STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A123	A. BUILDING _____ B. WING _____	01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINALD P WHITE NURSING FACILITY	1451 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 1/8/24 through 1/11/24. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F550, F812, and F880. The census at the time of the survey was 59 and the facility was licensed for 65 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		2/20/24

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

Electronically Signed | 01/25/2024

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident had a dignified dining experience for (1) one of seven (7) resident dining observations. (Resident #160) Findings include: Review of the facility's policy, "Rights and Responsibilities of Residents," revised October 2023, revealed, " ...It is the policy of (Proper Name) to protect and support the fundamental human, civil, and constitutional rights of each resident ...Procedure ... (10) Treated with respect and full recognition of their dignity and individuality ..." During an interview and observation on 1/8/24 at 12:05 PM, Resident #160 was in her room and had not received her meal tray. She stated that her roommate had received her meal tray and had already finished eating lunch. Resident #160	F 550	Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 1/8/24, Certified Nurses Assistant Coordinator set up and served Resident #160 her meal tray. Resident #160 reported happy feeling about receiving her meal. She complimented the taste of the food. On 1/8/24, resident # 160 was assessed by the Director of Nursing (RN). Resident was satisfied after receiving her meal. On 1/8/24, the Director of Nursing (RN) conferenced Certified Nursing Assistant # 1 on deficient practice of not serving residents who reside in the same room their meal tray at the same time.	

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F 550	Continued From page 2 said that for the last week, her tray has been served about an hour later than her roommate, and she was unsure as to why this has occurred. She expressed that she did not believe it was right that she had to watch her roommate eat and had to wait for her food to be served. In an interview with Certified Nurse Aide (CNA) #2, on 1/8/24 at 12:10 PM, she revealed that a CNA had recognized that Resident #160's meal tray was not on the meal cart and was currently at the Dietary Department to get her meal tray. She confirmed that Resident #160's meal tray should have been on the meal cart that was delivered to the hall at 11:15 AM and the roommate should not have been served until both meal trays were available. CNA #2 also confirmed that it was possible that Resident #160 would be bothered by not having food to eat while watching her roommate enjoy her meal. During an observation and interview on 1/8/24 at 12:15 PM, CNA #1 delivered and set up the lunch meal tray for Resident #160. She confirmed that she had delivered the roommate's meal tray earlier and that Resident #160 did not get a tray when the roommate's tray was delivered. CNA #1 explained that she did not check the cart for Resident #160's meal tray after serving the roommate because she passed the trays in the order they were set up on the cart. CNA #1 did not respond when asked how this practice affected Resident #160. An interview with the Director of Nursing (DON) on 1/08/24 at 12:50 PM, she revealed Resident #160 should not have had to wait an hour for her meal tray, confirming the staff that delivered the roommates tray should have delivered Resident	F 550	Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the deficient practice of failure to ensure residents have their meals served at the same time as their roommate. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; and, On 1/12/24, The Director of Nursing (RN) and Nursing Supervisors (RN) began training all Licensed Nurses and Certified Nurses Assistants on serving all resident their meals at the same time. On 1/22/24, the Director of Nursing (RN) trained all nurses on their responsibility of ensuring that all residents trays are accounted for on the tram before the Certified Nurses Assistants begin serving the trays as well as immediately notifying and obtaining residents meal trays that were not placed on the tram from Dietary Manager (DM) and/or Dietary worker. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action	

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F 550	Continued From page 3 #160's tray next and if it was not on the cart the staff should have gone to dietary and requested it then. The DON also confirmed that Resident #160 could have been bothered by having to watch her roommate eat. An interview with Dietary Manager #1 and Dietary Account Manager #2 on 1/09/24 at 2:33 PM, they both revealed they were not aware that Resident #160 had been receiving her meal trays late and confirmed Resident #160 should not have had to wait for an hour for her meal tray to be served, stating "if staff would have come to dietary sooner the dietary staff would have fixed the resident a tray." Record review of the "Face Sheet" revealed the facility admitted Resident #160 to the facility on 10/27/23 with diagnoses of Chronic Obstructive Pulmonary Disease and Anxiety. Record review of the Admission Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 11/2/23, revealed that Resident #160 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated that she was cognitively intact.	F 550	evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. On 1/17/24 a Quality Assurance meeting was held to discuss the deficient practice of Certified Nurses Assistants not serving resident meals at the same time. Beginning on 1/23/24, Nursing Supervisors (RNs) implemented monitoring 10% of residents during meals to ensure that Certified Nurses Assistants and Licensed nurses are serving the resident their meals at the same time during breakfast lunch and dinner. The monitoring will be done twice a week for four weeks for 100% compliance. Thereafter, observations will be twice a month for three months for 100% compliance This observation will continue until 100% compliance is met for three consecutive months. These monitoring observations completed by the Nursing Supervisor (RN) will be forwarded to the Quality Assurance Nurse for review. The Quality Assurance Nurse will discuss all findings in the monthly Quality Assurance Meeting beginning 2/13/24. The Quality Assurance committee will continue reviewing the monitoring observations in the Monthly Quality Assurance Meeting for three months or until 100% compliance is met for three	

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F 550	Continued From page 4	F 550	consecutive months.	
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 interview, record review, and facility policy review, the facility failed to record daily temperatures for refrigerators and a freezer for the last six (6) days prior to survey entrance on 01/08/24 and failed to date and label stored food in the facility refrigerator for one (1) of two (2) kitchen observations. The deficient practice had the potential to affect 50 of 59 residents in the facility. Findings include: A review of the facility's policy, "Food and	F 812	Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 1/8/24, Dietary Manager (DM) assessed the items in the front room refrigerator of the kitchen. She reported that none of the food/beverages were spoiled. On 1/12/24, all food/beverages were moved from refrigerator in the front room	2/20/24

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F 812	Continued From page 5 Nutrition Services", dated January 2023, revealed, " ...The purpose of this policy is to provide guidelines for the creation and maintenance of an environment that is physically and bacteriologically safe for the storage, preparation, serving, and disposal of food ...Procedure ... (1) Food is stored in the original packaging and is properly labeled ...B. Food Handling and Storage (1) Food will be held at the appropriate temperature to maintain quality and prevent the growth of harmful bacteria. (a) Immediately upon receipt, cold foods will be placed in the refrigerator or on ice to maintain 41 degrees Fahrenhiet or colder during holding ... (2) Refrigerator and freezer thermometers will be monitored once daily and documented on the Refrigerator Temperature Record Form ...and the Freezer Temperature Record Form ...(7) Opened containers will be labeled with the date the item was opened and the date of expiration ..." An observation and interview, on 01/08/24 at 11:15 AM, revealed a refrigerator in the front room of the kitchen was registering at 54 degrees on the thermometer located outside of the refrigerator, which was more than 40 degrees. The rubber gasket around the refrigerator door did not properly seal the refrigerator door when closed. Dietary Aide (DA) #3 confirmed that the gasket has not sealed in a long time and maintenance was aware. Record review of the "Freezer Temperature Log" for Jan (January) 2024 revealed there were no temperatures recorded on the 5th, 6th, or 7th. Record review of the "Refrigerator Temperature Log" for Jan 2024, for the refrigerator located on the "Front" revealed there were no temperatures	F 812	of the kitchen to the refrigerator in the back of the kitchen by the Dietary manager (DM). On 1/8/24 Dietary Manager (DM) assessed the food in the freezer. She reported that the food was frozen. The thermostat indicated that the freezer temperature was zero. On 1/12/24 Dietary Manager (DM) placed an out of order sign on the front room refrigerator. On 1/8/24, Dietary Manager (DM) assessed the food/beverages in the refrigerator located in the back room. She reported that the thermostat read 32 degrees. On 1/8/24, Dietary Manager (DM) placed a temperature log on the refrigerator located in the back room. On 1/9/24, the Dietary Manager (DM)conferenced Dietary worker # 3 on deficient practice of not maintaining a refrigerator and freezer temperature sheet. On 1/8/24, Dietary Manager discarded the bacon and toast that was wrapped in aluminum foil. On 1/8/24, Dietary Manager discarded the Gatorade drink and straw located on the top shelf of the refrigerator. On 1/8/24, Dietary Manager discarded the	

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F 812	Continued From page 6 recorded for the 3rd, 4th, 5th, 6th, or 7th. Record review of the "Refrigerator Temperature Log" for Jan 2024, for the refrigerator located on the "Back" revealed there were no temperatures recorded for the 5th, 6th, or 7th. On 1/8/24 at 11:18 AM, in an interview with DA #3, she confirmed that freezer and refrigerator temperature should be logged daily and if the food was not stored at a certain temperature, it could make the residents sick. An observation on 1/08/24 at 11:18 AM, revealed the food warmer in the front room in the kitchen contained bacon and toast that was wrapped in aluminum foil. There was no identifying label or date on the container. Upon observation of the back there was a an eight (8) ounce Gatorade drink with a straw inside it on the top shelf of the refrigerator, with no label indicating the date it was opened. There was a serving tray with individual prepared bowls of soup that did not have an identifying label and was not dated. An interview, on 01/08/24 at 2:00 PM, with the Dietary Account Manager confirmed that the refrigerator and freezer temperatures logs had omissions and should be documented daily to ensure food items remain at the correct temperature and does not make anyone sick. An interview on 01/09/24 at 09:30 AM, with the Maintenance Director confirmed that he was aware of the gasket not sealing on the refrigerator in the kitchen and that one had been ordered but not received at this time. The Maintenance	F 812	prepared bowls of soup that did not have an identifying label or dated. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the deficient practice of failing to record daily temps on the refrigerator and freezer. All residents have the potential to be affected by the deficient practice of failing to label and date open food. All residents have the potential to be affected by the deficient practice of failing to notify the Administrative Assistant to do a work order on broken items in the kitchen. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; and, On 1/9/24, Temp logs with instructions were placed on the outside of the freezer and refrigerator. by Dietary Manager. On 1/9/24, The Dietary Manager (DM) began training all Dietary staff on completing the daily temperature sheet for the refrigerator and freezer. On 1/9/24, the Dietary manager began training all dietary staff on labeling/dating/timing all open	

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F 812	Continued From page 7 Director confirmed that without the proper gasket in the refrigerator the temperature would not be 40 degrees or below and that food could be ruined. An interview on 01/11/23 at 08:30 AM, with Dietary Account Manager confirmed that she was aware of the issue with the gasket not working properly on the refrigerator and that it would not remain at a temperature of 40 degrees or below. The Dietary Account Manager confirmed that food could ruin and make someone sick if the refrigerator did not remain at the correct temperature. She stated that food must be labeled and dated and no personal food or drinks should be in the refrigerator.	F 812	food/beverage containers. On 1/22/24, the dietary manager began training all dietary staff to verbally report as well as email the administrative assistant to inform when equipment is broken in the kitchen so a work order can be produced for the maintenance department. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. On 1/17/24, a Quality Assurance meeting was held to discuss the deficient practice of Dietary Department not maintaining an accurate refrigerator/freezer temperature sheet; labeling open food/beverages with date and times; reporting broken equipment to the administrative assistant. Beginning on 1/9/24, Dietary Manager (DM) implemented monitoring of the refrigerator/freezer temperature sheet to ensure that Dietary workers are completing the temperature log daily. Beginning on 1/9/24, Dietary Manager (DM) implemented monitoring of the open food/beverage items to ensure that they	

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F 812	Continued From page 8	F 812	are labeled and dated. Beginning 1/22/24, Dietary manager (DM) implemented monitoring of the maintenance log of broken equipment in the kitchen to ensure that a work order was called into the administrative assistant. The monitoring will be done weekly times four weeks for 100% compliance. Thereafter, observations will be monthly times three months for 100% compliance This observation will continue until 100% compliance is met for three consecutive months. These monitoring observations completed by the Dietary Manager (DM) will be forwarded to the Quality Assurance Nurse for review. The Quality Assurance Nurse will discuss all findings in the monthly Quality Assurance Meeting beginning 2/13/24. The Quality Assurance committee will continue reviewing the monitoring observations in the Monthly Quality Assurance Meeting for three months or until 100% compliance is met for three consecutive months.	
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	F 880		2/20/24

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F 880	Continued From page 9	F 880		

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 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

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F 880	Continued From page 10 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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to prevent the possibility of the spread of infection as evidenced by staff failing to correctly wear a face mask on one (1) of four (4) days of survey and failed to perform hand hygiene during wound care for one (1) of five (5) wounds observed. (Resident # 57) Findings include: A review of the facility's policy "Pandemic Influenza/Coronavirus Disease 2019- Infection Control Practices," revised September 2023, revealed " ...It is the policy of (Proper Name) to	F 880	Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 1/8/24 Director of Nursing (RN) conducted a 1:1 in-service with Certified Nurses Assistant #1 on the proper infection control practces relating to correctly wearing a mask. On 1/8/24, Resident #57 was assessed by the Director of Nursing (RN). No harm was noted.	

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F 880	Continued From page 11 control and prevent pandemic influenza/coronavirus disease 2019 (COVID-19) in Individuals Receiving Services (IRS)/residents, employees, and visitors by providing guidelines for infection control practices. ...Procedure: A.) "The primary strategies for preventing COVID-19 are: (2) Use of infection control measures to prevent transmission ..." An interview with the Director of Nursing (DON) upon entrance to the facility on 1/08/24 at 11:05 AM, she revealed the facility was in an active COVID-19 outbreak with one positive resident on the Dogwood Hall rooms 101-131 and all staff were using extra precautions and wearing masks. During an observation and interview on 1/08/24 at 12:15 PM, Certified Nurse Aide (CNA) #1 exited a resident's room on the Dogwood Hall and was wearing a face mask that did not cover her nose. CNA #1 revealed that there was one resident with COVID-19 on the hall and confirmed the staff working on that hall were required to wear face masks. She also confirmed her mask was not covering her nose because it made it hard for her to breathe. She stated that she was aware that the proper way to wear a face mask was to cover the mouth and the nose to prevent the spread of infection. An observation on 1/8/24 at 12:30 PM, revealed CNA #1 exited a resident's room, walking down the Dogwood Hall, and the top of the face mask was resting on her upper lip, only covering her mouth, leaving her nose exposed. During an observation and interview on 1/08/24 at 12:38 PM, CNA #1 exited another resident's room with her face mask covering her mouth, and her	F 880	Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the deficient practice of failing to adhere to guidelines for infection control practices relating to correctly wearing masks. All residents have the potential of being affected by the deficient practice of failing to wash hands after cleaning a wound. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; and, On 1/12/24, all Licensed Nurses and Certified Nurses Assistants were in-serviced by the Director of Nursing (RN) and Nursing Supervisors (RN) on infection control practices relating to correctly wearing a mask. On 1/12/24, the Director of Nursing in-serviced all Nurses on immediately washing their hands after removing their gloves while performing wound care. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A123	A. BUILDING _____ B. WING _____	01/11/2024

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F 880	Continued From page 12 nose was not covered. CNA #1 confirmed she was not wearing her mask correctly and stated, "well it just keeps sliding down, I can't help it." An interview with the DON on 1/08/24 at 12:45 PM, she confirmed all staff should wear a face mask that covered the mouth and nose to reduce the possible transmission of infections. An interview with the Infection Preventionist (IP) on 1/09/24 at 2:11 PM, she confirmed the facility was in active outbreak status and staff are wearing masks. The IP revealed the purpose of adhering to infection control prevention measures such as masks is to protect residents and staff from infection and failing to wear a mask correctly could place residents and staff at risk of acquiring an infection. Resident #57 A review of the facility's policy "Standard Precautions", revised September 2023, revealed "Policy ...Employees will utilize Standard Precautions on all residents...Procedure ...C. 1. Gloves ...(c) Gloves will... (iv) Be removed and hands will be washed immediately upon glove removal..." Record review of the "Face Sheet" for Resident #57 revealed he was admitted by the facility on 7/13/23 with a diagnosis of Diffuse Traumatic Brain Injury (TBI).	F 880	assurance system. On 1/17/24 a Quality Assurance meeting was held to discuss the deficient practice of licensed nurses infection prevention practices and not having the correct supplies to provide wound care. Beginning 1/23/24, Nursing Supervisors (RNs) implemented monitoring 10% of residents during wound care to ensure that Licensed nurses are wearing masks, washing hands, providing privacy and having the correct supplies while providing wound care. The monitoring will be done weekly times four weeks for 100% compliance. Thereafter, observations will be monthly times three months for 100% compliance. This observation will continue until 100% compliance is met for three consecutive months. These monitoring observations completed by the Nursing Supervisor (RN) will be forwarded to the Quality Assurance Nurse for review. The Quality Assurance Nurse will discuss all findings in the monthly Quality Assurance Meeting beginning 2/13/24. The Quality Assurance committee will continue reviewing the monitoring observations in the Monthly Quality Assurance Meeting for three months or until 100% compliance is met for three consecutive months.	

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F 880	Continued From page 13 A Record review the "Physician Orders" for the month of January 2024 revealed Resident #57 had a physician's order, dated 12/21/23 to "Clean wound to left heel pressure ulcer with normal saline, pat dry, paint with betadine, cover with kerlix change daily..." On 1/10/24 at 11:55 AM, during an observation of wound care by Licensed Practical Nurse (LPN) #1, she cleaned the wound on Resident #57's left heel. She then removed her gloves and applied clean gloves without washing or sanitizing her hands. LPN #1 swabbed the wound with a betadine swab and covered it with a gauze dressing. Upon interview with LPN #1 on 1/10/24 at 12:00 PM, she agreed that she should have sanitized her hands before applying clean gloves and continued with wound care. She stated failure to sanitize her hands could put the resident at risk of acquiring an infection. Upon interview with the Director of Nursing (DON) on 1/10/24 at 12:10 PM, she agreed that LPN #1 should have sanitized her hands prior to applying clean gloves. She verified that failure to sanitize hands could place the resident at risk for infection.	F 880	Beginning 1/23/24, Nursing Supervisors (RNs) implemented monitoring of all employees to ensure that they are wearing masks correctly to prevent the spread of infections. The monitoring will be done twice a week for four weeks for 100% compliance. Thereafter, observations will be monthly times three months for 100% compliance. This observation will continue until 100% compliance is met for three consecutive months. These monitoring observations completed by the Nursing Supervisor (RN) will be forwarded to the Quality Assurance Nurse for review. The Quality Assurance Nurse will discuss all findings in the monthly Quality Assurance Meeting beginning 2/13/24. The Quality Assurance committee will continue reviewing the monitoring observations in the Monthly Quality Assurance Meeting for three months or until 100% compliance is met for three consecutive months.	