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TRACE EXTENDED CARE & REHABILITATION	1000 EAST MADISON STREET HOUSTON, MS 38851

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M 000	Initial Comments The State Agency (SA) determined during an annual recertification survey, conducted from date March 18-21 2024 that the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm with deficiencies cited at M500, M610, M625, M705, M1000, and M1570. Census at the time of the survey was 57 and the facility had beds for 66 residents.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his	M 500		4/30/24

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M 500	Continued From page 1 medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the	M 500		

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

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M 500	Continued From page 3 unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, facility policy review, the facility failed to ensure privacy for a resident as evidenced by a staff member changing a residents brief next to a	M 500	Resident #35's room had a blind placed on the window on 3/18/24 per the maintenance supervisor. Audit of all rooms was completed by Maintenance Supervisor and Administrator, to ensure there were no other rooms without window	

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M 500	Continued From page 4 window with no curtain or blind for one (1) of 57 residents observed for privacy. Resident #35 Findings include: Review of facility policy titled, "Resident Rights," with a revision date of 9/22/22 revealed, "The resident has the right to a dignified existence ...7. Privacy and confidentiality: The resident has a right to personal privacy ..." An observation on 3/18/24 at 10:35 AM revealed no curtains or blinds on the window in Resident #35's room with the resident's bed situated in front of the window with a view outside of a driveway with a trash dumpster and several parked cars. An interview on 3/18/24 at 1:54 PM, Resident #35 revealed in a slurred speech that she would like curtains on her window and wasn't sure why she didn't have a curtain. An interview on 03/18/24 at 2:30 PM, Certified Nurse Aide (CNA) #3 revealed the resident's window hadn't had a curtain or blind for a while but she was unsure how long it had been off. She revealed we change her briefs and do her peri care while she is standing up, we can't change her while she is in bed because her legs flail around so much. An observation on 03/18/24 at 2:55 PM, CNA #3 entered Resident # 35's room with an incontinence disposable brief in her hand, she pulled the privacy curtain between Resident A and Resident B's bed and was changing Resident #35's brief and administering peri-care in front of the open window that lacked any covering from the outside view.	M 500	coverings on 3/18/24. The facility has determined that all residents have the potential to be affected. An in-service education was conducted by the Director of Nursing Services with all staff on privacy, and to report improper/insufficient window coverings to Maintenance Supervisor or Administrator, on 3/22/24. The Administrator or Maintenance Supervisor will conduct a room audit of five (5) rooms weekly for four (4) weeks, three (3) rooms weekly for two weeks, and (1) one room weekly for two weeks to ensure window coverings are in place, starting 3/25/24. Any needed corrections will be made immediately. Findings of this audit will be discussed at the monthly Quality Assurance (QA) meeting for three months. QA Committee may make recommendations or changes to ensure consistent substantial compliance. Immediate QA meeting was held on 3/22/24 first monthly QA meeting will be held on 4/29/2024.	

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M 500	Continued From page 5 An interview on 03/18/24 at 3:05 PM, the Administrator confirmed there was no blind or curtain on the resident's window and revealed that it should be. She stated she wasn't sure how long it had been like this and confirmed this is a privacy and dignity issue. Record review of Resident #35's Face Sheet revealed she was admitted to the facility on 5/25/19 with diagnoses that included Huntington's disease, Slurred Speech, and Anxiety Disorder. Record review of the quarterly Minimum Data Set with an Assessment Reference Date of 1/20/24 revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderately impaired cognitive skills.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observations, staff, resident and resident representative interviews, record review,	M 610	1.Resident #216 was given a shower and shave per residents request on 3/19/24. Resident #1 received oral care per Certified Nursing Assistant (CNA) #4 on	4/30/24

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M 610	Continued From page 6 and facility policy review the facility failed to ensure dependent residents received appropriate oral care, nail care and shaving for four (4) of 57 residents observed. Resident #1, #13, #26 and #216. Findings include: Record review of facility policy titled, "Activities of Daily Living (ADLs), dated 12/15/22 revealed, "A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene". Record review of the facility policy titled, "Oral Care" with a revision date of 12/20/2022 revealed, "It is the practice of this facility to provide oral care to residents in order to prevent and control plaque-associated oral diseases....Assist in wiping resident's mouth with towel". Resident #1 On 3/18/24 at 11:20 AM, Resident #1 was observed in her wheelchair at the nurses's station. Her lips were noted to be covered with a white, crusty substance and a thick, white secretion. An interview with Resident #1's Resident Representative (RR) on 3/18/24 at 2:15 PM, revealed she visited the resident frequently and assisted with her care. She stated when she arrived today, the resident's lips were covered with a thick crusty build up and so she cleaned resident's lips and put moisturizer on them for protection. She stated this had also occurred on other occasions.	M 610	3/18/24. Resident # 13 received oral care per CNA #2 on 3/19/24. Resident #26 received nail care, getting her nails clipped per the Registered Nurse (Rn) Supervisor on 3/18/2024. All Percutaneous Endoscopic Gastrostomy (PEG) residents oral care was added to the treatment administration record (TAR). . Nursing staff did 100% audit of all residents nails on 3/28/24. 2.The facility has determined that all dependent residents have the potential to be affected by this practice. 3. Licensed nurses and Certified Nursing Assistant□s (CNA□s) were educated immediately on 3/19/24 per the Director of Nursing (DON) on Activities of Daily Living (ADL) care with emphasis on oral and nail care, grooming and bathing and Residents Rights. Nurses and CNA's were educated on ADL care, bathing per schedule or upon resident request, grooming, oral and nail care, documentation of or refusal of ADL care on 3/19/2024 per the DON. 4.DON implemented monitoring of ADL care by RN Supervisors 3/21/24. DON or Nurse Supervisor will monitor bathing, grooming, oral and nail care. Nail care, showers and grooming monitoring of five residents a week for three weeks, three residents a week for three weeks, two residents a week for two weeks and one resident a week for two weeks. Oral care monitoring on all PEG residents	

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M 610	Continued From page 7 During an observation on 3/19/24 at 8:20 AM, Resident #1's lips were noted to have some dry cracked skin/crusty dry secretions present. During an observation and interview on 3/19/24 at 2:00 PM, Certified Nurses Assistant (CNA) #4 revealed Resident #1 needed frequent mouth and lip care due to her moving her lips inside her mouth and not eating or drinking by mouth. She revealed Resident #1 developed a dry crust covered with secretions on her lips that required them to be cleaned with a cloth and moisturizer applied frequently. She revealed she was responsible for oral care and did care earlier this shift, but Resident #1 needed her lips to be cleaned again to protect them from cracking. During an observation and interview on 3/19/24 at 2:20 PM, Licensed Practical Nurse (LPN) #3 revealed she was the nurse for Resident #1. She revealed the resident was a mouth breather and she did not eat or drink by mouth, therefore, she required frequent oral/lip care. She stated the resident had a thick layer of dried and moist secretions on her lips which appeared to have been there a while, and oral care was needed. An observation and interview with the Director of Nursing (DON) on 3/19/24 at 2:40 PM, revealed Resident #1's lips were covered with a layer of secretions and also dry/flaky skin in some areas and oral care was needed. She stated mouth care was to be done every shift and as needed and the facility failed to ensure the resident's oral care was done as needed and this could lead to tender, dry, cracked, bleeding lips. Record review of Resident #1's "Face Sheet" revealed resident was admitted to the facility on	M 610	three times per week for four weeks, two times per week for four weeks, and one time per week for two weeks. Audit records will be reviewed by the administrator and DON with immediate corrective actions with staff as needed. Findings will be brought to the Quality Assurance (QA)/ Risk management committee for three months for determination for further interventions to assure consistent substantial compliance. Immediate QA meeting held on 3/22/24 with first QA meeting to be held on 4/29/2024.	

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M 610	Continued From page 8 8/5/20. Diagnoses included Spastic Quadriplegic Cerebral Palsy, Convulsions, and Intellectual Disabilities. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/26/24, revealed for oral hygiene, this resident was dependent. Review of the Brief Interview for Mental Status (BIMS) score of 0 indicated the resident was severely cognitively impaired. Resident #13 An observation on 3/18/24 at 10:45 AM, of Resident #13 revealed a large amount of thick, white dried substance on his upper and lower lips. An observation on 3/18/24 at 12:15 PM, of Resident #13 revealed a large amount of thick, white dried substance on his upper and lower lips. An interview on 3/19/24 at 2:45 PM, CNA #2 revealed he was assigned to the resident today, and when he came in this morning the resident had a large amount of the white substance on his lips and confirmed it was the CNA's responsibility on each shift to make sure Resident #13's oral care is being done. An interview on 3/19/24 at 2:55 PM, CNA #3 revealed the resident wears a patch behind his ear and she noticed when he doesn't have his patch on the buildup is a lot worse. She confirmed his mouth care is supposed to be done often and if it is built up then it hasn't been done in a while.	M 610		

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M 610	Continued From page 9	M 610		

An interview on 3/19/24 at 3:05 PM, LPN #1 revealed Resident #13 is Nothing by Mouth (NPO) and wears a scopolamine patch to reduce his oral secretions. She revealed a lot of times his scopolamine patch will come off and doesn't get reported to her. She revealed his mouth gets foamy and has a white substance that dries on his lips, but his oral care is supposed to be done more often because of this.

An interview on 3/19/24 at 3:15 PM, the DON confirmed Resident #13 not having the proper oral care is not acceptable. She confirmed it is the responsibility of the aides on each shift to make sure the resident's lips are taken care of and the responsibility of the nurses to ensure the scopolamine patch is on to help reduce his oral secretions.

Record review of the "Face Sheet" revealed Resident #13 was admitted to the facility on 1/24/13 with medical diagnoses that included Unspecified Convulsions, and Hemiplegia.

Review of the facility policy titled "Nail Care" with a revision date of 12/15/2023 revealed under, "Policy Explanation and Compliance Guidelines: ... 4. Routine nail care, to include trimming and filing, will be provided on a regular schedule or as needed. Nail care will be provided between scheduled occasions as the need arises..."

Resident #26

An observation and interview with Resident #26 on 03/18/2024 at 11:16 AM, revealed long fingernails on both hands measuring three-eights (3/8) inch in length. The resident's left fingers were contracted and bent inward toward the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRACE EXTENDED CARE & REHABILITATION	1000 EAST MADISON STREET HOUSTON, MS 38851

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M 610	Continued From page 10	M 610		

palm. She stated she would like to have her nails trimmed, but no one had offered.

An observation and interview with the DON on 3/19/2024 at 2:25 PM, revealed the aides were responsible for cutting the resident's nails during bathing or at any time they noticed the nails required trimming. She confirmed Resident #26's long nails could result in skin injury.

An interview with Registered Nurse (RN) #1 on 3/19/2024 3:45 PM, confirmed she was responsible for following up and ensuring the resident's ADL care was provided daily.

Record review of Resident #26's "Face Sheet" revealed the facility admitted the resident on 3/30/2022 with medical diagnoses that included Depression and Osteoarthritis.

Resident #216

Review of the facility policy titled "Grooming a Resident's Facial Hair" with a revision date of 12/20/2022 revealed under, "Policy: It is the practice of this facility to assist residents with grooming facial hair to help maintain proper hygiene as per current standards of practice..."

An observation and interview with Resident #216 on 3/18/2024 at 2:25 PM, revealed long, black facial hair (mustache and beard) measuring approximately one-half (1/2) inch in length. The resident stated he would like it shaved, but has been unable to do so due to weakness in his arm.

An interview with LPN #1 on 3/19/2024 at 2:43 PM, confirmed Resident #216 needed shaving. She stated that the aides were responsible for shaving the residents with bathing and as

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M 610	Continued From page 11 requested. An interview with the DON on 3/19/2024 at 2:55 PM, revealed she expected the aides shaved the male residents on bath days and as they requested. Record review of Resident #216's "Face Sheet" revealed the facility admitted the resident on 2/21/2024 with medical diagnoses that included Type 2 Diabetes Mellitus, and Paroxysmal Atrial Fibrillation.	M 610		
M 625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to apply a hand roll to a resident with a contracture for one (1) of 17 residents with contractures. Resident #46 Findings Include: Review of the facility policy titled "Splint and Brace Application and Use" undated, revealed under, "Purpose: 1. To assure that residents who have splints or braces prescribed will use them when ordered. 2. To use splints to prevent and/or correct contractures." Record review of Resident #46's "Physician Orders" revealed an order dated 7/04/2023,	M 625	Resident # 46 had hand roll splint applied to resident left hand per the Licensed practical nurse (LPN) #1 on 3/20/24. Director of Nursing (DON) observed resident for further contracture on 3/21/24 with no adverse outcomes noted. Occupation therapy screened resident for changes on 3/28/24 with no changes ordered. Facility audit determined that there were four residents with device orders that have the potential to be affected by this practice. Nursing staff were educated on administering treatments/device placement as per the physicians orders	4/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09FD	A. BUILDING: _____ B. WING _____	03/21/2024

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TRACE EXTENDED CARE & REHABILITATION	1000 EAST MADISON STREET HOUSTON, MS 38851

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M 625	Continued From page 12 "Hand roll to Lt (left) hand during waking hours to prevent further contractures ..." Record review of Resident #46's "Treatment Administration Record" (TAR) for the month of March 2024 revealed an order dated 7/04/2023, "Hand roll to Lt (left) hand during waking hours to prevent further contracture as resident will allow" with documented signatures that the hand roll was applied on 3/18 and 3/19. An observation of Resident #46 on 03/18/2024 at 11:14 AM revealed him lying in bed awake. The resident was observed with paralysis to the left arm and contractures to the left fingers, with no device in use. An observation of Resident #46 on 3/19/2024 at 1:59 PM revealed him sitting in a wheelchair at the nurse's station with no device in place to the left hand. An interview and observation on 3/19/2024 at 2:10 PM with Licensed Practical Nurse (LPN) #1 confirmed Resident #46 did not have a left hand roll. She revealed the aides were responsible for applying it, and she was responsible for ensuring it was in place. She revealed that the purpose of the hand roll was to prevent further worsening of the contracture and to prevent skin impairment from the contracted fingers. An interview with the Director of Nursing (DON) on 3/19/2024 at 2:30 PM revealed the aides were responsible for applying the hand roll and the order was also on the TAR for the nurses to ensure it was on. She confirmed that not applying the hand roll could result in worsening contractures.	M 625	and documentation of placement or refusal per resident by the DON beginning 3/20/24. Nurse Supervisor will check devices daily to ensure proper placement of ordered devices beginning 3/20/24. Registered Nurse (RN) will audit treatment administration record (TAR) for completeness daily starting 3/27/24 with device checks daily through 5/31/24. Audit records will be reviewed by the Administrator and DON with corrective actions as needed with staff. Findings will be brought to the monthly QA/Risk Management Committee for three months for determination of further interventions to assure consistent substantial compliance. Immediate QA meeting held on 3/22/24 with first monthly QA to be held on 4/29/2024.	

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M 625	Continued From page 13 Record review of the "Face Sheet" revealed the facility admitted Resident #46 on 4/08/2022 with medical diagnosis that included hemiplegia following cerebral infarction affecting the left nondominant side, type 2 diabetes mellitus, seizures, and depression.	M 625		
M 705	45.24.2 Policies and procedures Policies and procedures. Each facility shall have policies and procedures to assure the following: 1. Accurate acquiring; 2. Receiving; 3. Dispensing; 4. Storage; and 5. Administration of all drugs and biologicals. This Statute is not met as evidenced by: Level II Based on observation and staff interview, the facility failed to have policies and procedures to assure the proper storage of medications and the proper administration of all drugs and biologicals. Findings include: Record review of facility letterhead statement signed by the Administrator and dated 3/20/24, revealed "(Proper name of facility) does not have a current policy on giving medications through the PEG (Percutaneous Endoscopic Gastrostomy) tube".	M 705	A policy on enteral medication administration and a policy on medication storage was created and communicated to staff on 3/28/24. The facility has determined that all residents have the potential to be affected. An in-service education was initiated by the Director of Nursing (DON) on 03/29/24, with all direct care staff regarding these new policies. The Administrator and Director of Nursing will review and create/update all policies to ensure the facility has all needed policies	4/30/24

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M 705	Continued From page 14 Record review of facility's letterhead statement signed by the Administrator and dated 3/21/24, revealed, "(Proper name of facility) does not have a policy on medication storage". An observation of Licensed Practical Nurse (LPN) #1 during medication pass for Resident #13's Percutaneous Endoscopic Gastrostomy (PEG) tube medication administration on 3/20/24 at 8:45 AM, revealed LPN #1 crushed six medication tables and mixed with one liquid medication and administered these together by pushing into PEG tube and not given by gravity. An interview with the Director of Nursing (DON) on 3/20/24 at 9:50 AM confirmed that Resident #13 did not have a physician order to crush and administer the PEG medications together. She confirmed that LPN #1 did not follow the physician order for the PEG medications to be given individually. She also confirmed that PEG medications should be given by gravity for the resident's comfort and to prevent damage to the PEG tube and given individually with flush between each to ensure compatibility. She stated the facility used Potter and Perry as a nursing reference and did not have a policy for PEG medication administration. An observation on 03/21/24 at 10:20 AM, revealed an unattended medication cart in a resident hallway had a set of keys laying on top of cart. When Licensed Practical Nurse (LPN) #1 returned to the cart, she stated those were the keys to the medication cart, locked narcotic box, and medication room. She stated leaving the keys unattended was not acceptable and was a risk since "anybody that wanted to get them, could have and medications need to be out of reach". She stated any resident, visitor, or staff	M 705	beginning 3/25/2024. Policies will be taken to the Quality Assurance (QA) Committee for approval or recommendations to ensure consistent substantial compliance for three months. Education will be provided at the time new policies are approved. Immediate QA meeting held on 3/22/24 with first monthly QA meeting to be held on 4/29/2024.	

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M 705	Continued From page 15 could have obtained these since they were left unattended on top of cart in a resident hallway. During an interview on 3/21/24 at 10:25 AM, the Director of Nursing (DON) confirmed that by leaving the keys on a cart in an open hallway, the facility failed to ensure proper storage of medication. She stated this could have allowed an unauthorized person to have access to the medications and controlled medications. She stated the facility had no policy for medication storage.	M 705		
M1000	45.34.3 Medical Waste Management Plan Medical Waste Management Plan. All generators of infectious medical waste and medical waste shall have a medical waste management plan that shall include, but is not limited to, the following: 1. Storage and Containment of Infectious Medical Waste and Medical Waste: a. Containment of infectious medical waste and medical waste shall be in a manner and location which affords protection from animals, rain and wind, does not provide a breeding place or a food source for insects and rodents, and minimizes exposure to the public. b. Infectious medical waste shall be segregated from other waste at the point of origin in the producing facility. c. Unless approved by the licensing agency or treated and rendered non-infectious, infectious medical waste (except for sharps in approved containers) shall not be stored at a waste	M1000		4/30/24

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M1000	Continued From page 16 producing facility for more than seven days above a temperature of six (6) degrees Celsius (equivalent to thirty-eight [38] degrees Fahrenheit). Containment of infectious medical waste at the producing facility is permitted at or below a temperature of zero (0) degrees Celsius (equivalent to thirty-two [32] degrees Fahrenheit) for a period of not more than ninety (90) days without specific approval of the licensing agency. d. Containment of infectious medical waste shall be separate from other wastes. Enclosures or containers used for containment of infectious medical waste shall be so secured so as to discourage access by unauthorized persons and shall be marked with prominent warning signs on, or adjacent to, the exterior of entry doors, gates, or lids. Each container shall be prominently labeled with a sign using language to be determined by the licensing agency and legible during daylight hours. e. Infectious medical waste, except for sharps capable of puncturing or cutting, shall be contained in double disposable plastic bags or single bags (1.5 mills thick) which are impervious to moisture and have strength sufficient to preclude ripping, tearing, or bursting under normal conditions of usage. The bags shall be securely tied so as to prevent leakage or expulsion of solid or liquid wasted during storage, handling, or transport. f. All bags used for containment and disposal of infectious medical waste shall be of a distinctive color or display the Universal Symbol for infectious waste. Rigid containers of all sharps waste shall be labeled.	M1000		

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M1000	Continued From page 17 g. Compactors or grinders shall not be used to process infectious medical waste unless the waste has been rendered noninfectious. Sharps containers shall not be subject to compaction by any compacting device except in the institution itself and shall not be placed for storage or transport in a portable or mobile trash compactor. h. Infectious medical waste and medical waste contained in disposable containers as prescribed above, shall be placed for storage, handling, or transport in disposable or reusable pails, cartons, drums, or portable bins. The containment system shall be leak-proof, have tight fitting covers and be kept clean and in good repair: i. Reusable containers for infectious medical waste and medical waste shall be thoroughly washed and decontaminated each time they are emptied by a method specified by the licensing agency, unless the surfaces of the containers have been protected from contamination by disposable liners, bags, or other devices removed with the waste, as outlined in I.E. Approved methods of decontamination include, but are not limited to, agitation to remove visible soil combined with one or more of the following procedures: i. Exposure to hot water at least one-hundred eighty (180) degrees Fahrenheit for a minimum of fifteen (15) seconds. ii. Exposure to a chemical sanitizer by rinsing with or immersion in one of the following for a minimum of three (3) minutes: a. Hypochlorite solution (500 ppm available chlorine).	M1000		

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M1000	Continued From page 18 b. Phenolic solution (500 ppm active agent). c. Iodoform solution (100 ppm available iodine). d. Quaternary ammonium solution (400 ppm active agent). iii. Reusable pails, drums, or bins used for containment of infectious waste shall not be used for containment of waste to be disposed of as noninfectious waste or for other purposed except after being decontaminated by procedures as described in 133.03 (i) of this section. j. Trash chutes shall not be used to transfer infectious medical waste. k. Once treated and rendered non-infectious, previously defined infectious medical waste will be classified as medical waste and may be land-filled in an approved landfill. 2. Treatment or disposal of infectious medical waste shall be by one of the following methods: a. By incineration in an approved incinerator which provides combustion of the waste to carbonized or mineralized ash. b. By sterilization by heating in a steam sterilizer, so as to render it noninfectious. Infectious medical waste so rendered non-infectious shall be disposable as medical waste. Operating procedures for steam sterilizers shall include, but not be limited to, the following: i. Adoption of standard written operating procedures for each steam sterilizer including	M1000		

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M1000	Continued From page 19 time, temperature, pressure, type of waste, type of container(s), closure on container(s), pattern of loading, water content, and maximum load quantity. ii. Check or recording and/or indicating thermometers during each complete cycle to ensure the attainment of a temperature of one-hundred twenty-one (121) degrees Celsius (equivalent to two-hundred fifty [250] degrees Fahrenheit) for one-half (1/2) hour or longer, depending on quantity and density of the load, in order to achieve sterilization of the entire load. Thermometers shall be checked for calibration at least annually. iii. Use of heat sensitive tape or other device for each container that is processed to indicate the attainment of adequate sterilization conditions. iv. Use of the biological indicator Bacillus stearothermophilus placed at the center of a load processed under standard operating conditions at least monthly to confirm the attainment of adequate sterilization conditions. v. Maintenance of records of procedures specified in (i), (ii, (iii) and (iv) above for period of not less than a year. c. By discharge to the approved sewerage system if the waste is liquid or semi-liquid, except as prohibited by the Mississippi State Department of Health or other regulatory agency. d. Recognizable human anatomical remains shall be disposed of by incineration or internment, unless burial at an approved landfill is specifically authorized by the Mississippi State Department of Health.	M1000		

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M1000	Continued From page 20 e. Chemical sterilization shall use only those chemical sterilants recognized by the U. S. Environmental Protection Agency, Office of Pesticides and Toxic Substances. Ethylene oxide, glutaraldehyde, and hydrogen peroxide are examples of sterilants that, used in accordance with manufacturer recommendation, will render infectious waste non-infectious. Testing with Bacillus subtilis spores or other equivalent organisms shall be conducted quarterly to ensure the sterilization effectiveness of gas or steam treatment. f. Treatment and disposal of medical waste which is not infectious shall be by one of the following methods: i. By incineration in an approved incinerator which provides combustion of the waste to carbonized or mineralized ash. ii. By sanitary landfill, in an approved landfill which shall mean a disposal facility or part of a facility where medical waste is placed in or on land, and which is not a treatment facility. This Statute is not met as evidenced by: Level II Pattern Based on observation, staff interview, and record review, the facility failed to ensure infectious medical waste was not stored at the facility for seven (7) days or less and failed to ensure the medical waste was stored in a manner that afforded protection from the outdoor elements for one (1) of two (2) medical waste rooms. Findings Include: An observation of the outdoor biohazard storage facility on 3/21/2024 at 8:45 AM, and interview with Maintenance #1, revealed a metal door with	M1000	The medical waste vendor was contacted, and the contract was changed to be picked up every seven (7) days on 3/21/24. Maintenance Supervisor repaired the door on the building where medical waste is stored on 3/21/24. The facility has determined that all residents have the potential to be affected. Administrator put a new medical waste policy into place on 3/29/24. Maintenance staff and housekeeping were educated on state requirements and facility policy on medical waste on 3/22/24.	

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M1000	Continued From page 21 an opening at the top measuring 9 inches (in) length by 19 inches (in) width. He confirmed the medical waste was not protected from the outdoor elements. An observation inside the storage facility revealed the area was layered with medical waste from the floor to the ceiling, wall to wall, and the Survey Agent was unable to enter the building. He revealed they normally do not have a lot of hazardous waste, but the facility just came out of a Covid-19 outbreak. He revealed they recently started using "Proper Name Medical Waste" and they pick it up every two weeks. He stated the last pickup was on 3/08/2024. An interview with the Administrator (ADM) on 3/21/2024 at 9:35 AM, revealed they were storing infectious medical waste at the hospital until the hospital recently sold, and they were told they would have to store it at the facility. She stated they recently got the old storage shed opened up to store the waste in. She revealed they just signed a contract with "Proper Name Medical Waste" on 2/27/2024, and they have only picked up once. The ADM revealed they had an increase in biohazard waste because of the Covid-19 outbreak. She revealed she knew the biohazard storage area was a concern because they were in a rush to get something in place, and they just threw it together. She stated, according to the contract, "Proper Name Medical Waste" was supposed to pick up weekly, but they have not come weekly since they started. The ADM revealed they picked up 25 boxes on 3/8/2024 and had not picked up since. She acknowledged the hole in the door did not protect the infectious waste from outdoor elements. Record review of the "Medical Waste Contract" revealed an effective date of 2/27/2024 and a pickup frequency of every 2 weeks.	M1000	The Administrator will complete weekly audits of vendor manifest of pickups and medical waste building to ensure waste is picked up every seven days and building is secure, starting 3/29/24, for three months. Audit records will be reviewed by the Risk Management/Quality Assurance (QA) Committee for three months for needed recommendations or further interventions to ensure consistent substantial compliance. Immediate QA meeting was held on 3/22/2024 with first monthly QA meeting to be held on 4/29/2024.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRACE EXTENDED CARE & REHABILITATION	1000 EAST MADISON STREET HOUSTON, MS 38851

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M1000	Continued From page 22 Record review of the "Regulated Medical Waste Receipt" revealed a pickup date of 3/08/24. An interview with the Administrator on 3/21/2024 at 9:52 AM revealed the facility did not have a policy on storage of infectious medical waste.	M1000		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II	M1570	1.Licensed Practical Nurse (LPN) #1 was	4/30/24

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M1570	Continued From page 23 Based on observation, staff interview and facility policy review, the facility failed to decrease the likelihood of the spread of infection as evidenced by a nurse dropped a glove on the floor in a resident's room, retrieved it off the floor, put it on, and continued with medication pass and insulin administration for one (1) of four (4) resident medication administrations observed. Resident #3 Findings include: Record review of facility policy titled, "Infection Prevention and Control Program", dated 5/15/23, revealed, "This facility has established and maintains 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 as per accepted national standards and guidelines." The policy also revealed, "4. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. d. Licensed staff shall adhere to safe injection and medication administration practices." During an observation of medication pass on 3/20/24 at 8:20 AM, Licensed Practical Nurse (LPN) #1 prepared Resident #3's medications for administration. The medications consisted of 12 by mouth medications, one topical ointment, and one subcutaneous insulin injection. While in resident's room, LPN #1 washed her hands and preceded to put on her gloves, but dropped one on the floor. She picked this glove up and placed it on her hand and began to prepare for the	M1570	educated on proper infection control procedures during medication administration on 3/20/24 per the Infection Preventionist and Director of Nursing (DON). DON observed resident #3, for adverse outcomes beginning 3/20/24 with none noted. 2.The facility has determined that all residents have the potential to be affected by this practice. 3.All staff were educated on the facility's policy on hand hygiene and infection control procedures when donning/doffing and wearing of gloves and incidence of dropping items on the floor contaminating them by the Infection Preventionist and Director of Nursing beginning 3/25/2024. 4.Infection Preventionist will do infection control rounds three times per week for four weeks, two times a week for four weeks and one time a week for two weeks, starting 03/27/24. Audit records with be reviewed by the Administrator and DON with corrective actions with staff as needed, findings will be presented to the Quality Assurance (QA)/Risk Management Committee for three months for any recommendations for further interventions to assure consistent substantial compliance. Immediate QA meeting was held on 3/22/24 with first monthly QA meeting scheduled for 4/29/2024.	

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M1570	Continued From page 24 medication administration by opening the alcohol prep for the insulin injection. After medication administration was completed the nurse stated "I shouldn't have put it on. I should have washed my hands and started with new gloves for the meds". She stated this could spread infections especially since one medication was an injection. An interview with the Director of Nursing (DON) on 3/20/24 at 9:50 AM, revealed proper infection control techniques were not used when a glove that had been on the floor was picked up and put on by a nurse for resident care. She confirmed the facility failed to prevent the likelihood of the spread of infection and the nurse should have washed her hands and applied new gloves for the resident's medication administration. Record review of Resident #3's "Face Sheet" revealed the resident was admitted to the facility on 3/11/22. Diagnoses included Type 2 Diabetes Mellitus, chronic obstructive pulmonary disease, epilepsy, hypertension, schizophrenia.	M1570		