STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255291	A. BUILDING _____ B. WING _____	11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPIAH LIVING CENTER	806 WEST GEORGETOWN STREET CRYSTAL SPRINGS, MS 39059

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and Complaint Investigations (CIs) at the facility from 10/30/23 through 11/2/23. The SA investigated CI MS #23005 related to not following physician orders, not offering water, and residents being left wet and soiled for extended periods of time, CI MS#23078 was investigated related to admission, transfer, and discharge rights and CI MS #23081 was investigated for rehabilitation services and pressure sores. No deficiencies were cited for these investigations. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid related to CI MS #23080 residents being left wet for extended periods of time, not following physician orders and improper incontinent care and F690 was cited. CI MS #23079 related to notification of Resident Representative, adequate grooming, pressure sores, and infection control F880 was cited. Also cited during the annual survey for noncompliance was F637, F812, F880. The facility held a license for 60 beds, with a census of 52.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by	F 637		12/1/23

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

Electronically Signed | 11/20/2023

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F 637	Continued From page 1 implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to complete a Significant Change Minimum Data Set (MDS) assessment within 14 days for a resident with a physical and mental decline for one (1) of 21 sampled residents. Resident # 6 Findings include: A record review of the facility's policy "Resident Assessment," with revision date 9/2019, revealed " ...The assessment will describe the resident's physical and mental deficits, strengths, and the requirements of assistance to meet their needs. The assessment will also identify risk factors associated with possible functional decline and describe the resident's objectives for maintaining or improving their functional abilities ..." During an interview on 11/1/23 at 11:28 AM, with Resident # 6 she revealed she was admitted to the facility for rehabilitation following a stroke. The resident explained that since admission, she had a fall and broke her hip. The resident commented that prior to the fall, she was able to get up and go to the restroom and dress herself without assistance. After the fall, she stated she was not able to do what she had been doing previously. A record review of the "Departmental Notes" for 8/27/23 reveals that at 9:32 PM, Resident #6 was	F 637	a. On 11/15/2023, the facility Assessment Nurse completed a Significant Change Minimum Data Set (MDS) on Resident # 6 and was transmitted on 11/16/2023 to the Internet Quality Improvement and Evaluation System (IQIES). Resident # 6 was assessed by Registered Nurse Supervisor with no issues identified on 11/02/2023. b. All Residents that have a significant change in status have the potential to be affected by this alleged deficient practice. c. On 11/2/2023, the Director of Nurses and Registered Nurse Supervisor assessed all Residents for significant change and/or decline that will warrant the need to complete a Significant Change Minimum Data Set (MDS). No significant change or decline were identified. On 11/2/2023, current Registered Nurses and Licensed Practical Nurses were in-serviced on Resident Assessment Policy by the Director of Nurses. New hires and/or returns from Family Medical Leave (FMLA) will be in-serviced upon hire and/or upon return to work on Resident Assessment Policy. d. Beginning on 11/3/2023, the Director of Nursing and/or Registered Nurse	

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F 637	Continued From page 2 found of the floor. The resident reported in an attempt to go to the bathroom, as she attempted to sit in her wheelchair, it rolled backwards, causing her to fall. The nurse documented that the resident reported severe pain in her right hip and knee. The physician was called and the resident was sent by ambulance to a local hospital. A record review of therapy notes titled "Plan of Treatment for Rehabilitation," revealed in the Initial Assessment portion of the therapy notes, that Resident #6 was referred to therapy following hospitalization due to a right hip fracture with a potential for improvement in functional ADL (Activities of Daily Living) performance, dressing, positioning, functional mobility, and home safety. Therapy notes revealed that the resident's prior level of function regarding ADL was independent. Current evaluation revealed that following hospitalization for a fall resulting in a right hip fracture, the resident had a functional decline in transfers, gait, bed mobility, functional range of motion, safety awareness and skin health. An interview on 11/1/23 at 1:07 PM, with a COTA (Certified Occupational Therapy Assistant) revealed that Resident #6 had been admitted to the facility on 7/25/23 for rehabilitation following a stroke. The COTA stated that the resident had made significant progress and was working to return home prior to her fall. She explained that prior to her fall, the resident was able to get up and go to the restroom and dress herself without assistance. After the fall, there had been a significant change, as the resident was no longer able to do what she had been doing previously. Record review of Resident #6's medical record	F 637	Supervisor will review nurses' note to determine need for completion of Significant Change Minimum Data Set (MDS) 5 times a week for 4 weeks and then 3 times a week for 3 months. Areas of concern will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review. The QAPI Committee will convene on 11/29/2023 to discuss further recommendations as needed and then review for 3 months. The next QAPI Committee meeting will convene on 12/15/2023. Additional training and/or disciplinary action will be considered as warranted. By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the rights to consent the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	

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F 637	Continued From page 3 revealed a Significant Change MDS was not completed for the resident within 14 days after her significant change. An interview on 11/2/23 at 11:37 AM, with Licensed Practical Nurse (LPN) #1/MDS Nurse revealed that she had not completed a Significant Change MDS for Resident #6 within 14 days for a resident with a physical and mental decline, as she didn't see that criteria was met with two changes. An interview on 11/2/23 at 12:53 PM, with the Administrator confirmed that the MDS Nurse did not complete a timely Significant Change MDS Assessment for Resident #6 and that it should have been completed within 14 days after her significant physical and mental decline began. The Administrator revealed the failure of proper transmittal was within the time of staffing changes and could have been missed. A record review of the "Face Sheet" for Resident # 6 revealed the facility admitted the resident on of 7/25/23, with diagnoses that included Hemiplegia following Cerebral Infarction Affecting Left Nondominant Side, Chronic Pain, and Chronic Obstructive Pulmonary disease.	F 637		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		12/1/23

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F 690	Continued From page 4 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure an incontinent resident received appropriate care and services to prevent the possibility of a urinary tract infection for one (1) of four (4) residents observed for incontinent care. Resident #27 Findings include:	F 690	a. Root cause analysis was conducted by the Interdisciplinary Team (IDT) on 11/02/2023 and based on findings the Certified Nursing Assistant (CNA) #2 failed to thoroughly clean Resident #27's genital area. Resident #27 was assessed by the facility Registered nurse on 11/1/2023 with no issues identified. b. All Residents that receive perineal care	

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F 690	Continued From page 5 Record review of the facility's policy, "Perineal Care," revised 10/18, revealed, " ...Female-Without Catheter ... 5. Wash genital area moving from front to back, while using a clean portion of the washcloth or pre-moistened wash wipe for each stroke ... 7. Dry genital area moving from front to back with towel..." On 10/31/23 at 3:30 PM, an observation of perineal care on Resident #27, revealed Certified Nursing Aide (CNA) #2 did not thoroughly clean the genital area. The CNA used a pre-moistened wash wipe, but only wiped the exterior genital area front to back one time and did not dry the area with a towel. On 10/31/23 at 4:43 PM, in an interview with CNA #1, she stated she did not clean the perineal area properly. She stated she should have cleaned the genital area by wiping from front to back, using a clean portion of the wipe with each stroke. The CNA revealed she only wiped the external genital area one time and did not dry the area. She commented that the resident could get a urinary tract infection or have skin breakdown from the care she gave. On 11/1/23 at 4:17 PM, in an interview with Director of Nurses (DON), she stated CNA #1 should have used one peri wipe to wipe down one side of the perineum, used another clean wipe to wipe down the other side and used another clean wipe to wipe down the middle. She stated CNA #1 should clean the perineal area until it is clean. She stated the actions of the CNA could possibly cause the resident to get a urinary tract infection. Record review of the "Face Sheet" for Resident #27, revealed the facility admitted the resident on	F 690	have the potential to be affected by this alleged deficient practice. c. On 11/1/2023 the Infection Preventionist Nurse in-serviced Certified Nursing Assistant (CNA)#2 on Perineal Care Policy. On 11/1/2023, Infection Preventionist Nurse began in-servicing current Certified Nursing Assistants on Perineal Care policy and was completed on 11/14/2023. New hires and/or returns from family Medical Leave (FMLA) will be in-serviced with return demonstration upon hire or upon return to work on Perineal Care Policy. d. On 11/3/2023, Infection Preventionist Nurse observed 3 CNA's perform Perineal care with no concerns identified. Beginning on 11/6/2023 the Director of nursing, Register Nurse Supervisor, and or Infection Preventionist Nurse will observe a total of 6 Certified Nursing Assistants (CNA) perform perineal care 5 times a week for a week for 4 weeks and then 3 times per week for 4 weeks and 2 times a week for 4 weeks. Areas of concerns will be reported to Quality Assurance and Performance Improvement (QAPI) Committee for review. The QAPI Committee will convene on 11/29/2023 to discuss further recommendations as needed and then review for 3 months. The next QAPI committee meeting will convene on 12/15/2023. Additional training and/or disciplinary action will be considered as warranted.	

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F 690	Continued From page 6 an 1/11/21, with diagnoses that included Unspecified Dementia and Malignant Neoplasm of Pharynx. Record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/12/23, revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment.	F 690	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the rights to consent the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility policy review, the facility failed to ensure items in the kitchen refrigerators, freezers, and dry storage room were dated, labeled, and discarded by the expiration date for one (1) of three (3)	F 812	a. On 10/30/2023, all of the expired food items in the pantry and refrigerator were immediately removed by the facility's Dietary Manager and was discarded to prevent it from being served. All residents	12/1/23

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F 812	Continued From page 7	F 812		

dietary observations. This has a potential to affect all residents receiving meals prepared by the facility's dietary department.

Findings include:

A review of the facility's policy titled "Food Storage Labeling," with a revision date of 05/18, revealed, "Policy: The facility will ensure the safety and quality of food by following good storage and labeling procedures. Procedure: 1. Labeling a. All temperature-controlled foods and ready-to-eat foods prepared in the facility and held for longer than twenty-four hours will be labeled. Information included on the label: Name of the food, Date of storage... 3. Rotation ...b. Food stored in storage units will be surveyed routinely to identify and discard foods that have passed its manufacturer's use-by date or expiration date. Suggested time frames: Dry storage - Weekly, Refrigerator storage- Weekly ..."

During the initial tour of the kitchen with the Dietary Manager (DM) on 10/30/2023 at 9:46 AM, revealed expired food items in the pantry that included three (3) 128 oz. (ounce) plastic containers of Goldens Mustard with an expiration date of 8/06/23, two (2) 128 oz. plastic containers of Ken's Steakhouse Barbecue Dressing with an expiration date of 9/28/23 and (3) 128 oz. plastic containers of Kikkoman Sauce with an expiration date of 10/13/22. Observation of the items in the refrigerator revealed (2) 5 lb. (pound) containers of Wholesale Cottage Cheese, opened, with a green substance around the top. Both containers were unlabeled, with an expiration date of 7/15/23. There was (1) 5 lb. bag of shredded parmesan cheese unlabeled, with an expiration

that received a meal tray from the kitchen were assessed by the facility Registered Nurse with no issues identified.
b. All residents that receive meals from the kitchen have the potential to be affected by this alleged deficient practice.

c. On 10/30/2023 the Dietary manager began in-servicing Dietary staff on Food Storage Labeling Policy and Recommended Food Storage Chart and checking dates on deliveries prior to storing it. Dietary Staff In-services completed on 11/2/2023. All dry goods and dairy products delivered were checked in by the Dietary Manager and/or facility cook for the expiration date and ensure that all items were labeled and dated on 11/1/2023.

d. On 11/1/2023, Dietary Manager checked the expiration dates and labels on all food items that were delivered. Any food items that were found to be expired, was immediately discarded on 11/1/2023. On 11/6/2023, the Dietary Manager and Administrator began monitoring expiration dates on dairy products and condiments 5 times a week for 4 weeks, then 3 times a week for 4 weeks and then 2 times a week for 4 weeks. Areas of concern will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review. The QAPI Committee will convene on 11/29/2023 to discuss further recommendations as needed and then review for 3 months. The next QAPI committee meeting will convene on 12/15/2023. Additional

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F 812	Continued From page 8 date of 6/14/23. On 10/30/23 at 10:46 AM, in an interview with the DM, regarding kitchen duties, she specified that all staff members of her dietary department are accountable for the proper dating, labeling, and removal of expired foods. Additionally, she disclosed that the Registered Dietitian conducts a monthly inspection to verify that expired foods are appropriately dated, labeled, and removed from the kitchen. Furthermore, the DM affirmed that expired foods must be removed from the kitchen to prevent being served to the residents. She acknowledged that it would be harmful to the residents' health to serve them expired foods. On 11/2/23 at 10:04 AM, during an interview with Dietary Aide (DA) #1, she stated that the DM typically labels and dates food as soon as it is unloaded from the morning truck. However, the assigned responsibility of inspecting expired foods is not established. She stated that instead, it is dependent upon the amount of available time during the shift. DA #1 did not recall attending an in-service that focused on the dating, labeling, and removal of expired foods a few weeks ago. On 11/02/23 at 10:10 AM, during an interview with DA #2, she shared that the DM had a responsibility to verify the food's expiration dates. She acknowledges being new to the job and is still learning. She admitted that failure to remove expired goods from the kitchen could result in them being served to the residents, causing them to become sick. On 11/2/23 at 11:50 AM, the Administrator verified in an interview that she is ultimately liable for ensuring that expired foods are removed from the	F 812	training and/or disciplinary action will be considered as warranted. By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to consent the findings of allegations as part of any proceedings and submit the responses pursuant to the regulatory obligations.	

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F 812	Continued From page 9 kitchen. However, she mentioned that the Registered Dietician does monthly inspections to ensure the proper labeling, dating, and removal of expired foods from the kitchen. The Administrator acknowledged that residents could be harmed if expired foods are served.	F 812		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and	F 865		12/1/23

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F 865	Continued From page 10 §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and	F 865		

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F 865	Continued From page 11 addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and facility policy review the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to ensure the program was sustained during transitions in leadership and failed to maintain implemented	F 865	a. Quality Assurance and Performance Improvement (QAPI) meeting was held on 11/15/2023. b. All residents have the potential to be	

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procedures and monitor the interventions the committee put into place in November 2021. This was for one (1) recited deficiency originally cited in November 2021, on an annual recertification survey. The deficiency was in the area of Infection Control for failure to perform hand hygiene during perineal care. The facility's continued failure during two federal surveys shows a pattern of the facility's inability to sustain an effective QAPI Committee.

Findings include:

Record review of the facility's policy, "QAPI (Quality Assurance and Performance Improvement) Introduction and Purpose," with a revision date of 08/15, revealed ... "The QAPI program has been developed to incorporate the Continuous Quality and Quality Assurance (QA) process consisting of ongoing analysis of clinical data and program results, identifying and prioritizing opportunities for improvement, implementing interventions and evaluating the effectiveness of those interventions on the quality of care and services ..."

F 880: Cited in 11/2021 for failing to perform hand hygiene during peri care.

On 11/2/23 at 3:50 PM, in an interview with Director of Nurses (DON) sated she was aware of the infection control issue from previous survey. She stated they have completed in-services and monitoring. She stated they will re-evaluate and identify additional interventions.

On 11/2/23 at 04:00 PM, in an interview with Licensed Practical Nurse (LPN) #2/Infection Preventionist, she stated she was aware of the

affected by this alleged deficient practice.

c. On 11/3/2023, the Administrator in-serviced the Director of Nurses and Infection Preventionist Nurse Registered Nurse Supervisor, Social Service Director, Dietary Manager, Assessment Nurse, and Medical Records Nurse on Quality Assurance and Performance Improvement (QAPI) Program. On 11/1/2023, the facility Infection Preventionist Nurse in-serviced current Registered Nurses /Licensed Practical Nurses and Certified Nursing Assistants on Perineal Care Policy and Hand Hygiene Policy. New hires and/or returns form Family Medical Leave (FMLA) will be in serviced upon hire and or upon return to work on Hand Hygiene Policy and Perineal Care Policy.

d. On 11/3/2023, Infection Preventionist Nurse observed 3 CNA's perform Perineal care with no concern identified. Beginning on 11/6/2023 the Director of nursing, Register Nurse Supervisor, and or Infection Preventionist Nurse will observe a total of 6 Certified Nursing Assistants (CNA) perform perineal care 5 times a week for a week for 4 weeks and then 3 times per week for 4 weeks and 2 times a week for 4 weeks. Beginning on 11/6/2023 the facility Director of Nurses and/or Nurses and/or facility Infection Preventionist Nurse will observe one registered Nurse and/or one Licensed Practical nurse perform Percutaneous Endoscopic Gastrostomy (PEG) tube care 5 times a week for 4 weeks and then 3

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F 865	Continued From page 13 previous citations. She stated they are not in compliance based on previous survey results. She stated she was not aware of the issues with hand washing and peri care prior to the survey. She stated they met with QAPI after the previous survey and came up with solutions. She stated they did one-on-one training. She stated she plans to do more one-on-one observations and write ups. On 11/2/23 at 4:10 PM, in an interview the Administrator stated she was not the Administrator at the time of the previous survey in 11/2021. She stated she expects the staff to always follow policy and procedure while providing care. She stated she was not aware of the current handwashing issues.	F 865	times a week for 4 weeks and 2 times and week for 4 weeks. Beginning on 11/6/2023, the facility Administrator will review Rounds Flow Records (NS 676) on observation for perineal care and handwashing performance by Certified Nursing Assistants, Registered Nurses and/or Licensed Practical nurses are being completed 2 times a week for 4 weeks, then 1 time per week for 4 weeks. Areas of concerns will be reported to Quality Assurance and Performance Improvement (QAPI) Committee for review. The QAPI Committee will convene on 11/29/2023 to discuss further recommendations as needed and then review for 3 months. The next QAPI committee meeting will convene on 12/15/2023. Additional training and/or disciplinary action will be considered as warranted. By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the rights to consent the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		12/1/23

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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 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

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F 880	Continued From page 15 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 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 17 sampled residents. Residents #26 and #33 Findings include: Record review of facility's policy, "Hand Hygiene," with a revision date of 8/21, revealed, PURPOSE To cleanse hands to prevent transmission of infection or other conditions. To provide clean health environment for residents, staff, and visitor... INDICATIONS FOR HAND WASHING ... 3. Before and after procedures 4. Before and after applying gloves ... 9. Wearing gloves does	F 880	a. Root cause analysis was conducted by the Interdisciplinary Team (IDT) on 11/2/2023 and based on findings Certified Nursing Assistant (CNA) #2 and Registered Nurse (RN) #1 failed to follow hand hygiene policy. Resident #26 and Resident #33 were assessed by facility Registered Nurse Supervisor on 11/1/2023 with no issues identified. b. All residents receiving perineal care and Percutaneous Endoscopic gastrostomy (PEG) tube care have the potential to be affected by this alleged deficient practice. c. on 10/31/2023, the Infection Preventionist Nurse in-serviced Certified	

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F 880	Continued From page 16 not replace the need to perform hand hygiene ..." Resident #26 On 10/31/23 at 2:50 PM, an observation of Certified Nursing Aide (CNA) #2 performing perineal care for Resident #26 revealed she did not perform hand hygiene prior to applying gloves. After she applied gloves and before beginning care, the resident's call light fell on the floor and the CNA picked it up with her gloved hands and placed it on resident's bed. CNA #2 did not remove the soiled gloves, but instead, began cleaning the perineal area. During the procedure, CNA #2 removed her soiled gloves five (5) times, however, did not perform hand hygiene prior to applying clean gloves and continuing with care. On 10/31/23 at 4:33 PM, in an interview with CNA #2, she confirmed she should have performed hand hygiene before beginning care and should have removed her gloves, performed hand hygiene and applied clean gloves after picking up the call light. CNA #2 also confirmed she did not perform hand hygiene when she changed gloves during the procedure. She stated Resident #26 could get a urinary tract infection from her not washing her hands. CNA #2 revealed that she had attended recently attended an in-service on the importance of performing hand hygiene. On 11/1/23 at 4:13 PM, in an interview the Director of Nursing (DON) confirmed CNA #2 should have performed hand hygiene prior to beginning care and each time she removed her soiled gloves. The DON also confirmed CNA #2 should have removed her gloves and performed hand hygiene after picking up the call light from	F 880	Nursing Assistant (CNA) #2 and 11/01/23 the Registered Nurse (RN)#1 on the Hand Hygiene Policy. On 11/1/2023 Infection Preventionist Nurse began in-servicing current Certified Nursing Assistants, Registered Nurses and Licensed practical Nurses on Hand Hygiene Policy. New hires and/or returns from Family Medical Leave (FMLA) will be in-serviced upon hire and or return to work on Hand Hygiene Policy. d. On 11/3/2023, Infection Preventionist Nurse observed 3 CNA's perform Perineal care with no concern identified. Beginning on 11/6/2023 the Director of nursing, Registered Nurse Supervisor, and or Infection Preventionist Nurse will observe a total of 6 Certified Nursing Assistants (CNA) perform perineal care 5 times a week for 4 weeks and then 3 times per week for 4 weeks and 2 times a week for 4 weeks. Beginning on 11/6/2023 the Director of Nurses and/or Infection Preventionist Nurse will observe one Registered Nurse and /or Licensed practical Nurse perform Percutaneous Endoscopic Gastrostomy (PEG) tube care 5 times a week for 4 weeks and then 3 times a week for 4 weeks and 2 times a week for 4 weeks. Areas of concern will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for Review. The QAPI Committee will convene on 11/29/2023 to discuss further recommendations as needed and then review for 3 months. The next QAPI committee meeting will convene on 12/15/2023. Additional	

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the floor. She stated the actions of CNA #2 could cause Resident #26 to develop a urinary tract infection.

On 11/2/23 at 11:05 AM, in an interview with Licensed Practical Nurse (LPN) #2/ IP (Infection Preventionist) confirmed CNA #2 should have performed hand hygiene before beginning care and each time she removed her gloves. She also stated CNA #2 should have removed her gloves and performed hand hygiene after she picked up the call light from the floor. The IP commented that the actions of CNA #2 could cause Resident #26 to develop an infection.

Record review of the sign-in sheets for an in-service on handwashing, dated 8/29/23, revealed CNA #2's signature.

Record review of the "Face Sheet" for Resident #26 revealed the facility admitted the resident to the facility on 10/4/22, with diagnoses that included Alzheimer's Disease, Dysphagia, and Cognitive Communication Deficit.

Record review of the Admission Minimum Data Set (MDS), with Assessment Reference Date (ARD) 9/29/23, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 0 which indicated the resident was unable to complete the BIMS.

Resident #33

On 10/31/23 at 3:55 PM, during an observation of Percutaneous Endoscopic Gastrostomy (PEG) tube care for Resident #33 with Registered Nurse (RN) #1 revealed RN #1 did not perform hand hygiene after removing the PEG site dressing and

training and/or disciplinary action will be considered as warranted.

By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the rights to consent the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.

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before applying new gloves to clean the PEG site, or prior to applying the clean dressing. RN #1 removed her gloves and exited the room without performing hand hygiene. She then returned to room after touching the doorknob and removing a pen from her pocket to date the dressing and again failed to perform hand hygiene prior to touching the dressing to add the date.

On 10/31/23 at 4:20 PM, in an interview RN #1 confirmed that while she performed care, she should have performed hand hygiene each time she removed her soiled gloves and applied clean gloves. She stated there is a possibility Resident # 33 could get an infection from her care. She stated the resident's immune system is compromised due to health and age. RN #1 explained she knew she should have performed hand hygiene but forgot. She stated she has had attended in-services on PEG tube care and infection control.

On 11/1/23 at 4:16 PM, in an interview the Director of Nurses (DON) she stated RN #1 should have performed hand hygiene each time she removed her gloves. She stated she also should have performed hygiene when she returned to the room to continue care and should not have used a pen in her pocket to date the dressing. The DON confirmed that the actions of RN #1 could cause the Resident #33 to develop an infection.

On 11/2/23 at 11:11 AM, in an interview with LPN #2/IP confirmed RN #1 should have performed hand hygiene before leaving the room to get tape and when she returned to the room. She also confirmed that each time the nurse removed her soiled gloves, she should have performed hand

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hygiene. The IP stated the actions of RN #1 could cause Resident #33 to develop an infection.

Record review of the "Face Sheet" for Resident #33 revealed the facility admitted the resident to the facility on 3/22/19, with diagnoses that included Chronic Diastolic Heart Failure, Cognitive Communication Deficit, and Dysphagia.

Record review the MDS, with an ARD of 8/7/23 for Resident #33, revealed a BIMS score of 99, indicating the resident could not participate in the interview.

A record review of the physician orders revealed there was an order, dated 8/16/22, for Resident #33's PEG site to be cleaned and dressed every shift, due to increased drainage.

Record review of facility in-service sign-in sheets revealed RN #1 attended an in-service on PEG/wound care on 11/24/22.