstructive Pulmonary Disease, Dysphagia, Unspecified and Unspecified Severe Protein Calorie Malnutrition.

Record review of the Order Summary Report revealed a Physician order to change the dressing to the PEG tube site dressing daily or as needed.

Resident #181

On 9/27/23 at 3:05 PM, an observation of Resident #181's wound care performed by Registered Nurse (RN) #2/Wound Care Nurse, revealed that when the nurse removed the soiled dressing that was contaminated with feces and blood and did not perform hand hygiene after removing her soiled gloves and applying clean gloves. She then cleaned the wound with normal saline and applied SurePrep, removed her gloves and once again applied clean gloves without

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performing hand hygiene. After she applied the clean dressing, the nurse removed her gloves and washed hands.

On 9/27/23 at 3:38 PM, in an interview with RN #2, she confirmed that she should have sanitized or washed her hands when changing her gloves. She stated her actions could cause the resident to get an infection and prolong wound healing. The RN stated she "knew better" but forgot to do it.

On 9/27/23 at 4:25 PM, in an interview with the IP, she confirmed the RN should have washed or sanitized her hands between changing gloves. She stated RN increases the resident chances of getting an infection. She stated the resident could get septic and prolong wound healing time.

On 9/27/23 at 5:08 PM, in an interview with the DON, she confirmed that RN #2 should have washed or sanitized her hands every time she removed her gloves. She stated the nurse's action could possibly cause the resident to get infection and slow down wound healing.

Record review of the Admission Record for Resident # 181 revealed the facility admitted the resident on 9/5/23, with diagnoses that included Dysphagia following unspecified Cerebrovascular Disease and Essential Hypertension.

A record review of the Order Summary Report revealed Resident #181 revealed a Physician order to clean the stage 2 to the sacrum with normal saline, pat dry and apply SurePrep and cover with bordered gauze.