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	25A422	A. BUILDING _____ B. WING _____	02/28/2024

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WALTER B CROOK NURSING FACILITY	840 NORTH OAK AVENUE RULEVILLE, MS 38771

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 02/26/24 through 02/28/24. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation related to F640, F641, F686 and F880. The census at the time of the survey was 58 and the facility is licensed for 60.	F 000		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		3/22/24

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

Electronically Signed | 03/15/2024

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F 640	Continued From page 1 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to complete and submit a Discharge Minimum Data Set (MDS) assessment timely in accordance with the current federal and state submission timeframes for one (1) of 18 resident's MDS assessments reviewed. Resident #28 Findings include: Record review of the facility policy "Resident Assessments", revised November 2019, revealed, "Policy Interpretation and Implementation, 1. The resident assessment	F 640	F640 1. Minimum Data Set (M.D.S.) Coordinator completed identified Minimum Data Set (M.D.S) assessment on 02/29/2024. 2. All residents discharged from center have the potential to be affected. 3. Minimum Data Set (M.D.S.) Coordinator educated by Nursing Home Administrator (N.H.A) and Director of Nursing (D.O.N.) on 03/15/2024 on completing discharge assessments timely. Minimum Data Set (M.D.S.) Coordinator will audit past 30 days	

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F 640	Continued From page 2 coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessment and reviews according to the following requirements... (5) Discharge Assessment-Conducted when a resident is discharged from the facility." Record review of Resident # 28's "Face Sheet" revealed the facility admitted the resident on 8/17/16, with a diagnosis of Benign prostatic hyperplasia. Resident #28 was discharged on 10/31/23 due to death in the facility. During an interview with the MDS nurse on 2/28/24 at 8:40 AM, she revealed that she is responsible for scheduling all assessments. She verified that she was aware that Resident #28 died in the facility on 10/31/23 and his assessment was on her schedule. She verified that no discharge tracking MDS was completed for Resident #28 and did not know why she missed it. The MDS Nurse agreed the importance of completing the discharge tracking assessment was to report residents' status. In an interview with Administrator on 2/28/24 at 8:47 AM, she verified that it was her expectation that the discharge tracking MDS would be completed in a timely manner.	F 640	discharges to ensure needed Minimum Data Set (M.D.S) assessments are completed. Monthly auditing will occur beginning 02/29/2024 to ensure needed Minimum Data Set (M.D.S) assessments are completed. Audit completed 02/29/2024, and no new assessments were needed. 4. Minimum Data Set (M.D.S.) Coordinator will begin auditing discharges monthly starting 02/29/2024 and report findings every 30 days in the monthly Quality Assurance and Performance Improvement (Q.A.P.I.)for 6 months with Quality Assurance meetings beginning 03/22/2024.	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and	F 641	1. Minimum Data Set (M.D.S.)	3/22/24

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F 641	Continued From page 3 facility policy review the facility failed ensure the Minimum Data Set (MDS) accurately reflects the resident's status when the Discharge MDS was inaccurately coded for (1) one of 18 MDS assessments reviewed. (Resident #62) Findings include: Record review of the facility policy "Resident Assessments", revised November 2019, revealed "Policy Interpretation and Implementation, 1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments..." A review of the Departmental notes for Resident #62 dated 12/21/23 revealed the resident was discharged home at her request. Review of Resident #62's Discharge MDS with an Assessment Reference Date (ARD) date of 12/21/23 revealed Section A Item A2105 Discharge status was coded as the resident was discharged to a short term general hospital. An interview with Registered Nurse (RN) MDS Nurse on 02/28/24 at 11:14 AM, she revealed that Resident #62 was discharged home not to the hospital and confirmed the Discharge MDS was inaccurately coded and stated the purpose of the accurate coding is to identify where the resident is and for billing purposes. Review of Resident #62's Face sheet revealed the facility admitted the resident on 8/02/24 with medical diagnoses that included Cerebral Infarction and discharged the resident on 12/21/23.	F 641	Coordinator completed a modification on identified Minimum Data Set (M.D.S) assessment on 03/15/2024. 2. All residents discharged from facility have the potential to be affected. 3. Minimum Data Set (M.D.S.) Coordinator educated by Nursing Home Administrator (N.H.A) and Director of Nursing (D.O.N.) on 03/15/2024 on ensuring accuracy of discharge location on Minimum Data Set assessment. Minimum Data Set (M.D.S.) Coordinator will audit past 30 days discharges to ensure correct discharge location is marked. Audit completed on 02/29/2024, and no other modification of Minimum Data Set assessments needed. 4. Minimum Data Set (M.D.S.) Coordinator will begin auditing discharge locations marked on Minimum Data Set assessments for discharges monthly starting 02/29/2024 and report findings every 30 days for 6 months in the monthly Quality Assurance & Performance Improvement (Q.A.P.I.) and Quality Assurance meetings beginning 03/22/2024 and report the results to the committee monthly for 6 months.	

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F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review the facility failed to promote the healing of existing pressure injuries as evidenced by failure to perform hand hygiene during wound care. Resident #34 currently has a foul odor and purulent discharge to facility acquired pressure wounds of the right lower leg and right heel with a history of recent multiple pressure ulcer infections. Resident #42 has two (2) facility acquired pressure ulcers with a history of pressure ulcer infection. This is for two (2) of five (5) residents reviewed for pressure ulcers. (Resident #34 and Resident #42). Findings include: Review of the facility policy titled, "Wound Care," revised October 2010, revealed, "Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing." Steps in procedure: 2.) Wash and dry hands thoroughly.	F 686	F 686 1. One to one in-service conducted by Director of Nursing (D.O.N.) with Wound Care RN on 03/04/2024 upon her return to work regarding hand hygiene and clean dressing change. One to one in-service conducted by Registered Nurse (RN) with LPN #1 on 03/14/2024 on hand hygiene and clean dressing change. Resident #34 and resident #42 assessed by wound care MD. New orders given for wound care and care planned. 2. Six residents receiving wound care services have the potential to be affected. These six residents were evaluated by the Wound Care MD on March 1, 2024. Resident #34 and resident #42 exhibited signs and symptoms of wound infection along with 1 additional resident. New orders given for each resident. 3. Directed In-service conducted on	3/22/24

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F 686	Continued From page 5 ...4.) Put on exam gloves, loosen tape, and remove dressing. ...5.) Pull gloves over dressing and discard. Wash and dry hands thoroughly ...6.) Put on gloves. ...23.) Wash and dry hands thoroughly. ... Review of the facility policy titled, "Handwashing/Hand Hygiene," revised August 2019, revealed, "Policy Statement: The facility considers hand hygiene the primary means to prevent the spread of infections. ...Policy Interpretation and Implementation: 7.) Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following.) Before handling clean or soiled dressings, gauze pads, etc. ...h.) Before moving from a contaminated body site to a clean body site during resident care. ...i.) After contact with a resident's skin. ... j.) after contact with blood or bodily fluids. ...k.) After handling used dressings, contaminated objects. ... m.) After removing gloves. ... An observation and interview during the initial tour on 2/26/24 at 4:00 PM revealed a foul odor was coming from the room of Resident #34. An interview with the Registered Nurse (RN)-Wound Care Nurse that was in the resident's room revealed Resident #34 has pressure ulcers, some of them are having some malodorous drainage and she obtained an order to culture the wounds. Review of the physician's orders for Resident #34, revealed Right Lateral lower leg pressure ulcer stage 3: clean with NS (normal saline), apply Santyl to wound bed, cover with boarder dressing daily and prn (as needed). ...Right heel unstageable: cleanse with spray wound cleanser	F 686	02/28/2024 by an independent Registered Nurse consultant for nursing staff on infection prevention and control. Director of Nursing (D.O.N.), Staff Development Coordinator (S.D.C.), and Registered Nurse initiated hand hygiene check offs, clean dressing change check offs, peg tube care check offs, and catheter care check offs with licensed nursing staff on 02/28/2024. Competency checkoffs for licensed nursing staff will be completed by 03/18/2024. New hires will demonstrate competency via check offs prior to working with resident. 4. Quality Assurance & Performance Improvement (Q.A.P.I) and Quality Assurance meeting was held on 02/28/2024 with Medical Director, Nurse Practitioner, Director of Nursing (D.O.N.), Minimum Data Set (M.D.S.) Coordinator, Infection Preventionist (I.P.), and Nursing Home Administrator (N.H.A.). Director of Nursing (D.O.N.), Staff Development Coordinator (S.D.C.), Registered Nurse (RN) will monitor by conducting visual audits for hand hygiene and clean dressing change on 02/29/2024. The facility will monitor care delivery for appropriate infection control with wound care at the following frequency: 4 observations a week for 4 weeks 3 observations a week for 4 weeks 2 observations a week for 4 weeks 1 observation a week for 4 weeks The DON will turn in the visual audit forms to the N.H.A. weekly and report findings every 30 days in the monthly Quality Assurance & Performance Improvement for 6 months (Q.A.P.I) and Quality	

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F 686	Continued From page 6 pat dry, apply Santyl ointment to wound bed then calcium alginate to slough, wrap with kerlix, and secure with paper tape daily and prn....Unstageable wound to Dorsalis Pedis Right, cleanse with wound cleanser, pat dry with 4 x 4, apply Santyl ointment to wound bed, cover with ABD (abdominal gauze pad) then wrap with kerlix qd (every day) and prn. During an interview and record review of the treatment record for Resident #34 on 2/27/24 at 9:55 AM with the Registered Nurse (RN)- Wound Care Nurse, revealed that the wound to the right dorsalis pedis should read DTI (Deep Tissue Injury) not unstageable and she would do a clarification order. She stated that the right heel is now presenting as a stage 4 and would clarify that as well. An observation and interview during wound care for Resident #34 with the RN-Wound Care Nurse and Licensed Practical Nurse (LPN) #1 on 2/27/24 at 10:00 AM, revealed the RN-Wound Care Nurse sanitized hands applied gloves and verbalized during wound care she always cleans the peg (percutaneous endoscopic gastrostomy) site, the Foley catheter site first and then takes care of the wounds. She then cleaned around the stoma of the peg tube site and applied a clean dressing around the site with the same gloves used to clean the peg stoma site ... The RN-Wound Care Nurse then pulled down Resident #34s brief and cleaned around the Foley catheter with a wet washcloth with the same gloves used to perform peg site care with no hand hygiene before or after the catheter care. The RN-Wound Care Nurse then removed the glove off her right hand and applied a clean glove, left the dirty glove on her left hand, began to cut,	F 686	Assurance meetings beginning 03/22/2024 and report the results to the committee.	

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and date tape with no hand hygiene performed. LPN #1 performed hand hygiene, removed dressings off the resident's right heel, right dorsalis pedis area (top of right foot), and right lateral leg then discarded them in a red bag. She then grabbed moistened gauze and patted the leg wound once and discarded the gauze, then patted the right heel wound bed once and discarded the gauze, and patted the right dorsalis pedis wound bed with a gauze pad and discarded it with no hand hygiene performed between wounds. LPN #1 then applied an ointment to the wound bed of each wound with the same gloves used to remove the soiled dressings and clean the wound beds, the RN- Wound Care nurse then handed LPN #1 clean dressings and dated tape to cover the wounds with the same contaminated gloves worn during catheter care. LPN #1 applied clean dressings and dated tape, removed her gloves, and performed hand hygiene.

Record review of the Wound Assessment Details from the local hospital for the right lateral leg lower pressure ulcer assessments revealed initial onset 11/27/23. Further review of the Wound Assessment Report revealed last assessment dated 2/22/24 now a stage 3 measuring 5.50 cm (centimeters) length x (times) 1.30 cm width x 0.50 cm depth. This wound was facility acquired.

Record review of the Wound Assessment Report for the right heel pressure ulcer assessments revealed initial 9/21/23 DTI (deep tissue injury) measuring 1.60 cm length x 1.00 cm width. Further review revealed last assessment dated 2/21/24 now worsened to a stage 4, measuring 7.00 cm length x 6.00 cm width x 0.20 cm depth. This wound was facility acquired.

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Record review of an Infection Report-Basic for Resident #34 dated 12/3/23, revealed a culture of the right heel pressure ulcer with growth of Proteus mirabilis- Intervention: Ceftriaxone 1 (one) gram IV (intravenous) daily times 10 days ordered related to right heel wound infection. Infection source: It is likely infection developed in the facility.

Review of an Infection Report-Basic for Resident #34 dated 12/22/23 culture of right heel pressure ulcer related to purulent/malodorous drainage with growth of multiple organisms Bacteroides fragilis, Staphylococcus aureus, Enterococcus faecalis, Finegoldia magna, Morganelli morganii, and Proteus mirabilis. Treated with Invanz 1-gram IV daily times 10 days and Tygacil 50 mg (milligrams) IV every 12 hours times 10 days.

Record review of the Wound Assessment Report for the right dorsalis pedis revealed initial onset of 2/14/24 as a DTI measuring 4.50 cm length x 4.50 cm width x 0.25 cm depth. Further review of the Wound Assessment Report dated 2/21/24 revealed the DTI measuring 5.00 cm length x 5.00 cm width x 0.25 cm depth. This revealed an increase in size of the wound and this wound was facility acquired.

A review of a physician's order for Resident #34 dated 2/25/24 revealed an order to obtain wound culture on 2/26/24 related to foul odor and purulent discharge to wounds right lower leg and right heel.

An interview with the RN-Wound Care Nurse on 2/27/24 at 2:30 PM, confirmed she had noticed an increase in the number of wound infections that Resident #34 has had and confirmed there

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was worsening to all her wounds. She then confirmed she did not perform hand hygiene between any of the treatments for Resident #34 and stated it did not occur to her to wash her hands after cleaning the peg tube, catheter care, and wound care revealing she normally sanitizes her hands before she starts the treatments of a resident and when she finishes doing all the treatments for the resident. She revealed that not performing hand hygiene between the treatments could lead to cross contamination and could have resulted in increased risk for infections and may cause wounds to worsen or cause a systemic infection.

An interview with the Infection Control (IC) nurse on 2/27/24 at 3:00 PM, revealed she has watched the RN-Wound Care Nurse do treatments in the past and she did break infection control barriers and was educated. She revealed she had noticed the increase in the number of wound infections and had done three one on one check offs with the RN-Wound Care Nurse related to wound care but did not document the check offs. She revealed she had reported to the Administrator and the Director of Nurses (DON) on Friday 2/23/24 of her concerns with the RN-Wound Care Nurse but was unaware of the finding of what they did. She verbalized that these residents are vulnerable and more susceptible to infection and confirmed failing to perform hand hygiene during treatments and between different treatments increased the risk for infections and could have been a factor in the increase in wound infections.

An interview with the Administrator and the DON on 2/27/24 at 4:00 PM, revealed that they were aware that the RN-Wound Care Nurse was having problems with time management but was

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unaware of her having any infection control issues. The Administrator also revealed they have met with the RN-Wound Care Nurse on several occasions about her understanding of her role and time management and had reached out to HR (Human Resource) on Monday 2/26/24 about beginning a 30-day performance program of action to see improvement. The DON confirmed that failing to perform hand hygiene between treatments and during wound care places the residents at risk for increased infection and worsening wounds.

An interview with LPN #1 on 2/28/24 at 8:49 AM, confirmed she did not perform hand hygiene while doing wound care to Resident #34's wounds. She revealed that she was unaware that she should have performed one treatment at a time and performed hand hygiene in between cleaning the wounds and applying the clean wound supplies but confirmed that she can see where that would be cross contamination and lead to increased risk for infection.

A phone interview with the Medical Director on 2/28/24 at 9:34 AM, confirmed that poor infection control practices could lead to wound infections and worsening of wounds.

Record review of Resident #34's "Face Sheet" revealed that the resident was admitted to the facility on 10/19/18 with medical diagnoses that included Atherosclerotic heart disease of native coronary artery.

Record review of Resident #34's Minimum Data Set (MDS) Section M with an Assessment Reference Date (ARD) of 12/04/23 revealed M0210 was coded as yes resident has one or

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more unhealed pressure ulcers/injuries.

Resident #42

Record review of Resident #42's "Wound Assessment Report" revealed the resident currently has three pressure wounds revealing the following:

-Wound to the Sacrum -Stage 3-Identified on 11/18/19 after readmission from the hospital with measurements of 9.00 centimeters (cm) (length) x 11.00 cm (width) x 0.20 cm (depth) and a current measurement on 2/22/24 of 7.50 cm x 7.90 cm x 0.40 cm with a wound status of "Improved."
-Wound to the Right Buttock; lower-Stage 2-Identified on 2/9/23-facility acquired-with measurements of 1.50 cm x 2.00 cm x 0.10 cm and a current measurement on 2/22/24 of 1.90 cm x 1.30 cm x 0.30 cm Stage 3 with a wound status of "Improved."
-Wound to the Right Lateral Shin; right medial leg lower-Stage 3-Identified on 1/30/24-facility acquired-with measurements of 2.20 cm x 1.20 cm x 0.20 m and a current measurement on 2/22/24 of 1.70 cm x 0.60 cm x 0.01 cm with a wound status of "Improved."

An observation on 2/27/24 at 1:26 PM revealed RN-Wound Care Nurse, LPN #2 and Certified Nurse Assistant (CNA) #1 with Resident #42 for wound care. RN-Wound Care Nurse washed her hands, applied gloves, and cleaned the supra pubic catheter. She removed those gloves, did not perform hand hygiene, applied new gloves, pulled the residents draw sheet that revealed bowel movement on the bed pad draw sheet and

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F 686	Continued From page 12	F 686		

up the residents back above the brief and on the legs below the brief. She removed the residents brief which revealed the resident's buttocks were covered in bowel movement, removed the coccyx wound dressing and the lower buttock wound dressing which revealed there was bowel movement under the dressings and in the wounds. She cleaned the bowel movement up with a washcloth and warm water, no soap, removed gloves, did not perform hand hygiene, applied new gloves, and cleaned the coccyx wound with normal saline. She then removed her gloves, did not perform hand hygiene, applied new gloves, applied silver cell to the coccyx wound, covered it with a 4x4 pad, and covered that with an ABD pad. She then rolled the dirty brief under the wound and held the pad in place while LPN #2 took her gloves off, washed her hands and handed RN-Wound Care Nurse the tape for the dressing. She then taped down the dressing, removed the dirty brief and put it in a biohazard bag, applied two more pieces of tape to the coccyx wound dressing, removed gloves, picked up new gloves then laid them back inside the box with multiple clean gloves. She washed her hands then applied those same gloves that she had picked up and laid down. She cleaned the lower left buttock wound removed gloves, did not perform hand hygiene, put on new gloves, and helped apply a new brief.

An interview on 2/27/24 at 2:50 PM with LPN #2 confirmed that RN-Wound Care Nurse did not wash her hands when she changed her gloves and should have. She confirmed that was a break in infection control and could lead to the spread of infections.

An interview with RN-Wound Care Nurse on

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F 686	Continued From page 13 2/27/24 at 3:40 PM confirmed that she broke infection control when she was doing wound care on Resident #42 by not washing her hands after changing gloves from a dirty procedure, which could cause a spread of infection or cross contamination leading to a wound infection. Record review of Resident #42's "Final Report" for the residents wound culture from the Coccyx wound with a final result date of 11/17/23. This culture revealed a result of Acinetobacter baumannli, Bacteroides fragilis, Escherichia coli, Morganella morganii, Proteus mirabilli, Pseudomonas aeruginosa, Clostridium perfringens, Enterococcus faecalis with an order to start Levaquin 500 milligram (mg) 1 tab via PEG tube daily for 14 days (Start 11/27-Stop 12/10) Record review of Resident #42's "Infection Report-Basic" dated 11/27/23 revealed the resident had a wound infection that indicated "Infection Source: It is likely infection developed in the facility". Record review of Resident #42's "Face Sheet" revealed the resident was admitted to the facility on 9/20/19 with medical diagnoses that included Unspecified Sequelae of Cerebral Infarction. Record review of Resident #42's MDS with an ARD of 1/22/24 revealed in Section C a Brief Interview for Mental Status (BIMS) with no score, which indicates the resident is severely cognitively impaired and in Section M that the resident had one or more unhealed pressure ulcers at Stage 1 or higher.	F 686		
F 880 SS=G	Infection Prevention & Control	F 880		3/22/24

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F 880	Continued From page 14 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 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	F 880		

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F 880	Continued From page 15 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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review the facility failed to perform hand hygiene during wound care, Foley and suprapubic catheter care, and Percutaneous Endoscopic Gastrostomy (PEG) tube care (Resident's #34 and #42) Resident #34 currently has a foul odor and purulent discharge from facility acquired pressure wounds of the right lower leg and right heel with a history of recent multiple pressure ulcer infections. Resident #42	F 880	1. One to one in-service conducted by Director of Nursing (D.O.N.) with Wound Care RN on 03/04/2024 upon her return to work regarding hand hygiene and clean dressing change. One to one in-service conducted by Registered Nurse (RN) with LPN #1 on 03/14/2024 on hand hygiene and clean dressing change. Resident #34 and resident #42 assessed by wound care MD. New orders given for wound	

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F 880	Continued From page 16 has two (2) facility acquired pressure ulcers with a history of pressure ulcer infection. This is for two (2) of 10 residents observed during direct patient care. Resident's #34 and 42 Cross reference F686 Findings include: Review of the facility policy titled, "Standard Precautions," effective 01/01/2020, revealed, "Policy: Standard Precautions are designed for care of all patients in facilities, regardless of diagnosis or presumed infection status, to reduce the risk of transmission from both recognized and unrecognized sources of infection." ...Standard Precautions include Gloves: To be worn when touching blood, body fluids, secretions, mucous membranes, non-intact skin, and other contaminated items ...Gloves do not take the place of hand hygiene ...Hands are to be washed after removing gloves ...Gloves should be changed between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms. ... Review of the facility policy titled, "Handwashing/Hand Hygiene," revised August 2019, revealed, "Policy Statement: The facility considers hand hygiene the primary means to prevent the spread of infections...Policy Interpretation and Implementation: 7.) Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following. Before handling clean or soiled dressings, gauze pads, etc. ...h.) Before moving from a contaminated body site to a clean body site	F 880	infection and careplanned. 2. All residents have the potential to be affected. Residents with wounds assessed by wound care MD on 03/01/2024. Residents with PEG Tubes and catheters were assessed by Nurse Practitioner or MD on 03/15/2024. No new signs or symptoms of infections noted. 3. Directed In-service conducted on 02/28/2024 by an independent Registered Nurse consultant for nursing staff on infection prevention and control. Director of Nursing (D.O.N.), Staff Development Coordinator (S.D.C.), and Registered Nurse initiated hand hygiene check offs, clean dressing change check offs, peg tube care check offs, and catheter care check offs with licensed nursing staff on 02/28/2024. Competency checkoffs for licensed nursing staff will be completed by 03/18/2024. New hires will demonstrate competency via check offs prior to working with resident. 4. Quality Assurance & Performance Improvement (Q.A.P.I) and Quality Assurance meeting was held on 02/28/2024 with Medical Director, Nurse Practitioner, Director of Nursing (D.O.N.), Minimum Data Set (M.D.S.) Coordinator, Infection Preventionist (I.P.), and Nursing Home Administrator (N.H.A.). Director of Nursing (D.O.N.), Staff Development Coordinator (S.D.C.), Registered Nurse will monitor by conducting visual audits for hand hygiene, clean dressing change, peg tube care, and catheter care starting 02/28/2024. The facility will monitor care delivery for appropriate infection control	

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F 880	Continued From page 17 during resident care. ...i.) After contact with a resident's skin. ... j.) after contact with blood or bodily fluids. ...k.) After handling used dressings, contaminated objects. ... m.) After removing gloves..." Review of the facility policy titled, "Catheter Care," revised September 2014, revealed, "Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections...Infection Control: 1.) Use standard precautions when handling or manipulating the drainage system..." Review of the facility policy titled, "Gastrostomy/Jejunostomy Site Care," revised October 2011, revealed, "Purpose: The purpose of this procedure is to promote cleanliness and to protect the gastrostomy or jejunostomy site from irritation, breakdown and infection....Steps in the procedure: 2.) Wash hands and dry thoroughly. ...2.) Wear clean gloves. ...14. Remove gloves and discard. ... 15.) Wash your hands..." Review of the facility policy titled, "Wound Care," revised October 2010, revealed, "Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing...Steps in procedure: 2.) Wash and dry hands thoroughly ...4.) Put on exam gloves, loosen tape, and remove dressing ...5.) Pull gloves over dressing and discard. Wash and dry hands thoroughly ...6.) Put on gloves. ...23.) Wash and dry hands thoroughly..." Observation of wound care for Resident #34's wound care with the (Registered Nurse) RN-Wound Care Nurse and Licensed Practical	F 880	with catheter care, PEG tube care, and wound care at the following frequency: 5 observations a week for 4 weeks 3 observations a week for 4 weeks 2 observations a week for 4 weeks 1 observation a week for 4 weeks The DON will turn in the visual audit forms to the N.H.A. weekly and report findings every 30 days in the monthly Quality Assurance & Performance Improvement for 6 months (Q.A.P.I.) and Quality Assurance meetings beginning 03/22/2024 and report the results to the committee.	

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Nurse (LPN) #1 on 2/27/24 at 10:00 AM revealed, the RN-Wound Care Nurse sanitized hands applied gloves and verbalized during wound care she always cleans the PEG tube site, and the Foley catheter site first and then takes care of the wounds. She then cleaned around the stoma of the PEG tube site and applied a clean dressing around the stoma site with the same gloves used to clean the PEG stoma site. The RN-Wound Care Nurse then pulled down Resident #34's brief and performed catheter with the same contaminated gloves used to perform PEG site care. There was no observation of hand hygiene before or after the Foley catheter care. The RN-Wound Care Nurse then removed the glove off of her right hand and applied a clean glove, began to cut, and date tape, with no observation of hand hygiene and no observation of removing the soiled glove from the left hand. LPN #1 performed hand hygiene, removed dressings off of the residents right heel, right dorsalis pedis area (top of right foot), and right lateral leg and discarded them in a red bag. She then grabbed moistened gauze and patted the leg wound once and discarded the gauze, then patted the right heel wound bed once and discarded the gauze ,and patted the right dorsalis pedis wound bed with a gauze pad and discarded it with no observation of hand hygiene between cleaning each wound. LPN #1 then applied an ointment to the wound bed of each wound with the same gloves used to remove the soiled dressings and clean the wound beds. The RN-Wound Care Nurse then handed LPN #1 clean dressings and dated tape to cover the wounds with the same contaminated gloves worn during PEG site and catheter care. LPN #1 applied clean dressings and dated tape, removed her gloves she applied at the beginning of wound care, and performed

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hand hygiene.

Record review of an Infection Report - Basic for Resident #34 dated 12/3/23, revealed an order for a culture of right heel pressure ulcer for foul and purulent drainage with growth of Proteus mirabilis- Ceftriaxone 1(one) gram IV (intravenous) daily times 10 days ordered related to right heel wound infection.

Record review of an Infection Report - Basic for Resident #34 dated 12/22/23 culture of right heel pressure ulcer related to purulent/malodorous drainage with growth of Bacteroides fragilis, Staphylococcus aureus, Enterococcus faecalis, Finegoldia magna, Morganelli morganii, and Proteus mirabilis. Treated with Invanz 1-gram IV daily times 10 days and Tygacil 50 mg (milligrams) IV every 12 hours times 10 days.

A record review of a physician's order for Resident #34 dated 2/25/24 revealed an order to obtain wound culture on 2/26/24 related to foul odor and purulent discharge to wounds.

Record review of the facility infection log for dates 9/27/23-2/27/24, revealed there were 11 wound infections.

During an interview with the RN-Wound Care Nurse on 2/27/24 at 2:30 PM confirmed she had noticed an increase in the number of wound infections that Resident #34 has had and confirmed there was worsening to all her wounds. She then confirmed she did not perform hand hygiene between any of the treatments for Resident #34 and stated it did not occur to her to wash her hands after cleaning the PEG tube, catheter care, and wound care revealing she

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normally sanitizes her hands before she starts the treatments of a resident and when she finishes doing all the treatments for the resident. She then confirmed that not performing hand hygiene between the treatments could lead to cross contamination and could have resulted in increased risk for infections and may cause wounds to worsen or cause a systemic infection.

During an interview with the Infection Control (IC) nurse on 2/27/24 at 3:00 PM, revealed she has watched the RN treatment nurse do treatments in the past and she did break infection control barriers and was educated. She revealed she had noticed the increase in the number of wound infections and had done three one on one check offs with the treatment nurse related to wound care but did not have documentation and revealed she had reported to the Administrator and DON on Friday of her concerns with the treatment nurse but was unaware of the finding of what they did. She verbalized that these residents are vulnerable and more susceptible to infection and confirmed failing to perform hand hygiene during treatments and between different treatments increased the risk for infections and could have been a factor in the increase in wound infections.

On 2/27/24 at 4:00 PM an interview with the Administrator and Director of Nurse (DON) revealed that they were aware that the treatment nurse was having problems with time management but was unaware of her having any infection control issues. The Administrator also revealed they have met with the RN treatment nurse on several occasions about her understanding of her role and time management and had reached out to HR (Human Resource)

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on Monday 2/26/24 about beginning a 30-day performance program of action to see improvement. The DON confirmed that failing to perform hand hygiene between treatments and during wound care places the residents at risk for increased infection.

During an interview with LPN #1 on 2/28/24 at 8:49 AM, revealed that she was unaware that she should have performed one treatment at a time and performed hand hygiene in between cleaning the wounds and applying the clean wound supplies but confirmed she can see where that would be cross contamination and lead to increased risk for infection. She confirmed she did not perform hand hygiene while doing wound care to Resident #34's wounds.

During a phone interview with the Medical Director on 2/28/24 at 9:34 AM confirmed that poor infection control practices could lead to wound infections.

Record review of the Face Sheet revealed that the facility admitted Resident #34 to the facility on 10/19/18 with a diagnosis of Atherosclerotic heart disease of native coronary artery.

Resident #42

During an observation on 2/27/24 at 1:26 PM revealed Registered Nurse (RN)-Wound Care Nurse, LPN) #2 and Certified Nurse Assistant (CNA) #1 with Resident #42 for wound care. The RN-Wound Care Nurse removed the Percutaneous Endoscopic Gastrostomy (PEG) tube dressing that revealed a yellow drainage around the site. She then cleaned the area, removed her gloves, and did not perform hand

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hygiene. She applied a new PEG dressing and did not perform hand hygiene before or after applying the new dressing. She then applied new gloves and cleaned the supra pubic catheter. RN-Wound Care Nurse then pulled the residents draw sheet back that revealed bowel movement (BM) on the bed pad, draw sheet, and up the residents back and legs. She removed the residents brief which revealed the resident's buttocks were covered in BM. The RN -Wound Care Nurse removed the coccyx wound dressing and the lower buttock wound dressing which revealed there was BM under the dressings and in the wounds. She cleaned the BM with a washcloth and warm water. She did not use any soap to clean the BM. She removed her gloves but did not perform hand hygiene. After applying new gloves, she cleaned the coccyx wound and changed her gloves did not perform hand hygiene and proceeded to apply the dressing to the coccyx wound. She then rolled the BM soiled brief under the wound and held the pad in place while LPN #2 handed RN-Wound Care Nurse the tape for the dressing. She then taped down the dressing, removed the soiled brief and put it in a biohazard bag, and applied two more pieces of tape to the coccyx wound dressing all while wearing the same gloves. She removed her gloves and did not perform hand hygiene. She then picked up new gloves then laid them back inside the box with multiple clean gloves. She washed her hands then applied those same gloves that she had previously picked up and laid down prior to washing her hands. She cleaned the lower left buttock wound and removed her gloves but did not perform hand hygiene and helped apply a new brief. She then applied new gloves and cleaned the right shin pressure wound. She removed her gloves, washed her

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hands, picked up a 4x4 off the top of the protected barrier table with wound treatment supplies and dried her hands with it.

During an interview on 2/27/24 at 2:50 PM with LPN #2 confirmed that RN-Wound Care Nurse did not wash her hands when she changed her gloves and should have. She confirmed that was a break in infection control and could have led to the spread of infections.

During an interview with RN-Wound Care Nurse on 2/27/24 at 3:40 PM confirmed that she did not follow infection control when she was providing wound care for Resident #42 because she did not wash her hands after changing gloves from a dirty procedure, which could cause a spread of infection or cross contamination leading to a wound infection.

Record review of Resident #42's "Final Report" for the residents wound culture from the Coccyx wound with a final result date of 11/17/23. This culture revealed a result of Acinetobacter baumannli, Bacteroides fragilis, Escherichia coli, Morganella morganii, Proteus mirabilli, Pseudomonas aeruginosa, Clostridium perfringens, Enterococcus faecalis with an order to start Levaquin 500 mg 1 tab via PEG tube daily for 14 days (Start 11/27-Stop 12/10)

Record review of Resident #42's "Infection Report-Basic" dated 11/27/23 revealed the resident had a wound infection that indicated "Infection Source: It is likely infection developed in the facility".

Record review of Resident #42's "Face Sheet" revealed the resident was admitted to the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A422	A. BUILDING _____ B. WING _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTER B CROOK NURSING FACILITY	840 NORTH OAK AVENUE RULEVILLE, MS 38771

(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 880	Continued From page 24 on 9/20/19 with medical diagnoses that included Unspecified Sequelae of Cerebral Infarction. Record review of Resident #42's Minimum Data Set with an Assessment Reference Date of 1/22/24 revealed in Section C a Brief Interview for Mental Status with no score, which indicates the resident is severely cognitively impaired and in Section M that the resident had one or more unhealed pressure ulcers at Stage 1 or higher.	F 880		