STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255148	A. BUILDING _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE CENTER	102 WOODCHASE PARK DRIVE CLINTON, MS 39056

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey along with two (2) Complaint Investigations (CI MS #24636 and CI MS #24697), at the facility from 04/09/24 through 04/11/24. The SA investigated CI MS #24636 for dialysis after care and CI MS #24697 for resident-on-resident abuse, grooming, and facility staff. Based on the findings of the Complaint Investigations, the SA determined the facility was not in compliance with the requirement of participation in Medicare and Medicaid and cited F657 and F698. During the Annual Recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F641, F644, F657, F759, and F880. The facility had a census of 137 and license beds 145.	F 000		
F 641 SS=D	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 interviews, record reviews, and facility policy review, the facility failed to accurately code a Minimum Data Set (MDS) for one (1) of 26 sampled residents. Resident #126 Findings include: Review of the facility's policy titled, "MDS (Minimum Data Set) Coding Policy," reviewed 1/4/23, revealed, "(Proper Name) affiliated	F 641	1.Resident #126 was discharged from the facility on 1/18/2024. The discharge Minimum Data Set (MDS) assessment was modified and submitted on 4/11/2024 by the MDS Registered Nurse (RN) to reflect Resident #126 discharging home and not the hospital. The discharge Minimum Data Set (MDS) assessment was accepted on 4/12/2024.	5/23/24

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

Electronically Signed | 05/03/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 641	Continued From page 1 facilities utilize the most up to date Resident Assessment Instrument (RAI) manual for determination of coding each section of the Resident Assessment, timely and accurately ..." Review of the facility's, "Admission Record," for Resident #126, revealed an admission date of 12/29/23. The resident's admission diagnoses included Acute kidney failure and Type 2 Diabetes Mellitus. A record review of the Discharge MDS dated 1/18/24, revealed Resident #126 had the Type of Assessment coded as a discharge assessment with return not anticipated. However, further review of the MDS revealed the Discharge Status as a discharge as a short-term general hospital discharge. A record review of the facility's "Progress Notes," dated 1/88/24 at 17:00 (5PM) revealed Resident #126 was discharged to home with medications with home health, that included physical therapy, occupational therapy, and speech therapy. During an interview on 4/11/24 at 10:01 AM, the Social Worker Assistant explained that Resident #126 was discharged home to live with her sister. During an interview on 4/11/24 at 10:10 AM, Registered Nurse (RN) # 2 explained she is the MDS Coordinator. The MDS Coordinator confirmed Resident #126 was sent home with her family, so the MDS was not coded correctly. The MDS Coordinator confirmed Licensed Practical Nurse (LPN) #2 coded the MDS. During an interview on 4/11/24 at 11:37 AM, the Director of Nursing (DON) confirmed the	F 641	2.The facility has determined that 53 residents had the potential to be affected. 3.On 4/11/2024 an audit was conducted by the Registered Nurse MDS Coordinator. The audit reviewed 53 residents that were discharged from 3/12/2024-4/11/2024. This audit had a 1% error rate. One of 53 residents reviewed that were discharged from 3/12/2024-4/11/2024 was amended. On 4/16/2024, an in-service was conducted by the Regional Case Mix Registered Nurse via Teams with MDS Nurses on requirements to accurately code A2100: OBRA Discharge Status per the Resident Assessment Instrument (RAI) Manual. 4.Beginning on 4/11/2024, an audit will be conducted weekly for twelve (12) weeks by the Minimum Data Set (MDS) Registered Nurse Coordinator, that will be submitted to the Administrator, Director of Nursing (DON) and Regional Case Mix Registered Nurse, then monthly for three (3) months with a review of 10% of all discharges for the month by facility MDS Registered Nurse to review accuracy of coding A2100: OBRA Discharge Status. A report of audit findings beginning on 05/01/2024 will be submitted by MDS coordinator to the Quality Assurance Performance Improvement committee monthly for three (3) months for further review and recommendations. The Administrator is responsible for monitoring and compliance.	

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F 641	Continued From page 2 Residents MDS was coded incorrectly because the resident was discharged to home with her family. The DON confirmed the MDS nurse should have done a discharge home MDS instead of a hospitalization discharge. The DON commented that she expected the nurse to code the MDS correctly. During an interview on 4/11/24 at 12:29 PM, the Administrator stated that she expects the staff to code the MDS correctly. The Administrator said she thought the MDS Coordinator checked behind the other MDS nurses to make sure the coding was correct.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by:	F 644		5/23/24

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F 644	Continued From page 3 Based on interviews, record reviews, and facility policy review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR) Level II was obtained for a resident diagnosed with a serious mental disorder for one (1) of 26 sampled residents. (Resident #31) Findings include: Review of the facility's policy titled," PASRR policy and Procedure," reviewed 1/24/23, revealed, "(Proper Name) uses the most current version of PASRR Rules of the Mississippi Division of Medicaid: Administrative Code, Medicaid Title 23: Part 207, Chapter: Long Term Care Pre-Admission Screening as they pertain to the Level 1 (PAS) and Level 2 (PASSR) long term care processes and procedures ..." Review of "Admission Record" for "Resident #31 revealed the facility admitted the resident on 5/30/23, with diagnoses that included Paranoid Schizophrenia. Review of the Pre-Admission screening (PAS) dated 6/19/23, for Resident #31 revealed the PAS was completed when Resident #31 was admitted to the facility for short term therapy. Review of the PAS revealed that the resident needed orthopedic after care and was directly admitted from a hospital for short-term convalescent care. On 04/10/24 at 10:01 AM in an interview, the Assistant Business Office Manager (ABOM) stated she answered the questions on the PAS. She stated Resident #31 came in for skilled care, however, Resident #31 was not able to go back home after therapy and it was necessary for the resident to stay in the facility as a long-term care	F 644	1.On 4/10/2024, the Assistant Business Office Manager corrected the Preadmission Screening and Resident Review (PASARR) and sent a Level II Change in Status for Resident #31 to Maximus. Maximus reviewed and evaluated the level II change in status for Resident #31 and the facility received a final determination dated 4/17/2024. The determination was that the resident is nursing facility appropriate. 2.The facility has determined that all residents admitting short term but remaining long term had the potential to be affected. 3.On 4/11/2024, the Business Office Department and Social Services Department was in-serviced by the Administrator on requirement of validity of information on the PASARR prior to submission. On 04/11/2024, Medical Records Director audited prior 3 months' admissions to ensure that short-term convalescent care residents who transitioned to long-term care were evaluated for PASARR services through Maximus. This audit revealed that 2 additional residents required level II change in status updates. 4.Beginning 04/12/2024, the Administrator will audit three (3) PASRRS for residents that converted to long term after their short term stay per week for the next three (3) months. A report beginning on 5/1/2024 will be submitted by the Administrator to the Quality Assurance	

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F 644	Continued From page 4 resident. The ABOM confirmed she should have updated the PAS once the resident was changed to long term care. Review of the medical records for Resident #31 revealed there was no documentation the facility referred Resident #31 for a PASRR Level II screening when Resident #31 became a long term care resident. On 04/11/24 at 3:55 PM, in an interview the Administrator stated she was not aware that when Resident #31 became a long-term care resident, she should have been referred for a Level II PASRR. The Administrator confirmed that she expects staff to follow the state guidelines to ensure that residents get the care that they need. Review of Resident #31 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/12/24 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated resident was cognitively intact.	F 644	Performance Improvement (QAPI) committee for monthly review and recommendations for three (3) months. The Administrator is responsible for monitoring and compliance.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		5/23/24

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F 657	Continued From page 5 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and the facility policy review, the facility failed to revise the Care Plans for two (2) of 26 sampled residents. (Residents #80 and #105) Findings include: Review of facility's policy titled, "Care Plans, Comprehensive Person-Centered," reviewed 1/23, revealed, " ... A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident ... Facility Interpretation and Implementation ... 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's conditions; b. When the desired	F 657	1.On 04/11/2024, Director of Nursing contacted (dialysis facility) to get clarification on communications related to dialysis pressure dressing removal for resident #80. On 04/11/2024, Resident #80□s care plan was updated by Minimum Data set (MDS) Registered Nurse to include interventions for the removal of the dialysis pressure dressing. On 4/10/2024, Resident # 105 care plan was updated by the Minimum Data Set (MDS) Licensed Practical Nurse (LPN) to resolve continuous feeding orders and add current bolus feeding orders. 2.The facility has determined that ten (10) dialysis residents and nine (9) tube feed residents had the potential to be affected. 3.On 4/12/2024, DON initiated in-servicing with all licensed nurses and registered nurses on checking dialysis	

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F 657	Continued From page 6 outcome is not met ..." Resident # 80 Record review of the Care Plan, undated revealed "Focus: The resident needs hemodialysis r/t (related to) renal failure. There were no interventions listed for the removal of the dialysis pressure dressing. The facility added an additional intervention to address the dressing removal after the State Agency (SA) entered the facility. On 4/10/24 at 9:29 AM, an observation and interview of Resident #80 revealed a dressing to the resident's right forearm at the location of the AV (Arteriovenous) graft . The resident indicated that the dressing was from the previous day's dialysis session. Record review of the "Hemodialysis Communication" form dated 3/21/24 revealed " ...Follow up includes: Please remove dialysis bandage 1 day after dialysis treatment." Record review of the "Hemodialysis Communication" form dated 3/30/24 revealed " ...Follow up includes: ... Please remove dressing 4-6 hrs (hours) after returning to facility." During an interview on 04/10/24 at 10:56 AM, with Registered Nurse (RN) #4, the dialysis unit Facility Administrator, revealed communication has been sent on several occasions stressing the importance of not the leaving pressure dressing, as it may damage his new access. During an interview on 4/10/24 at 3:00 PM, with RN #2 revealed that it is the responsibility of the	F 657	communication forms. On 4/16/2024, an in-service was conducted by the Regional Case Mix Registered Nurse via Teams with Minimum Data set (MDS) Nurses on actuarily documenting care plans and reviewing order changes daily. On 4/11/2024, DON initiated contact with all current dialysis facilities to get clarification related to dialysis pressure dressing removal for all current residents receiving dialysis services. This was completed on 4/12/2024. New orders were obtained for eight (8) of ten (10) residents receiving dialysis on removal of pressure dressings on 04/15/2024 by Medical Records Nurse. On 4/30/2024 Medical Records updated and clarified dialysis pressure dressing removal physician order to reflect change for resident #80. On 5/1/2024 MDS Registered Nurse conducted an audit of current dialysis residents to review care plan for accurate documentation of interventions related to the removal of dialysis pressure dressing. Five (5) current dialysis care plans were updated by the Minimum Data Set (MDS) Registered Nurse on 5/1/2024. On 5/1/2024, an audit of all nine (9) residents requiring tube feeding was conducted to ensure accurate care planning by Director of Nurses (DON). No other negative outcomes were found. 4.Beginning 04/12/2024 the Minimum Data Set Coordinator (MDS) will review new orders daily via the order listing report for twelve (12) weeks for any new orders, discontinued orders, order changes, and will develop and implement	

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F 657	Continued From page 7 RN's and Licensed Practical Nurses (LPNs) to maintain accurate documentation and communication with the multidisciplinary team to make sure care plans are up to date with the most recent information for better patient outcomes. She commented the facility failed to get clarification on communications from dialysis regarding the timely removal of the AV shunt dressing. RN #2 confirmed the facility had made no revisions to the care plan for the timely removal of the pressure dressing on Resident #80's AV site, prior to the entrance of the SA. During an interview on 4/10/24 at 3:31 PM, an interview with the Director of Nursing (DON) revealed that it is the responsibility of Registered Nurses and Licensed Practical Nurses (LPNs) to maintain accurate documentation and communication with multidisciplinary team to make sure care plans are up to date with the most recent information for better patient outcomes. The DON revealed the facility failed to get clarification on communications to revise the care plan of Resident # 80. The DON also confirmed the facility did not have revisions to Resident #80's care plan regarding timely removal of the pressure dressing of the resident's AV site prior to SA entrance. Resident #105 Record review, of Resident #105's Comprehensive Care Plan, revealed "Focus The resident requires tube feeding r/t Dysphagia ...Interventions Glucerna 1.5 at 50 cc/hr (cubic centimeters/hour) x 22 hours ..." On 04/10/24 at 10:00 AM, observed Resident #105 sitting up in wheelchair by the nurse's	F 657	the corresponding care plan needed. The order reviews will be given to the Director of Nursing (DON) for review daily attached with any corresponding care plan developed and or changed. A report will be submitted to the Quality Assurance Performance Improvement on 05/01/2024 for review and recommendations then monthly for three (3) months. The Minimum Data Set Coordinator (MDS) is responsible for monitoring and compliance.	

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F 657	Continued From page 8 station with no tube feeding infusing. On 4/10/24 at 1:00 PM, during an interview with LPN #1, she explained Resident #105 is NPO (nothing by mouth) and gets bolus feedings five (5) times a day, instead of the continuous feedings, as the resident had been known to unhook the feeding, making him a high risk for aspiration. On 4/10/24 at 3:53 PM, during a record review and an interview with LPN #2/Care Plan Nurse, she explained care plans are updated with each new orders daily. LPN #2 reviewed Resident #105's care plan and physician orders and confirmed the resident was no longer on continuous tube feedings, as the order was changed on 3/4/24. The nurse acknowledged that the care plan continued to indicate that the resident was receiving continuous feedings. The Care Plan Nurse confirmed that the care plan was not updated to reflect the new order. Record review of Resident #105's "Order Summery Report" with active orders as of 04/11/24 revealed an order dated 3/4/24 "Enternal Feed Order five (5) times a day Tube Feeding: Glucerna 1.5 Cal, 1 can bolus 5 times a day." At 1:31 PM, on 4/11/24, during an interview with the DON, she explained she expects the care plan nurses to update the care plans daily with all new orders. She revealed the staff has daily meetings to ensure all new orders are recognized and care planned and does not know how orders were missed.	F 657		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)	F 759		5/23/24

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F 759	Continued From page 9 §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to maintain less than a 5% medication error administration rate for two (2) errors of 25 medication administration opportunities. This observation resulted in an 8% medication error rate. Findings Include: Review of the facility's, "Instillation of Eye Drops," revised January 2014, revealed, " ... General Guidelines ... 4. When administering two or more different eye drops allow three to five minutes between each application ..." During a medication administration observation on 04/10/24 at 9:00 AM, Registered Nurse (RN) # 1 instilled one (1) drop of Prednisolone Acetate Ophthalmic Suspension 1 % in the left eye of Resident #81. The nurse immediately instilled one (1) drop of Ofloxacin Ophthalmic Solution 0.3 % 1 into the resident's left eye. The nurse failed to wait three (3) to five (5) minutes between drops. During an interview on 04/10/24 at 9:23 AM, RN # 1 confirmed she failed to wait three (3) to (5) minutes before administering the second eye drop. RN #1 stated "I only waited 20 seconds."	F 759	1.On 4/11/2024 Director of Nurses (DON) assessed Resident #81 for any adverse reactions to eye drop administrations. No adverse reactions were found. No infections were evident or identified. On 4/12/2024, RN #1 was in-serviced 1 on 1 by DON on the medication administration policy regarding Instillation of Eye Drops. 2.Sixteen (16) residents identified as receiving multiple eye drops have the potential to be affected by this practice, no other negative outcomes were identified. 3.On 04/12/2024, Staff Development Coordinator (SDC) initiated in service with all active nurses on Medication Administration policy/procedure to include administration of multiple eye drops. On 4/12/2024, Administration of eye drops skills checkoffs were initiated by SDC to include all active licensed and registered nurses. 4.Beginning 04/15/2024 the Staff Development Coordinator (SDC) will conduct Medication Pass Observations for three (3) nurses weekly for the next three (3) months to ensure compliance with Medication Administration. A report will be submitted to the Quality Assurance	

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F 759	Continued From page 10 During an interview on 04/11/24 at 1:20 PM, the facility Pharmacist explained RN # 1 should not administer the eye drops together because one drop will wash out the other. The Pharmacist confirmed the nurse should wait three (3) to five (5) minutes between drops. The Pharmacist said they do not put the instructions on the box about the eye drops, because this is taught in nursing school. During an interview on 04/11/24 at 2:13 PM, the Director of Nursing (DON) states that RN #1 should have waited three (3) to five (5) minutes between the eye drops to keep one from washing out the other. The DON said this nurse has been trained on how to administer eye drops because she has been a nurse for several years. Record review of an inservice dated 1/22/24, titled "EDUCATION AND REMINDERS" revealed " ... Follow medication procedures/guidelines/orders for each medication administered..." RN #1's signature was on the inservice sign in sheet as having attended the inservice. Review of the "Order Summary Report," with active orders as of revealed physician orders dated 3/22/24 for Resident #81 for Ofloxacin ophthalmic solution 0.3 % instill one (1) drop in left eye four times a day for eye surgery and Prednisolone Acetate Ophthalmic Suspension 1 % instill one (1) drop in left eye four times a day for eye surgery." Record review of the "Admission Record" for Resident # 81 revealed the facility admitted the resident on 03/24/23. Current diagnoses included Total retinal detachment of left eye and Presence	F 759	Performance Improvement on 05/01/2024 for review and recommendations then monthly for three (3) months. The Director of Nursing (DON) is responsible for monitoring and compliance.	

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	255148	A. BUILDING _____ B. WING _____	04/11/2024

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F 759	Continued From page 11 of intraocular lens.	F 759		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and 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	F 880		5/23/24

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F 880	Continued From page 12 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and the facility policy review, the facility failed to transport dirty linen in a manner to prevent the possible spread of infection, for one (1) of three (3) days of observations. Findings include:	F 880	1.On 4/12/2024, CNA (Certified Nursing Assistant) #2 received a one-to-one demonstration and written in-service by the Director of Nursing (DON) completed pertaining to proper transporting and handling of soiled laundry, bedding, and linen. On 4/12/2024, the Director of Nursing (DON) assessed all eleven (11)	

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F 880	Continued From page 13 Review of the facility's policy titled, "Laundry and Bedding, Soiled," revised 10/18, revealed, " ...Soiled laundry/bedding shall be handles, transported and processed according to best practices for infection prevention and control ... Handling 1. All used laundry is handled as potentially contaminated until it is properly bagged and labeled for appropriate processing... b. Laundry... is placed in leak proof bags or containers. c. Contaminated laundry is placed in a bag or container at the location where it is used... Transport 1. Contaminated laundry bags/containers are not held close to the body or squeezed during transport ..." During an observation on 04/09/24 at 9:18 AM, Certified Nursing Assistant (CNA) #2 was observed walking down the hallway with dirty linen braced against her clothes. CNA #2 placed the linen in the dirty clothes barrel several rooms down the hall. During an interview on 04/09/24 at 9:20 AM, CNA #2 confirmed she had the dirty linen braced against her clothes. CNA #2 explained that she should have place the linen in a plastic bag because she could get an infection or cause other residents and staff to become infected. CNA #2 said she could not find a bag at that time. During an interview on 04/11/24 at 2:34 PM, the Director of Nursing (DON) confirmed CNA #2 should have placed the linen in a plastic bag prior to taking it down the hallway to the dirty clothes barrel. The DON said the CNA's actions could cause other residents, herself, or other staff to be infected. In an interview on 04/11/24 at 3:21 PM with the	F 880	residents assigned to CNA#2 for any adverse reactions related to the deficient practice. No adverse reactions were found. 2.All eleven (11) residents assigned to the care area of Certified Nursing Assistant (CNA)#2 on 4/9/2024 have the potential to be affected by this practice, no other negative outcomes were identified. 3. Beginning on 4/9/2024, an in-service on Infection Control policy and transport of soiled laundry, linen, and bedding was initiated by Staff Development Coodinator (SDC) and Certified Nursing Assistant (CNA) educator for all CNA's (Certified Nursing Assistants). On 4/12/2024, The Staff Development Coordinator (SDC) and CNA educator-initiated skills check offs with return demonstration all Certified Nursing Aides (CNA) related to infection control practices while transporting soiled linen, laundry, and bedding. 4. Beginning on 4/12/2024, the Staff Development Coordinator (SDC), Director Of Nursing (DON), and the Risk Manager, Registered Nurse will observe infection control practices being met related to transportation of soiled linen, laundry, and bedding with one (1) CNA per day for one week, then one (1) CNA weekly for one month, then one (1) CNA monthly for three months. A report will be submitted to the Quality Assurance Performance Improvement on 05/01/2024 for review and recommendations then monthly for three (3) months. The Director of Nursing	

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F 880	Continued From page 14 Administrator explained she expect the staff to follow the infection control policy at all times. Record review of an orientation checklist dated 12/12/23 revealed CNA #2 had been trained in infection control. Review of a completion certificate dated 1/23/24 revealed CNA #2 had successfully completed an eLearning educational activity titled "Infection Prevention in Long-Term Care Settings."	F 880	is responsible for monitoring and compliance.	