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	255312	A. BUILDING _____ B. WING _____	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNION CO HEALTH AND REHAB CENTER, INC	1111 BRATTON ROAD NEW ALBANY, MS 38652

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification at the facility from 8/05/24 through 8/08/24. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550, F580, F584,and F880. The facility held a license for 60 beds, with a census of 47.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		9/20/24

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

Electronically Signed | 08/23/2024

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F 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to promote the dignity of a resident who was observed with a urinary catheter with no privacy bag for (1) one of (5) five residents with catheters. (Resident #26) Findings include: A review of the facility policy titled, "Dignity," dated February 2021, revealed "Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction, with life, and feeling of self-worth and self-esteem....Policy Interpretation and Implementation...12. a. Helping the resident to keep urinary catheter bags covered." An observation of Resident #26 from the open doorway of her room on 8/5/24 at 10:10 AM, revealed the resident to have a urinary catheter with no privacy bag hanging on the side of the	F 550	F550 * On 8/5/2024 Charge Nurse, Registered Nurse (RN) did place a privacy bag over resident #26"s urinary catheter bag to ensure resident #26 is cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction, with life, and feeling of self-worth and self-esteem. * All residents with a urinary catheter bag could be affected by this deficient practice of not covering resident urinary catheter bags when in use. * Unit one Charge Nurse (RN), License Practical Nurse (LPN) and Certified Nursing Assistant (CNA), which were assigned to provide care to resident #26 were given an in-service on resident rights and dignity concerns related to covering urinary catheter bag with a privacy bag to promote resident rights and dignity	

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F 550	Continued From page 2 bed facing the doorway. An observation of Resident #26 on 8/05/24 at 12:00 PM, revealed the door to the room to be open, a catheter bag and catheter drainage tube were observed to contain light yellow colored liquid with no privacy bag in use. An observation of Resident #26 on 8/05/24 at 12:02 PM, with Certified Nurse Assistant (CNA) #2 she confirmed the urine in the catheter bag was visible from the resident's doorway and that there was no privacy bag in use for the catheter. She revealed that it was a dignity issue because the bag with urine was visible from the doorway and stated anyone walking by could see it. Review of the "Order Summary Report" with active orders as of 8/6/24, revealed an order dated 8/2/24 "Urinary Catheter ...related to Obstructive and Reflux Uropathy" In an interview with Licensed Practical Nurse (LPN) #2 on 8/06/24 at 9:27 AM, she revealed all residents with catheters should have a privacy bag in place to keep others from seeing the urine for the resident's dignity. In an interview with the Infection Preventionist on 8/06/24 at 9:33 AM, she confirmed that Resident #26 should have had a privacy bag covering her catheter bag to promote dignity. Review of the "Admission Record" revealed Resident #26 was admitted by the facility on 7/17/20 with diagnoses that included Obstructive and Reflux Uropathy.	F 550	concerns by the Quality Assurance Nurse (QA) on 8/5/2024. Staff received in-service on resident rights on August 13, 2024 and August 14, 2024, conducted by Quality Assurance Performance Improvement (QAPI) Nurse. Resident #26 was monitored daily for negative signs and symptoms of psyco-social well being by the QAPI Nurse or Charge Nurse starting on 8/9/2024 and ending on 8/16/2024. No negative signs or symptoms have been noted. * All resident rooms in the Facility will be divided between ten (10) key staff, Minimum Data Set nurse (MDS), Admissions Nurse, Infection Control Nurse, Staff Development Nurse, Restorative Nurse, Quality Assurance Performance Improvement Nurse (QAPI), Medical Records Nurse, Activities Director, and Social Services Director. The Administrator, DON, or Business Office Manager (BOM) will substitute when there is an absence of one of the key staff. Each key staff member identified will inspect their assigned rooms per the facility room inspection form with focus on compliance on resident rights and dignity. Completed inspection sheets will be turned into the Administrator or DON daily, five times per week, for four weeks starting August 12, 2024 and then twice a week on starting September 9th, 2024, for four weeks. The Administrator or DON will review completed Facility room inspection sheets and assign corrective actions to appropriate department, i.e., Housekeeping, Maintenance and Nursing.	

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F 550	Continued From page 3	F 550	Upon completion of corrective action, individual completing task will sign Facility inspection sheet and return to Administrator or DON. The Administrator and/or DON will spot check at least two resident rooms per week, starting August 12 ending Oct 1st, 2024 and record results on Facility room inspection form and assign corrective actions to appropriate personnel if needed and then verify completion. The Administrator and/or Director of Nurses (DON) will present findings of daily resident room round inspection sheets to the QA Committee for review monthly starting in August 30, 2024 thru November 2024, at which time Facility will resume Quarterly QA meeting to discuss effectiveness of QA programs and make recommendations to modify or change QA program as it relates to resident rights and Dignity. The QA Committee and Medical Director met on 8/9/2024 to discuss and implement this plan to correct.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		9/20/24

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F 580	Continued From page 4 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and	F 580	F580	

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F 580	Continued From page 5 facility policy review, the facility failed to notify the physician before holding a resident's long-acting insulin for (1) one of 14 residents reviewed. (Resident #30) Findings include: Review of the facility policy titled, "Change in a Resident's Condition or Status," revised February 2021 revealed "Policy Statement: Our facility promptly notifies the attending physician ... of changes in the resident's medical/mental condition and/or status ...." Review of the August 2024 Medication Administration Record for Resident #30 revealed Insulin Glargine Solution Pen-Injector 100 unit/milliliters (ml)-Inject 40 units subcutaneously two times a day related to Type 2 Diabetes was not administered on 8/1/24-8/4/24 at 2100 hours (9:00 PM) and 8/5/24 at 0600 hour (6:00 AM). An interview with the Director of Nursing (DON) on 8/07/24 at 9:09 AM, revealed that she spoke with Licensed Practical Nurse (LPN) #4, and she stated that she had held the scheduled insulin Glargine on those days because Resident #30's blood sugars were low and stated she had notified the charge nurse of the blood sugars but did not notify the physician. The DON confirmed that LPN # 4 should not have held the long-acting insulin Glargine without notifying the physician. LPN #4 was not available for an interview during the survey. In an interview with LPN #3 on 8/7/24 at 9:45 AM, she revealed she would notify the physician before holding a scheduled long-acting insulin and stated that the physician would be notified of	F 580	* On 8/7/24 the Director of Nurses (DON) notified the physician by telephone that the medication nurse had failed to notify the physician that Glargine, a scheduled long acting insulin, had been withheld on 8/1/24 thru 8/4/24 and again on 8/5/24 from resident #30, because of low blood sugar values at the times Glargine was to be administered, review of the medical record by the DON indicated no adverse events were experienced by resident #30 because the medication was with held. The physician gave DON instructions to be called before withholding Glargine in the future. * All residents receiving scheduled insulin in the Facility could be affected by this deficient practice. * LPN Nurse #4 received a one on one in-service on 8/8/24 at 2000 hours by the DON on the requirement of notifying the residents physician before withholding scheduled insulin. Medication nurses received an in-service on 8/7/24 by the DON on the requirement to notify residents physician before with holding scheduled insulin. * Starting on 8/12/24 the Quality Assurance (QA) nurse will audit the medical record of residents receiving insulin daily to insure physician was notified if insulin was withheld and record results on Insulin administration worksheet. In the event the QA nurse is absent, the charge Nurse, Registered Nurse (RN) will conduct the audit. These	

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F 580	Continued From page 6 any changes in the resident's condition. A phone interview with the Nurse Practitioner on 8/7/24 at 10:14 AM, confirmed she was made aware that Resident #30 had recent episodes of low blood sugars at night but confirmed she was not notified that the staff were not giving her long-acting insulin Glargine because of low blood sugars. She revealed the long-acting insulin Glargine would not have affected the low blood sugars, and she should have been notified before holding the insulin because she would have instructed staff not to hold the insulin. Review of the "Admission Record" revealed Resident #30 was admitted by the facility on 3/29/23 with diagnoses that included Type 2 Diabetes Mellitus. Record review of Resident #30's of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/2/24, Section C revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident was severely cognitively impaired. Section N0350 Insulin Injections : coded received seven injections during the last 7 days.	F 580	audits are to be conducted five days a week for four weeks and then once a week thru December 31, 2024, beginning on 8/12/24. Results of the audits will be reported to the Administrator or DON the day of completion. The QA Committee met on 8/9/24 to discuss this plan of correction for nursing staff failing to notify the physician when with holding scheduled insulin. The actions proposed have been discussed and recommended by the QA Committee. The Administrator or DON will present results of daily audits to the QA Committee monthly starting on August 30, 2024 and then starting Quarterly in December of 2024. At monthly Quality Assurance (QA) a meeting, effectiveness of actions taken with our current plan of correction will be discussed, evaluated and changes recommended if warranted.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584		9/20/24

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F 584	Continued From page 7 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident, and staff interviews and facility policy review, the facility failed to maintain the building in a safe manner for one (1) of 47 resident rooms observed. (Resident #41).	F 584	F584 * The metal frame surrounding the sprinkler system control access panel in the room of resident #41 was bent back to its original position which will prevent any injury to a resident if they come in contact	

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F 584	Continued From page 8 Findings include: Record review of the facility policy titled, "Maintenance Service "undated, revealed " ...Policy Interpretation and Implementation 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times ..." An observation on 8/5/24 at 10:30 AM, of Resident #41's room revealed a 22 inch by 10 inch panel surrounded with a one (1) and one-half (1/2) inch metal frame on the wall that was one (1) inch above the headboard of the resident's bed. A three (3) inch section of the bottom part of the metal frame was noted to be bent and protruding outward from the wall. During an interview on 8/5/24 at 10:32 AM, with Resident #41 stated that the metal frame of the panel had been bent for quite some time, but she could not recall how long. In an interview on 8/5/24 at 10:40 AM, with the Maintenance, he stated that the panel was the door to the sprinkler system controls and that he was not aware that the metal frame was bent. He agreed that the metal frame protruding from the wall was dangerous and could cause an injury to the resident. On 8/5/24 at 11:00 AM, during an interview with Certified Nursing Assistant (CNA) #1, she stated that she did notice that the metal frame of the sprinkler panel was bent, protruding outward from the wall this morning, and she should have notified the Charge Nurse, but she did not. She stated that the bed did have a metal bar to keep	F 584	with the panel. * Resident #41's is the only resident room in the Facility that has a control valve door access panel which could possibly cause harm or injury to a resident. * On 8/9/24 Maintenance staff examined each and every resident room in the Facility to determine if there were other resident rooms with the same or similar hazards and found none. A new sprinkler system control panel and door was installed in resident #41's room by Facility maintenance staff on 08/12/2024. Maintenance staff received an in-service on 8/9/2024 by the Administrator on how to identify hazards to resident safety in resident rooms. * Maintenance staff will inspect/examine all Facility resident rooms for unsafe equipment or hazards once a day for five days each week starting 8/12/24 for four weeks and then once a week until December 31, 2024. Results of these inspections/examinations will be recorded on a Facility room inspection sheet and turned into the Administrator or Director of Nurses (DON) upon completion. The Administrator or DON will present findings of maintenance room inspections/examinations to the Quality Assurance (QA) Committee monthly from August 30, 2024 thru November 2024, and then quarterly as part of Facilities ongoing maintenance/safety program. Information provided by the Administrator or Director of Nurses (DON) will be	

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F 584	Continued From page 9 the headboard from hitting the wall, but it is only used if the resident has a trapeze bar or equipment that may damage the wall. She denied knowing that the metal bar needed to be down on Resident #41's bed to prevent it from bending the sprinkler panel frame. In an interview on 8/6/24 at 8:45 AM, with the Housekeeper, she stated that she usually cleans Resident 41's room and that she had never noticed the sprinkler panel frame being bent. The Housekeeper also stated that she was not aware of the metal bar on the bottom of the bed that would keep the headboard from hitting the bed, and that no one ever informed her that it needed to be down to prevent Resident 41's headboard from hitting the sprinkler panel frame. During an interview on 8/6/24 at 9:23 AM, the Director of Nursing (DON) stated she was not aware that there was a sprinkler panel located in Resident 41's room or that the metal frame around the panel was bent. She stated she was not aware that the metal bar on the frame of the bed should have been down to prevent the headboard from hitting and bending the sprinkler panel frame. The DON agreed that there was nothing in place to prevent the headboard from bending the metal frame on the sprinkler panel and that it was dangerous and could cause an injury to the resident. Record review of the "Admission Record" revealed Resident #41 was admitted to the facility on 3/20/2024 with diagnoses that included Cerebral Infarct. Record review of the Quarterly Minimum Data Set Assessment (MDS) with an Assessment	F 584	reviewed by the Quality Assurance (QA) Committee to determine effectiveness of the facility plan of correction and recommend modifications or changes if warranted. The QA Committee met on 8/9/2024 and discussed and recommend this plan to correct this deficiency.	

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F 584	Continued From page 10 Reference Date (ARD) of 6/26/24 revealed, Resident 41's Brief Interview for Mental Status (BIMS) score was 12, indicating that she had moderate cognitive impairment.	F 584		
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	F 880		9/20/24

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F 880	Continued From page 11 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 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 the spread of infection as evidenced by a urinary catheter bag and drainage tubing laying on the floor for (Resident	F 880	F880 * On 8/7/24 medication nurse removed catheter tubing from the floor and positioned it so as it did not touch the floor. License Practical Nurse #1 was	

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	255312	A. BUILDING _____ B. WING _____	08/08/2024

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F 880	Continued From page 12 #26) and failure to perform hand hygiene after handling a urinary catheter bag during wound care for (Resident #38) for (2) two of (7) seven care area observations. Findings include: A review of the facility policy titled, "Urinary Tract Infections (Catheter-Associated). Guidelines for Preventing," revised September 2017, revealed "Purpose: The purpose of this procedure is to guide guidelines for the prevention of catheter-associated urinary tract infections ...Steps in the Procedure ... 4. Always practice vigilant hand hygiene and standard precautions when handling catheter systems ...6. c. Do not place the drainage bag on the floor..." A review of the facility policy titled, "Changing a Dressing," undated, revealed Procedure Guideline for Changing a Dressing: 1. Perform hand hygiene ...14. Dispose of the gloves and soiled dressing ... Perform hand hygiene ... Apply clean gloves...16. Dispose of gloves and perform hand hygiene..." Resident #26 In an observation of Resident #26 on 8/5/34 at 10:10 AM, the resident was observed to have a urinary catheter hanging on the right side of the bed, with the bottom of the catheter bag and drainage tubing observed sitting on the floor beside the bed. An observation of Resident #26 on 8/05/24 at 12:00 PM revealed a catheter bag and catheter drainage tube to be sitting on the floor.	F 880	administered a one on one in-service on proper hand hygiene by the Director of Nurses (DON) on 8/7/24. * All residents receiving personal care, wound care or having a catheter could be subject to negatives outcomes related to these deficient practices. * On 8/9/24 the DON and the Quality Assurance (QA) Nurse assessed resident #26 and #38 for possible signs and symptoms of negative outcomes related to the catheter tubing and or bag touching the floor or failure of LPN #1 to perform proper hand hygiene while executing wound care on resident #38. No negative outcome was noted during the assessment. LPN #1, LPN #2, and CNA #2 received an in-service on 8/9/24 by Facility QA Nurse on Infection control policies and procedures, possible negative infection control outcomes of failure to perform proper catheter care and hand hygiene when providing care to residents. Facility Direct Care Staff, Nurses, and CNA's received in-service on August 8/9/24 by the QA Nurse covering the requirements of Facility Infection control policy and procedure. * Key staff will observe for catheter bags or tubing touching the floor each day, five times weekly, for a period of six weeks starting 8/12/24 thru November 29th, 2024, then twice a week during routine Facility room round inspections through 12/31/24, documenting results on the facility room rounds sheet and turning the	

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F 880	Continued From page 13 An observation of Resident #26 on 8/05/24 12:02 PM with Certified Nurse Assistant (CNA) #2 confirmed the bag should not be hanging down touching the floor because it was an infection control concern. In an interview with Licensed Practical Nurse (LPN) #2 on 8/06/24 at 9:27 AM revealed that catheters should not be touching the floor because it increases the risk of the transmission of infection. In an interview with the Infection Preventionist on 8/06/24 at 9:33 AM, she confirmed that Resident #26 catheter bag should never be touching the floor because of what might be on the floor and increases the risk of transmission of infection. Review of the "Admission Record" revealed Resident #26 was admitted by the facility on 7/17/20 with diagnoses that included Cerebral Infarction. Resident #38 An observation of wound care for Resident #38 on 8/7/24 at 10:15 AM, with LPN #1 revealed she entered the room, sanitized her hands and applied gloves, she then picked up the resident's catheter bag and sat in on the side of the resident's bed. She then continued setting up the wound supplies on the bedside table on a clean barrier after handling the catheter bag that was laying on the floor. LPN #1 then cleansed Resident #38's wound bed to his sacrum and applied the clean dressing supplies with the same gloves that were placed on her hands when she initially entered the room.	F 880	room round sheet into the Administrator or DON upon completion. The QA or infection control Nurse will observe wound care with focus on hand hygiene compliance once a day for five days weekly, beginning 8/12/24, for six weeks, ending 11/29/24, then resume QA/infection control observations on 11/30/24, through 12/31/24 once weekly, documented on Infection Control Audit sheet and reporting results to the Administrator or DON upon completion. The QA Committee will meet monthly for four months beginning in August 30, 2024 and ending in November 2024. The QA Committee will then resume the Quarterly meeting scheduled in December 2024. QA Committee may meet additional times if a special meeting is needed and called by any member of the QA Committee. The Administrator or DON will present results of the Catheter and infection control observations at each meeting of the QA Committee. Should it be necessary as QA Committee reviews observations, audits and infection control performance in the Facility, the QA Committee will recommend modifications or changes to Facility plan to correct deficient practices. The QA Committee met on 8/9/24 and discussed and recommended the above actions.	

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F 880	Continued From page 14	F 880		

In an interview with LPN #1 on 8/7/24 at 10:30 AM, she confirmed she did not perform hand hygiene after handling the catheter bag and cleaning the sacral wound bed. She also confirmed she did not perform hand hygiene before applying the clean dressing to the sacral wound bed. She then revealed by failing to perform hand hygiene, she placed the resident at risk for the transfer of bacteria to the wound and increased the risk for a wound infection.

In an interview with the Director of Nursing (DON) on 8/07/24 at 10:32 AM, she confirmed that hand hygiene should have been performed after handling the catheter bag and during wound care. She revealed by not performing proper hand hygiene that it placed the resident at increased risk for infection.

Review of the "Admission Record" revealed Resident #38 was admitted by the facility on 9/29/23 with diagnoses of Pressure ulcer of unspecified buttock, unspecified stage and Neuromuscular dysfunction of bladder.

Record review of Resident #38's the Minimum Data Set (MDS) with an Assessment Reference Date of 5/07/24, Section C , revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was severely cognitively impaired .... Section H0300: was coded Resident #38 had a catheter for last seven days.... Section M0300 : was coded Resident #38 had one Stage 3 pressure ulcer.