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	255101	A. BUILDING _____ B. WING _____	09/13/2024

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MCCOMB NURSING AND REHABILITATION CENTER LLC	415 MARION AVE MCCOMB, MS 39648

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and Complaint Investigations (CIs), MS #26374, MS #26386, CI MS #26295 and CI MS #25712, at the facility from 09/09/24 through 09/13/24. CI MS #26374 was investigated for verbal abuse, neglect, nursing services, and resident not being treated with dignity and respect. CI MS #26295 was investigated related to neglect and quality of care related to medication administration. CI MS # 25712 was investigated related to resident rights regarding privacy and CI MS #26386 was investigated related to misappropriation of resident property. There were no citations related to the complaint investigations. 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 F625, F656, F677, F690, F695, F880. The facility is licensed for 140 beds and at the time of the survey the census was 104.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing	F 625		10/23/24

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

Electronically Signed | 10/03/2024

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F 625	Continued From page 1 facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to provide the resident or the Resident Representative (RR) with written notification of the bed-hold policy at the time of transfer for one (1) of one (1) sampled residents reviewed for hospitalization. Resident #18. Findings Include: Record review of a typed statement on facility letterhead, dated September 13, 2024, and signed by the Administrator revealed, "(Proper name of facility) does not have a policy regarding bed holds." On 09/13/24 at 8:16 AM, during an interview with the RR for Resident #18, he stated that he did not receive a call from the Business Office Manager (BOM) or anyone from the facility regarding his father's bed hold for the hospital transfer that	F 625	Please consider this plan of correction as McComb Nursing and Rehabilitation Center, LLC, credible allegation of compliance. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare and Medicaid requirements. Submission of this plan of correction is not an admission that a deficiency exist or that the facility agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents and are submitted solely as a requirement of the provisions of Federal and State Law. Resident #18 Resident Representative	

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F 625	Continued From page 2 occurred on 09/10/24. The RR explained that no written notification or information was provided about the bed-hold process On 09/13/24 at 8:36 AM, during an interview with the BOM she revealed that she does not send out a bed-hold letter to families when residents are transferred to the hospital. She explained that residents and their families are given the bed-hold information upon admission to the facility. She stated that after each hospital transfer, she typically calls the family to notify them about the bed hold. When the State Agency (SA) requested a copy of the documented bed-hold notification in her system as proof of RR notification for Resident #18, the BOM admitted that she had not placed a note in the system. She also confirmed that she does not document bed-hold notifications in the system for any residents. On 09/13/24 at 11:02 AM, during an interview with the Administrator, she explained that the facility's procedure for notifying families of bed holds occurs upon admission. She stated that she was unaware that the facility was required to provide bed-hold notification at each hospital transfer. The Administrator acknowledged that the facility did not have a policy regarding bed-hold notifications for hospital transfers. A record review of the "After Visit Summary" revealed that Resident #18 was transferred to the hospital on 09/10/24 and returned to the facility on 09/12/24. A record review of the "Admission Record" revealed that the facility admitted Resident #18 on 01/10/2022 with diagnoses that included Atrial	F 625	was contacted on September 25, 2024 by the Business Office Manager to inquire if the Resident Representative desired a bed hold for Resident #18 due to his transfer to the hospital on September 10, 2024. The results of the telephone conversation with the Resident Representative was documented in the business office notes. An audit performed by the Executive Director on September 25, 2024 revealed the Resident Representatives of the residents that were currently in the hospital on September 25, 2024 had been notified of the bed hold policy and written documentation was observed regarding notification and the status of the bed hold. Residents of the facility that transfer to the hospital have the potential to be affected. The Executive Director in-serviced the Business Office Manager and the Assistant Business Office Manager on September 18, 2024 regarding contacting the Resident Representative of each resident that is transferred to the hospital and obtaining written documentation regarding the bed hold status or documenting the bed hold decision in the business office notes for each resident. The Executive Director will perform audits regarding bed hold communication and documentation on each resident that is transferred to the hospital beginning September 18, 2024 for five (5) days a week four (4) weeks and one (1) time weekly for two (2) months to ensure the	

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F 625	Continued From page 3 Fibrillation and Heart Failure. A record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/11/24 revealed that Resident #18 had a Brief Interview for Mental Status (BIMS) score of fourteen (14), which indicated the resident was cognitively intact.	F 625	Resident and/or Resident Representative is contacted and written documentation is available regarding the bed hold status. The Executive Director will present the results of the audits to the Quality Assurance Committee on October 22, 2024 and then for two (2) consecutive months. The Quality Assurance Committee and make recommendations as necessary.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		10/23/24

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F 656	Continued From page 4 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and facility policy review, the facility failed to implement the care plan interventions as reflected in the resident's comprehensive Care Plan related to a fall for one (1) of twenty-three (23) sampled residents. Resident #37. Findings Include: A review of the facility's policy titled "Comprehensive Person Centered Care Plans," (D.3) dated 3/18, revealed, "Each resident will have a person centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care ...Definitions ...Comprehensive Person Centered Care Plan (CCP) - contains services provided, preference,	F 656	On September 12, 2024 a Dycem non-slip mat was applied to Resident #37's wheelchair. Residents that are care planned for fall interventions have the potential to be affected. Nursing staff were in-serviced on September 25, 2024 - October 1, 2024 by the Director of Nursing and Nursing Supervisors regarding ensuring fall interventions that are documented on the residents care plans are implemented and in place. On September 25, 2024 thru September 30, 2024, all residents with fall interventions documented on the care plan were observed to ensure the fall	

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F 656	Continued From page 5 ability, goals for admission and desired outcomes, and care level guidelines ...Procedure: ...4. The Interdisciplinary Team along with the resident and /or Resident Representative will identify resident problems, needs, strengths, life history, preferences, and goals ..." A record review of Resident #37's care plan with a start date of 5/7/2024 revealed "(Proper name of Resident #37) has the potential for falls ...Intervention: Dycem to w/c (wheelchair) ..." A record review of Resident #37's care plan with a start date of 5/7/2024 revealed "(Proper name of Resident #37) has a self care deficit ...Intervention: Dycem to w/c ..." During an interview on 09/12/24 at 9:13 AM, Certified Nursing Assistant (CNA) #1 stated that she had not witnessed any falls during the day shift but recalled receiving a report of a fall approximately two weeks ago. She confirmed that there was not a Dycem non-slip mat in the Resident #37's wheelchair. On 09/12/24 at 9:15 AM, during an interview and observation with Licensed Practical Nurse (LPN) #3, she explained that the staff assisted the resident whenever she called and routinely asked if she needed to be repositioned, even when performing other tasks in the room. She emphasized reminding the resident to use the call light and avoid getting up without assistance. LPN #3 confirmed that there was not a Dycem nonslip mat in the resident's wheelchair. During an interview on 09/12/24 at 9:40 AM, with the Speech Therapist (ST), Director of the Therapy Department, she explained that they	F 656	interventions were in place. The Director of Nursing and/or Nursing Supervisors will observe ten (10) residents daily beginning September 30, 2024 for four (4) weeks and then weekly for four (4) weeks to ensure fall interventions documented on the resident care plan are in place. The Director of Nursing will present the results of the observations to the Quality Assurance Committee on October 22, 2024 and then for (2) consecutive months. The Quality Assurance Committee will make recommendations as necessary.	

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F 656	Continued From page 6	F 656		

held weekly Interdisciplinary Team (IDT) fall meetings to review falls, assess previous interventions, and analyze the circumstances leading to each fall. She remarked, "You can't stop a fall, but the purpose of these interventions is to minimize the risk and keep residents safe." The ST emphasized that failing to follow recommendations could compromise both resident and staff safety.

On 09/13/24 at 9:14 AM, Resident #37 was observed asleep in her bed, with her wheelchair positioned at the bedside. There was not a non-slip mat (Dycem) noted in the resident's wheelchair as indicated as an intervention on the care plan.

A record review of Resident #37's "Order Summary Report" with active orders as of 9/13/24, revealed an order dated 8/20/24 "Skilled Physical Therapy four (4) times a week for six (6) weeks, including therapeutic exercise, therapeutic activities, neuromuscular reeducation, gait training, moderate complexity evaluation, electrical stimulation, ultrasound, and short-wave diathermy for diagnoses of Muscle Weakness (M62.81) and Difficulty Walking (R26.2)."

A record review of Resident #37's "Admission Record" revealed the facility admitted the resident on 5/27/24 with diagnoses that included Unspecified Dementia, with other behavioral disturbance and Other symptoms and signs involving the musculoskeletal system.

A record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/2/24, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of

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F 656	Continued From page 7 8, which indicated the resident had moderate cognitive impairment. Review of Section J revealed that the resident had experienced two (2) or more fall since admission without injury.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide timely incontinence care and oral care for one (1) of four (4) residents reviewed for activities of daily living (ADL) care. Resident #73 Findings Include: A review of the facility's policy titled "A.M. Care," dated 10/09, revealed: "Policy: A.M. Care will be given to residents daily. Responsibility: All Nursing Assistants ..." On 09/09/24 at 11:48 AM, during an interview, the Resident Representative (RR) of Resident #73 stated that the Certified Nursing Assistants (CNAs) did not regularly brush her daughter's teeth or wash her hair. She explained that her daughter was unable to perform personal care independently and could not feed herself. The RR expressed her wish was that staff would more consistently perform these tasks. On 09/09/24 at 11:52 AM, an observation revealed Resident #73's RR brushing and	F 677	Resident #73 was provided oral care, peri-care and her hair was washed on September 13, 2024 by the Certified Nursing Assistant. Residents that require assistance with activities of daily living (ADL) care have the potential to be affected. Nursing staff were in-serviced by the Nursing Supervisors, the Certified Nursing Assistant Coordinator, and the Director of Nursing on September 17, 2024 thru September 24, 2024 regarding providing residents timely peri-care, hair washing and oral care. All residents requiring assistance with ADL care were observed on 9/26/2024 to ensure timely peri-care, oral care and hair washing was performed. The Nursing Supervisors and the Director of Nursing will observe fifteen (15) residents a day beginning on September 27, 2024 for four(4) weeks and then	10/23/24

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F 677	Continued From page 8 flossing the resident's teeth. The resident's hair appeared short and oily. On 09/12/24 at 2:39 PM, during an interview, CNA #4 stated that ADL care, which includes perineal care, tooth cleaning, and hair care, is performed daily. She explained that if residents refuse care, the refusal is documented in the CNA book, and occasionally the nurse is notified. On 09/13/24 at 9:52 AM, during an observation and interview with Licensed Practical Nurse (LPN) #6, the Unit Manager, he explained that ADL care includes cleaning the face and brushing the teeth and should be completed before breakfast. He noted that Resident #73's hair was oily and could benefit from a wash. He emphasized that he expects CNAs to provide total ADL care. On 09/13/24 at 10:07 AM, during an interview, CNA #1 stated that she washed Resident #73's face before breakfast and would perform peri-care once the resident got up. She initially stated that she had completed all ADL care for Resident #73 but later admitted that she had not brushed the resident's teeth or washed her hair that day or week. She confirmed that both tasks should have been completed. On 09/13/24 at 1:15 PM, during an interview, the Director of Nursing (DON) confirmed that ADL care includes brushing teeth and washing hair as needed. She emphasized that CNAs are responsible for ensuring that residents' nails are clean and that all aspects of ADL care are performed. A record review of Resident #73's "Admission	F 677	weekly for two months to ensure residents receive timely ADL care. The Director of Nursing will present the results of the observations to the Quality Assurance Committee on October 22, 2024 and then for two (2) consecutive months. The Quality Assurance Committee will make recommendations as necessary.	

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F 677	Continued From page 9 Record" revealed that the facility admitted the resident on 7/28/22 with diagnoses that included Hemiplegia, Unspecified Affecting the Left Non-Dominant Side and Unspecified Intellectual Disabilities. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/29/24 revealed Resident #73 had a Brief Interview for Mental Status (BIMS) score of 99, indicated the resident could not participate in the interview. Section GG of the MDS revealed that Resident #73 is dependent on staff for oral hygiene, showering, and hair care.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		10/23/24

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F 690	Continued From page 10 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record reviews, and facility policy review, the facility failed to provide urinary catheter care in a manner that prevents possible complications for one (1) of one (1) residents reviewed for urinary catheter care. Resident #18. Findings Include: A review of the facility's policy titled "Catheter Care," dated 5/22, revealed, "Catheter care is performed to keep the catheter insertion site clean ...3. Cleanse around the area where the catheter enters the urethral meatus with an incontinent wipe in a downward motion about 4 inches ... Discard soiled incontinent wipes and plastic bag appropriately." On 09/09/24 at 02:38 PM, during an observation and interview, it was noted that Resident #18 had a urinary catheter. The resident was unable to recall how long he had a urinary catheter, however, he stated that it had been "for some time."	F 690	The Certified Nursing Assistant #2 that provided catheter care to Resident #18 was in-serviced and checked off with return demonstration regarding providing urinary catheter care in a manner that prevents possible complications on September 13, 2024 by the Certified Nursing Assistant Coordinator. Residents that require bowel/bladder incontinence care and catheter care have the potential to be affected. All Certified Nursing Assistants were checked off on incontinent care including urinary catheter care with return demonstration by the Certified Nursing Assistant Coordinator on September 17, 2024 thru September 25, 2024. All Certified Nursing Assistants were in-serviced on September 25, 2024 thru September 30, 2024 by the Director of Nursing and Nursing Supervisors regarding the importance of performing	

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F 690	Continued From page 11 A record review of "Order Summary Report", with active orders as of 9/13/24, revealed Resident #18 had a physician order, dated 8/15/24, for urinary catheter and another order, with the same order date, for urinary catheter care every twelve (12) hours as needed. On 09/13/24 at 10:25 AM, during an observation of perineal care, including urinary catheter care provided for Resident #18 by Certified Nursing Assistant (CNA) #2, revealed CNA #2 used the same area of the wipe with each stroke while cleaning the resident's penis. Rather than cleaning the resident's penis with a downward stroke, CNA #2 wiped from bottom to top. CNA #2 then cleaned the urinary catheter tubing, using a back to forth motion, once again using the same area of a single wipe. On 09/13/24 at 10:53 AM, during an interview, CNA #2 admitted that he should have used a clean wipe for each stroke and cleaned from the top to bottom, while providing perineal care to Resident #18. He acknowledged that his care could possibly cause complications. On 09/13/24 at 11:14 AM, during an interview, Licensed Practical Nurse (LPN) #5, the Infection Preventionist, confirmed that CNA #2 should have used downward strokes while cleaning the resident and used clean wipes with each stroke. She emphasized that improper cleaning could lead to complications. On 09/13/24 at 1:07 PM, during an interview, the Director of Nurses (DON) stated that she expected CNA #2 to perform care correctly, as taught during in-service training. She explained	F 690	urinary catheter care and incontinence care in a manner that prevents possible complications. The Director of Nursing and Nursing Supervisors will observe fifteen (15) residents daily for four (4) weeks beginning on September 26, 2024 and then weekly for two (2) months to ensure urinary catheter care and incontinent care are performed in a manner to prevent possible complications. The Director of Nursing will present the results of the observations to the Quality Assurance Committee on October 22, 2024 and then for two (2) consecutive months. The Quality Assurance Committee will make recommendations as necessary.	

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	255101	A. BUILDING _____ B. WING _____	09/13/2024

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F 690	Continued From page 12 that going from a dirty area to a clean area could possibly result in the resident developing a urinary tract infection (UTI) or skin irritation. A record review of Resident #18's "Admission Record" revealed that the facility admitted the resident on 1/10/22, The resident's diagnoses included Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Retention of Urine, and Urinary Tract Infection. A record review of Resident #18's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/11/24 revealed a Brief Interview for Mental Status (BIMS) score of fourteen (14), which indicated the resident was cognitively intact.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of 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 provide respiratory care in a manner to prevent the possibility of complications as evidenced by oxygen tubing that was not dated to indicate weekly oxygen tubing/nasal cannula changes and not cleaning the oxygen concentrator filter as	F 695	Resident #26 oxygen tubing was replaced with new tubing and dated on September 9, 2024 by the Director of Nursing. The oxygen concentrator filter for Resident #26 was cleaned on September 9, 2024 by the Licensed Practical Nurse.	10/23/24

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F 695	Continued From page 13 required for one (1) of one (1) resident reviewed for respiratory care. Resident #26 Findings Include: A review of the facility's policy titled "Oxygen Therapy," dated 8/14 revealed, "Oxygen (O2) is administered to promote adequate oxygenation and provide relief of symptoms of respiratory distress ...Procedure: ... 8. Change tubing weekly. 9. Date tube when changed (weekly)." On 9/9/24 at 10:30 AM, during an observation of Resident #26, who was sitting in her wheelchair in her room with a nasal cannula in her nose, it was noted that the oxygen tubing was not dated. On 9/9/24 at 10:35 AM, during an observation and interview with the Director of Nursing (DON), she explained that staff should write the date on a clear plastic bag when the tubing is changed weekly. Upon inspection of the bedside table, the DON pulled out two clear plastic bags, neither of which were dated. She confirmed that the bags should have been dated and that staff are expected to check the tubing and when not in use, store it in a clear plastic bag, which should be changed weekly to maintain infection control. She added that she expects staff to clean the filter when they change the tubing. On 9/9/24 at 10:40 AM, during an interview with Licensed Practical Nurse (LPN) #4, she stated that oxygen tubing is changed weekly for infection control purposes and should be dated when changed. On 9/9/24 at 12:55 PM, during an interview and observation with LPN #4, the oxygen concentrator	F 695	Residents that require the use of oxygen tubing have the potential to be affected. Residents that us an oxygen concentrator have the potential to be affected. On September 9, 2024 the Licensed Practical Nurses checked all concentrator filters to ensure they were clean and free from grey lint. On September 9, 2024 the Licensed Practical Nurses checked all oxygen tubing to ensure the oxygen tubing was dated. On September 19, 2024 the Nursing Supervisors performed a 100% audit regarding oxygen tubing and concentrator filters to ensure the oxygen tubing was dated and the concentrator filters were clean and free from grey lint. On September 10, 2024 thru September 13, 2024 the licensed nurses were in-serviced by the Nursing Supervisors and the Staff Development Nurse regarding ensuring concentrator filters are clean and the oxygen tubing is dated. The Director of Nursing and Nursing Supervisors will observe 10 residents beginning on September 26, 2024 with oxygen tubing and with concentrators daily for four (4) weeks and then weekly for two (2) months to ensure the tubing is dated and the oxygen concentrator filters are clean and free from grey lint. The Director of Nursing will present the results of the observations to the Quality Assurance Committee on October 22, 2024 and then for two (2) consecutive months. The Quality Assurance Committee will make recommendations	

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F 695	Continued From page 14	F 695		

filter for Resident #26 was found to have a moderate amount of grey lint along the edges and support grid. LPN #4 confirmed that the filter should have been cleaned when the tubing was changed. She acknowledged that the filter had not been cleaned, citing the amount of lint as evidence. She emphasized that cleaning the filter is necessary to ensure the resident receives clean air.

On 9/12/24 at 3:39 PM, during an interview with LPN #5, the Infection Preventionist (IP), he stated that the oxygen tubing is supposed to be changed weekly to prevent the buildup of bacteria and reduce the risk of respiratory infections for the resident.

On 9/13/24 at 9:56 AM, during an interview with LPN #6, Unit One Nurse Manager, he confirmed that oxygen tubing should be changed every Saturday night and dated to verify it had been changed. He explained that the tubing is replaced to protect the resident from infection and that the oxygen concentrator filter should also be cleaned at the same time, as it filters the air.

A record review of Resident #26's "Admission Record" revealed the facility admitted the resident on 2/9/24. The resident's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory Failure with Hypoxia, and Dependence on Supplemental Oxygen.

A record review of the "Order Summary report, with active order as of 9/1/24 revealed Resident #26 had a physician order, dated 2/9/24, to change the oxygen tubing and clean the oxygen filter every Saturday night.

as necessary.

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F 695	Continued From page 15 A record review of Resident #26's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/29/24 revealed a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated the resident was cognitively intact. Section O indicated that the resident was receiving oxygen therapy.	F 695		
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 §483.71 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	F 880		10/23/24

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F 880	Continued From page 16 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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to	F 880	The Certified Nursing Assistant Coordinator performed a check off	

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F 880	Continued From page 17 ensure proper hand hygiene and enhanced barrier precautions were followed prior to providing care for a resident with an indwelling catheter, for one (1) of one (1) resident observed for urinary catheter care. Resident #18. Findings Include: A review of the facility's policy titled "Enhanced Barrier Precautions" (EBP), dated 4/24, revealed " ... Definition: 1. Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDROs) in Nursing Homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk for MDRO acquisition (e.g. residents with wounds or indwelling medical devices) A review of the facility's policy titled "Catheter Care," dated 5/22 revealed, "Catheter care is performed to keep the catheter insertion site clean ...Procedure: 1. Complete perineal care. 2. Wash hands and apply gloves ..." A review of the facility's "Hand Washing" policy, dated 9/19, revealed "Staff are expected to use proper handwashing techniques to prevent the spread of infection ..." On 9/9/24 at 2:38 PM, prior to entering the room on Resident #18, signage of resident's door was observed. The sign indicated that the resident was on Enhanced Barrier Precautions and stated that everyone entering the resident's room must clean their hands when entering and leaving the	F 880	regarding incontinent care and hand washing with return demonstration from Certified Nursing Assistant #2 on September 13, 2024. The Director of Nursing in-serviced Certified Nursing Assistant #2 on enhanced barrier precautions and infection control procedures regarding hand washing and personal protective equipment on September 13, 2024. Residents requiring care from staff and residents that require enhanced barrier precautions have the potential to be affected. Nursing staff were in-serviced by the Nursing Supervisors on September 17, 2024 - September 25, 2024 regarding hand hygiene. Nursing staff were in-serviced regarding enhanced barrier precautions by the Staffing Coordinator and Nursing Supervisors on September 13, 2024 thru September 25,2024. Certified Nursing Assistants were checked off with return demonstration regarding hand hygiene by the Certified Nursing Assistant Coordinator on September 17, 2024 thru September 24, 2024. The Director of Nursing and Nursing Supervisors will observe ten (10) employees a day beginning September 26, 2024 for four (4) weeks and then weekly for two (2) months regarding hand hygiene and enhanced barrier precautions. The Director of Nursing will present the findings of the observations to the Quality Assurance Committee on	

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F 880	Continued From page 18 room. Further information intended for staff directed staff performing high-contact resident care activities to wear gloves and a gown. Upon entering the room, it was noted that Resident #18 had an indwelling urinary catheter. On 09/13/24 at 10:25 AM, during an observation of care provided by Certified Nursing Aide(CNA) #2, entered Resident #18's room without performing hand hygiene. Prior to beginning perineal care, CNA #2 applied gloves, however, CNA#2 did not put on a gown. During the procedure, CNA #2 did not remove his soiled gloves to open the drawer to the bedside table to retrieve additional supplies. At one point, CNA #3, who was assisting CNA #2, reminded CNA #2 to remove his gloves prior to opening the resident's closet door to retrieve a clean brief for the resident. CNA #2 removed his gloves, but failed to perform hand hygiene prior to applying clean gloves. On 09/13/24 at 10:53 AM, during an interview, CNA #2 admitted that he forgot to wear a gown and should have washed his hands prior to beginning care and after each glove change. He acknowledged that failing to wash his hands could increase the risk of infection to the resident. On 09/13/24 at 11:14 AM, during an interview, Licensed Practical Nurse (LPN) #5, the Infection Preventionist, confirmed CNA #2 failed to follow proper hand hygiene protocols. She emphasized that the CNA's failure to wear a gown and perform hand hygiene increased the risk of infection for Resident #18. On 09/13/24 at 1:07 PM, during an interview, the DON, also reiterated that by CNA #2 not wearing	F 880	October 22, 2024 and then for two consecutive months. The Quality Assurance Committee will make recommendations as necessary.	

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F 880	Continued From page 19 a gown and his lack of hand hygiene could increase the risk of infection for Resident #18, as well other residents receiving care provided by the CNA. A record review of Resident #18's "Admission Record" revealed that the facility admitted the resident on 1/10/22, The resident's diagnoses included Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Retention of Urine, and Urinary Tract Infection. A record review of Resident #18's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/11/24 revealed a Brief Interview for Mental Status (BIMS) score of fourteen (14), which indicated the resident was cognitively intact.	F 880		