STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255206	A. BUILDING _____ B. WING _____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE COLUMBUS, MS 39702

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey along with a complaint investigation (CI) MS#24074 at the facility on 04/01/24 through 04/04/24. The SA determined that the facility was not in compliance with requirements for participation in Medicare and Medicaid Services and cited deficiencies at F641 related to accuracy of assessments and F880 related to infection control. The SA found the facility was in compliance for CI MS#24074 related to resident rights. The census at the time of the survey was 82 with a license for 120 beds.	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 observation, resident and staff interview, record review, and facility policy review the facility failed to properly code a resident for a restraint on the Minimum Data Set (MDS) for one (1) of 21 residents MDS assessments reviewed during survey. Resident #56 Findings Include. A review of the facility policy revised 04/2019 titled "Resident Assessment Instrument (RAI)/CARE PLANNING MANAGEMENT" revealed it is the practice of this facility to conduct a comprehensive, accurate assessment of each resident's functional capacity.	F 641	On 4/3/2024, Minimum Data Set (MDS) Coordinator corrected the MDS for resident #56 to reflect no use of trunk restraint. A Modification of Quarterly MDS was submitted and accepted on 4/3/2024. All residents have the potential to be affected. On 4/3/2024, a 100% audit of MDS coding for restraints was completed by the MDS Nurses. No other residents had coding errors related to restraint usage. On 4/5/2024, the Quality Assurance Committee reviewed the facility policy	5/6/24

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

Electronically Signed | 04/15/2024

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F 641	Continued From page 1 A record review of Resident #56's Minimum Data Set (MDS) Quarterly Assessment dated 03/12/24 section P revealed "used a trunk restraint less than daily." An observation and interview, on 04/02/24 at 10:29 AM, of Resident #56 revealed the resident lying in bed resting. The observation revealed that the resident did not have a restraint on. The resident confirmed that he does not have any type of restraint. An interview, on 04/02/24 at 10:40 AM with Registered Nurse (RN) #1 confirmed that Resident #56 has not had a restraint on that she can remember. A record review of Resident #56's Physicians' Orders revealed there is no order for restraint. An interview, on 04/03/24 at 10:10 AM, with Certified Nursing Assistant (CNA) #2 confirmed that Resident #56 has not had a restraint for the seven (7) years that she has worked here. An interview on 04/03/24 at 10:20 AM, with the MDS Nurse confirmed that under Section P of the MDS completed on 03/12/24 that trunk restraint was marked by mistake. MDS Nurse confirmed that Resident #56 has never had a restraint and that it was marked in error and that she will have to complete a modification to remove it. She confirmed that the purpose of the MDS is to gather knowledge about the resident through an assessment to guide the care that the resident received and payment for resident services. The MDS Nurse confirmed that coding the MDS incorrectly can affect the resident's level of care.	F 641	titled RAI/Care Planning Management with no recommended changes to the policy. On 4/5/2025, the Nursing Home Administrator (NHA) in-serviced 2 of 2 MDS Coordinators on the RAI/Care Planning Policy and accuracy of assessment. The MDS Coordinator will complete a 100% weekly audit of all MDS submitted to ensure usage of restraints was properly coded. Audits began on 4/4/2024 and will be weekly for the next 8 weeks or until the stated deficient practice has been resolved and/or until 100% compliance is achieved. Negative findings will be addressed immediately. Beginning on 4/18/2024 and for the next 2 months, the Quality Assurance Committee will review the data obtained from the MDS quality assurance audits, analyzing for patterns/trends. The Quality Assurance/Performance Improvement Committee will make recommendations as needed.	

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F 641	Continued From page 2 An interview on 04/03/24 at 1:00 PM, with the Administrator confirmed that the purpose of the MDS is to determine the level of care that the resident needs and that coding it incorrectly could result in the resident receiving the wrong level of care. A review of the "Admission Record" for Resident #56 revealed that he was admitted to the facility on 3/19/20.	F 641		
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	F 880		5/6/24

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F 880	Continued From page 3	F 880		

procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility 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

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F 880	Continued From page 4 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 prevent the possibility of an infection as evidence by a suction connecting tubing not being replaced after making contact with a trash can during respiratory care for one (1) of seven (7) residents direct care observations. Resident #47 Findings Include Review of the facility policy titled, "Infection Control" with a revision date of 5/2023 revealed under "Standard Explanation and Compliance Guidelines #11. Equipment Protocol: e. All contaminated disposable items shall be discarded in a waste receptacle lined with a RED plastic bag". An observation and interview on 4/3/24 at 8:12 AM, revealed the Respiratory Therapist (RT) performed suctioning and trachea care on Resident #47. After the RT suctioned the resident's tracheostomy, she removed the suction connecting tubing that was placed inside the resident's trachea and placed it in the trash, allowing the suction tubing to fall and lay on the side of the resident's trash can that was full of trash. The RT went to the restroom, washed her hands, returned, placed gloves on and poured sterile water into a cup, picked up the suction tubing from the side of the trash can, suctioned some of the sterile water through the tubing and then wrapped the tubing around the suction canister and covered it in plastic. This observation revealed the suction canister was labeled and dated 4/1/24. An interview with the	F 880	On 4/3/2024, the Respiratory Therapist (RT) removed, discarded and replaced the contaminated suction tubing and tubing connector for resident #47. All residents that require respiratory care for suctioning have the potential to be affected. 6 residents that require respiratory care for suctioning have the potential to be affected. On 4/8/2024 the RT, removed, discarded and replaced suction tubing and tubing connector for 6 out 6 residents. All residents with a physician order for respiratory care for suctioning have the potential to be affected. On 4/5/2024, the Quality Assurance Committee reviewed the facility policy titled Infection Control- Equipment Protocol and Supplies Protocol with no recommended changes to the policy. On 4/10/2024, the Nurse Educator (NE) in-serviced 3 of 6 Respiratory Therapist and 14 of 23 Registered Nurses. All other Respiratory Therapist and Registered Nurses will be in-serviced prior to resident care assignment. The NE will observe respiratory care for suctioning, monitoring for proper infection control on 3 residents 2 times a week for 4 weeks, then 1 time a week for 4 weeks or until the stated deficient practice has been resolved and/or until 100% compliance is achieved. Observations	

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F 880	Continued From page 5 RT revealed she covered it to be used for the next suctioning. She stated the suction tubing and canister get changed weekly and is due to be changed on 4/8/24. She confirmed that the end of the suction tubing that would have connected to the suction connector had touched the trash can and could have caused an infection. She revealed the tubing should have been changed, instead of wrapping it up for it to be used the next time. An interview on 4/3/24 at 9:30 AM, with the Infection Preventionist confirmed the suction tubing touching the trash can in the resident's room should have been changed, because that would have been a break in infection control. She stated it was dirty and could have caused a problem. An interview on 4/3/24 at 12:05 PM, with Director of Nurses (DON) confirmed that the suction tubing used to connect to the suction connector should have been changed after the tip of the suction tubing touched the resident's trash can because that could have caused an infection. Record review of Resident #47's "Order Summary Report" revealed a physician's order dated 9/30/21 to ensure proper storage, stocking and covering of respiratory therapy equipment in residents' room every shift. Record review of Resident #47's "Admission Record" revealed the resident was admitted to the facility on 8/25/21 with medical diagnoses that included Cerebral Infarction and Tracheostomy Status.	F 880	began on 4/15/2024. Negative findings will be addressed immediately. Beginning on 5/6/2024 and for the next 2 months, the Quality Assurance Committee will review the data obtained from the NE quality assurance audits, analyzing for patterns/trends. The Quality Assurance/Performance Improvement Committee will make recommendations as needed. 5/6/2024	