STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255309	A. BUILDING _____ B. WING _____	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS HEALTH CENTER	2800 WEST MAIN STREET TUPELO, MS 38801

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 08/05/24 to 08/8/24. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid cited regulatory deficiencies F584, F641, F656, F677, F759, and F880. Census at the time of survey was 130 and the facility has beds for 140 residents.	F 000		
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 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	F 584		9/13/24

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

Electronically Signed | 08/25/2024

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F 584	Continued From page 1 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, staff and resident interview, record review and facility policy review, the facility failed to ensure a resident's wheelchair was in good repair for one (1) of 26 residents reviewed during survey. Resident #236 Findings Include: Review of facility policy titled, "Safe and Homelike Environment" date implemented 1/2024, revealed under the "Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belonging to the extent possible. This includes ensuring 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 ..." An interview and observation on 08/05/24 at 2:20 PM, with Resident #236 revealed she was	F 584	I. Resident #236's wheelchair arm was padded with a vinyl cushioned wrap on 8/6/24 by the Occupational Therapist working with Resident #236. Resident #236 refused to allow the arm of the chair or the wheelchair to be replaced at this time. The Occupational Therapist is working with a local durable medical equipment company to get Resident #236 a custom wheelchair. II. All Residents in a wheelchair have the potential to be affected. III. Two Maintenance Assistants evaluated every wheelchair on 8/6/24 to ensure all wheelchairs were in good repair. An inservice was initiated on 8/8/24 with the Therapy staff, Maintenance staff, and Certified Nursing Assistants to put in a work order or replace any wheelchair that might be in ill repair immediately. The Maintenance Director will add in the Preventative Maintenance Software	

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F 584	Continued From page 2 complaining of her wheelchair arm on the right side being messed up and bothering her. She stated that she had told the nurse twice, but no one has done anything. This observation revealed that the leather covering for the resident's right wheelchair arm rest was missing about three (3) to four (4) inches back from the front, exposing foam and metal that was rough to the touch in places. An observation and interview on 08/05/24 at 2:32 PM, with Certified Nurse Assistant (CNA) #1 confirmed that Resident #236's right wheelchair arm was torn. She stated she had not heard the resident complain. She stated that they could notify maintenance. The State Agency (SA) observed CNA #1 place a call to maintenance and reported Resident #236 needed a new wheelchair immediately. An interview on 08/06/24 at 10:09 AM with the Director of Therapy confirmed that Resident #236's right wheelchair arm torn, exposing foam and the metal was rough to the touch in places. She stated that the therapist had told her that the resident refused to have her wheelchair replaced, but wanted the arm fixed, but had failed to document any of that information. She admitted that the therapist should have documented something about the condition of the wheelchair. She stated that the therapist needed to make sure they are documenting issues like this because we want to be sure and provide the elders with all that they need. An interview with Occupational Therapy (OT) on 08/06/24 at 11:41 AM, confirmed that she noticed when she picked the resident up for therapy on 6/6/24 that her personal wheelchairs overall	F 584	Program to evaluate the functionality/condition of all wheelchairs once a quarter to ensure they remain in good repair. IV. The Administrator and Maintenance Director will monitor five wheelchairs a week starting the week of 8/19/24 for four weeks then five wheelchairs monthly for three months to ensure all wheelchairs remain in good repair. A Quality Assurance Performance and Improvement (QAPI) committee meeting is scheduled for 8/29/24, 9/12/24, and 9/26/24 to review and revise the plan of correction if additional concerns are identified through the wheelchair audits.	

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F 584	Continued From page 3 condition was not good but does not recall specifically noticing the condition of the right arm rest. She revealed she talked with the resident about getting a new wheelchair, but the resident declined. She admits that she never documented anything and confirmed that today the resident complained of her right wheelchair arm and noticed the armrest was in bad condition. An interview on 8/7/24 at 9:45 AM with the Administrator confirmed that the Resident #236's wheelchair arm should have been repaired. She revealed that her expectation was that staff would document that the resident and family had been spoken with about getting a new chair, plus "we have plenty of wheelchairs here, it could have been replaced." Record review of Resident #236's "Admission Record" revealed the resident was admitted to the facility on 3/1/24 with medical diagnoses that included Muscle Weakness.	F 584		
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 staff interview, record review, and facility policy review, the facility failed to accurately submit information into the Minimum Data Set (MDS) assessment system for one (1) of 26 residents sampled. Resident #34 Findings include:	F 641	I. A modification was completed of the Minimum Data Set (MDS) assessment for Resident #34, to correct the MDS assessment on 8/7/24 by the Registered Nurse MDS Coordinator to ensure Ozempic was not coded as an insulin injection. II. All residents receiving the Ozempic	9/13/24

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F 641	Continued From page 4 Record review of facility policy titled, "Conducting an Accurate Resident Assessment", dated October 2023, revealed, " ...The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. "Accuracy of assessment" means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) ..." Record review of Center for Medicare and Medicaid Services (CMS)'s Resident Assessment Instrument (RAI) dated October 2023 revealed, "Insulin is a medication used to treat diabetes mellitus (DM). Steps for Assessment: 1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days). 2. Determine if the resident received insulin injections during the look-back period. 3. Determine if the physician ... changed the resident's insulin orders during the look-back period. 4. Count the number of days insulin injections were received and/or insulin orders changed...." Record review of Resident #34's Order Review History Report for May 2024 revealed no order for Insulin. Review revealed an order for Ozempic dated 9/29/23 to be given every seven (7) days. Record review of Resident #34's Minimum Data Set (MDS) with Assessment Reference Date	F 641	injection were identified as having the potential to be affected. III. The Registered Nurse MDS Coordinators were inserviced on the completion of accurate MDS assessments by the Regional Corporate Registered Nurse Consultant on 8/7/24. All residents with orders for Ozempic were evaluated for accurate coding by the MDS Coordinators on 8/7/24. IV. The Director of Nursing or the Assistant Director of Nursing began monitoring medication orders weekly for four weeks starting on 8/9/24 to observe for any Ozempic orders. If any resident has an order for Ozempic the Director of Nursing or Assistant Director of Nursing will audit the MDS assessment to ensure the medication was not coded as an insulin injection. A Quality Assurance Performance and Improvement (QAPI) committee meeting is scheduled for 8/29/24, 9/12/24, and 9/26/24 to review and revise the plan of correction if additional concerns are identified through the audit. The Director of Nursing or Assistant Director of Nursing will continue to monitor medication orders monthly times three months, and thereafter until a time in which consistent substantial compliance has been achieved and as determined by the committee.	

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F 641	Continued From page 5 (ARD) of 5/31/24, Section N - Medications, revealed one (1) insulin injection was received during the last seven (7) days or since admission/entry or reentry if less than 7 days. During an interview on 8/7/24 at 9:55 AM, the Registered Nurse MDS Coordinator revealed that due to her misunderstanding, she entered Ozempic as an insulin and since it is not an insulin, it should not have been coded as one. She stated this was an error on her part and this led to inaccurate information being submitted into the MDS system. She confirmed she entered that Resident #34 was receiving insulin when she was not, therefore, the MDS was submitted inaccurately. During an interview on 8/7/24 at 10:05 AM, the Administrator confirmed that Ozempic was not an insulin and it should not have been coded as an insulin on the MDS assessment. She confirmed the MDS assessment represents each resident's status at the time of the assessment and the facility failed to accurately complete the MDS assessment for this resident. Record review of Resident #34's "Admission Record" revealed the facility admitted the resident initially on 10/16/17. Resident #34 has current diagnoses that included Type 2 diabetes mellitus and Dementia. Record review of MDS with Assessment Reference Date (ARD) of 5/31/24 revealed a Brief Interview for Mental Status (BIMS) of 5 indicating the resident has severe cognitive impairment.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		9/13/24

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F 656	Continued From page 6	F 656		

§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 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

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F 656	Continued From page 7 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 observation, staff interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan for a resident that required the use of Enhanced Barrier Precautions (EBP) (Resident #85) and assistance with Activities of Daily Living (ADL's) (Resident #106) for two (2) of twenty-six care plans reviewed. Resident #85 and #106 Findings Include: Record review of the facility policy titled "Comprehensive Care Plans" dated 10/2022 revealed "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." Resident #85 Record review of Resident #85's Care Plan revealed "Focus: The resident requires tube feeding r/t (related to) Dysphagia ...Interventions ...Elder to remain on enhanced barrier precautions with care at all times d/t (due to) presence of PEG (Percutaneous Endoscopic	F 656	I. The Infection Preventionist reviewed the care plan with Licensed Practical Nurse #1 for Resident #85 regarding utilizing enhanced barrier precautions when providing percutaneous endoscopic gastrostomy (PEG) tube care and inserviced the nurse on following the comprehensive care plan on 8/8/24. The Administrator inserviced the Certified Nursing Assistants working in the Green House in which Resident #106 lives on following the comprehensive care plan on 8/8/24 regarding activities of daily living. II. All residents were identified as having the potential to be affected. III. An inservice was initiated by the Administrator, Director of Nursing, Assistant Director of Nursing, and Registered Nurse Clinical Coordinators on 8/8/24 regarding following the comprehensive care plans for all residents. All Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants will be inserviced on following the comprehensive care plan by 8/31/24. IV. The Administrator, Green House Guides, Director of Nursing, Assistant Director of Nursing, or Registered Nurse Clinical Coordinators started reviewing	

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F 656	Continued From page 8 Gastrostomy) tube and Foley catheter..." During an observation on 08/06/24 at 11:00 AM, of Resident #85's PEG tube care revealed an Enhanced Barrier Precaution sign on the inside of his door. Licensed Practical Nurse (LPN) #1 entered Resident #85's room, washed her hands, applied gloves and failed to apply a protective gown. During an interview on 08/06/24 at 11:20 AM, Licensed Practical Nurse (LPN) #1 revealed that she should have put on a gown before she provided Resident #85's PEG tube care to help prevent the spread of germs. She revealed that Enhanced Barrier Precautions were put in place to protect the nurse and to protect the resident from the spread of infection and she stated, "I knew to do it, I was just nervous." LPN #1 revealed that residents with foley catheters, PEG tubes or open wounds were placed on enhanced barrier precautions. During an interview on 08/07/24 at 9:45 AM, Registered Nurse (RN) Infection Preventionist, revealed that LPN #1 should have worn gloves and a gown while providing PEG tube care as part of the enhanced barrier precautions. She revealed that residents with open wounds and those with indwelling devices such as PEG tubes were placed on Enhanced Barrier Precautions to protect the resident and the staff member to help prevent the spread of germs and possible infection. During an interview on 08/07/24 at 1:30 PM, RN Minimum Data Set (MDS) Coordinator, revealed that the purpose of the comprehensive care plan was to outline each resident's plan of care and	F 656	and monitoring five care plans a week for four weeks, then five care plans a month to ensure they are being followed for three months on 8/9/24. A Quality Assurance Performance and Improvement (QAPI) committee meeting is scheduled for 8/29/24, 9/12/24, and 9/26/24 to review and revise the plan of correction if additional concerns are identified through the audits. If any issues are identified with implementation of the care plans, the QAPI plan committee will track and trend any noncompliance and make recommendations that may include further training or corrective actions of employees.	

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F 656	Continued From page 9	F 656		

what individualized care was needed and provided. She agreed that LPN #1 failed to follow the care plan when she did not wear a gown while she provided Resident #85's PEG Tube care.

Record review of Resident #85's "Order Summary Report" revealed an order dated 04/01/24, "Elder to remain on enhanced barrier precautions with care at all times d/t (due to) presence of PEG tube and Foley catheter."

Record review of Resident #85's "Admission Record" revealed an admission date of 12/15/2023 and had diagnoses that included Dysphagia and Encounter for Attention to Gastrostomy.

Resident #106

Record review of the "Care Plan" with a date initiated of 12/23/22, for Resident #106 revealed "Focus: Resident needs assist with ADL's (activities of daily living) ... Interventions: Assist with adl's as needed ..."

During an observation of Resident #106 on 8/5/2024 at 12:09 PM revealed, he was lying in bed, alert with confusion. The resident was unkempt, with his hair unbrushed and greasy on the edges. Gray facial hair observed on his face and above his lip, measuring approximately one fourth (1/4) inch in length. Long fingernails observed on both hands measuring approximately three-eights (3/8) inch in length.

During an observation and interview with Licensed Practical Nurse (LPN) # 2 on 8/6/2024 at 10:35 AM, confirmed Resident #106 was unkempt, had long nails and needed to be

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F 656	Continued From page 10 shaved. During an interview with the Minimum Data Set (MDS) Coordinator on 8/7/2024 at 1:40 PM, revealed the purpose of the care plan was to provide an outline for resident care. She confirmed the activity of daily living (ADL) care plan was not followed for Resident #106. Review of the "Admission Record" revealed the facility admitted Resident #106 on 12/23/2022 with medical diagnoses that included Unspecified dementia.	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, staff interview, record review, and facility policy review, the facility failed to provide the necessary assistance with activities of daily living (ADLs) for a resident dependent on staff for bathing, shaving, and nail care for one (1) of 26 residents sampled. Resident #106 Findings Include: Record review of the facility policy titled "Activities of Daily Living" dated 10/2023 revealed "Policy... Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care ..." An observation of Resident #106 on 8/5/2024 at	F 677	I. Resident #106 was bathed with nails cut on 8/6/24 by two Certified Nursing Assistants working in the Green House in which the Resident lives. II. All Residents in the Green House where Resident #106 lives were identified as having the potential to be affected. III. The Administrator evaluated the condition of all Residents in the Green House where the incident occurred with no other Residents appearing unkept on 8/6/24. An inservice was initiated on 8/6/24 by the Administrator regarding providing necessary assistance with activities of daily living for the Certified Nursing Assistants working in the Green	9/13/24

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F 677	Continued From page 11 12:09 PM revealed, he was lying in bed, alert with confusion. The resident was unkept, with his hair unbrushed and greasy on the edges. Gray facial hair was observed on his face and above his lip, measuring approximately one fourth (1/4) inch in length. Long fingernails were observed on both hands measuring approximately three-eights (3/8) inch in length. An observation and interview with Certified Nurse Aide (CNA) # 2 on 8/6/2024 at 10:25 AM revealed, Resident # 106 was scheduled to get his shower on Monday, Wednesday, and Friday on the 3-11 shift. She explained that the resident should have gotten a shower last night and stated, "He does not look like he was showered." CNA #2 revealed the aides were responsible for shaving the male residents with showers and cutting their nails if the resident was not a diabetic. She confirmed Resident #106 needed shaving, and his nails needed to be cut. CNA #2 revealed the resident could scratch himself and cause injury. An observation and interview with Licensed Practical Nurse (LPN) # 2 on 8/6/2024 at 10:35 AM, confirmed Resident #106 was unkempt, had long nails and needed to be shaved. She revealed the resident was not a diabetic, so the aides were responsible for cutting his nails when needed. Record review of the "Kardex" for Resident #106 revealed ..."Bathing: ADL -Bathing as ordered ..." An interview with the Director of Nursing (DON) on 8/7/2024 at 1:35 PM, revealed with Resident #106's ADL care, her expectations were for the aides to include nail care (cleaning, cutting, and	F 677	House where the incident occurred. All Certified Nursing Assistants will be inserviced by the Administrator, Green House Guides, or Registered Nurse Clinical Coordinators by 8/31/24 regarding providing necessary assistance with activities of daily living. IV. The Administrator, Green House Guides, or Registered Nursing Clinical Coordinators will evaluate the conditions of five Residents daily for thirty days and five Residents weekly for one quarter starting on 8/19/24. The evaluations will be reviewed at the Quality Assurance Performance and Improvement (QAPI) plan committee meetings. The first QAPI meeting will be 8/29/24, then 9/12/24, and 9/26/24 to review and revise the plan of correction if additional concerns are identified through the evaluations. If any issues are identified with the observations/evaluations, the QAPI plan committee will track and trend any noncompliance and make recommendations that may include further training or corrective actions of employees.	

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F 677	Continued From page 12 filing) and shaving on designated shower day. Review of the "Admission Record" revealed the facility admitted Resident #106 on 12/23/2022 with medical diagnoses that included Unspecified dementia	F 677		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §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 observation, staff interview, record review, and facility policy review, the facility failed to ensure the medication error rate was less than five (5) % (percent) for two (2) of 28 medication opportunities involving Resident #84. Medication error rate was 7.14%. Findings Include: Review of the facility policy titled "Medication Administration" dated 1/2024 revealed "Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice ...Policy Explanation and Compliance Guidelines:..10. Ensure that the six rights of medication administration are followed ...c. Right dosage ..." An observation of medication pass, with Licensed Practical Nurse (LPN) #3 on 8/7/2024 at 8:09 AM,	F 759	I. Resident #84 was given the correct dose of MiraLax and Fluticasone Propionate Suspension on 8/7/24 by Licensed Practical Nurse #3, once it was identified by the surveyor. Licensed Practical Nurse #3 was inserviced on 8/7/24 on preventing medication errors by using the five rights of administering medications by the Registered Nurse Clinical Coordinator. No adverse/negative outcomes were identified from being administered the incorrect dose of medications since it was corrected immediately for Resident #84. II. All residents were identified as having the potential to be affected. III. An inservice was initiated on 8/7/24 for all registered nurses and licensed practical nurses on preventing medication errors using the five rights of administering medications by the Director of Nursing and Assistant Director of	9/13/24

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F 759	Continued From page 13 revealed she prepared and administered MiraLax 17 grams one capful mixed in water to Resident #84. She then handed the resident a bottle of Flonase (Fluticasone Propionate) nasal spray, in which he administered one spray to each nostril. Record review of Resident #84's August 2024 Medication Administration Record (MAR) revealed an order dated 11/1/2022, "Fluticasone Propionate Suspension (Allergies) 50 MCG (micrograms)/ACT (actuation) 2 (two) spray in each nostril one time a day related to Allergic Rhinitis." Also revealed an order dated 4/29/2024, "MiraLax Oral Powder (stool softener) 17 GM (grams)/scoop give 34 gram orally two times a day for constipation in 240 ml (milliliters) of liquid". An interview on 8/7/2024 at 8:16 AM with LPN #3, confirmed she did not administer Resident #84's MiraLax and Flonase according to the physician order. She stated the resident liked to give his own nasal spray, but she should have instructed him to give the two sprays instead of one. She explained that she overlooked that the resident was supposed to have 34 grams of MiraLax, and she should have given two capfuls. LPN #3 stated, "I just missed it." She revealed not getting the entire dosage of MiraLax could cause constipation. An interview on 8/7/2024 at 10:10 AM, with the Director of Nursing (DON), confirmed Resident #84's physician orders were not followed. She revealed her expectations were for the nurses to view the Medication Administration Record (MAR) and ensure they were giving the correct ordered dose before administration.	F 759	Nursing. All licensed nurses will be inserviced by 8/31/24 by the Director of Nursing, Assistant Director of Nursing, or Registered Nurse Clinical Coordinators. IV. The Director of Nursing, Assistant Director of Nursing, or Registered Nurse Clinical Coordinator will conduct five medication administration audits weekly for four weeks and then monthly for three months to ensure continued compliance. Medication audits were initiated on 8/12/24. A Quality Assurance Performance and Improvement (QAPI) committee meeting is scheduled for 8/29/24, 9/12/24, and 9/26/24 to review and revise the plan of correction if additional concerns are identified through the audits. If any issues are identified with the mediciation administration audits, the QAPI plan committee will track and trend any noncompliance and make recommendations that may include further training or corrective actions of employees.	

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F 759	Continued From page 14 Record review of the "Admission Record" revealed the facility admitted Resident #84 on 12/20/2023 with medical diagnoses that included Allergic Rhinitis and Constipation.	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	F 880		9/13/24

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F 880	Continued From page 15 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 interviews, record review, and facility policy review the facility failed to prevent the possibility of the spread of infection as evidenced by failing to ensure Enhanced Barrier Precautions were followed during a	F 880	I. Licensed Practical Nurse #1 was inserviced by the Infection Preventionist on using proper enhanced barrier precautions on 8/7/24. Resident #85 was discharged on 8/9/24 to the local inpatient	

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F 880	Continued From page 16 resident care treatment for one (1) of four (4) resident care treatments observed. Resident #85. Findings Included: Record review of the facility policy "Gastrostomy Site Care" dated 05/2023 revealed "Policy: It is the policy of the facility to perform gastrostomy site care as ordered and per current standard of practice. Policy Explanation and Compliance Guidelines ...10. Apply any other PPE (Personal Protective Equipment) as needed to protect self from any exposure to infectious material and to comply with any isolation precautions ordered..." Record review of the undated facility policy titled, "Enhanced Barrier Precautions" revealed " ...Enhanced barrier precautions" (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities ....4. High-contact resident care activities include ...g. Device care or use: ... urinary catheters, feeding tubes....." An observation on 08/06/24 at 11:00 AM, of Resident #85's Percutaneous Endoscopic Gastrostomy (PEG) tube care revealed an Enhanced Barrier Precaution sign on the inside of the door. Licensed Practical Nurse (LPN) #1 entered Resident #85's room, washed her hands, applied gloves and failed to apply a protective gown prior to beginning care. An interview on 08/06/24 at 11:20 AM with LPN #1 revealed that she should have put on a gown before providing Resident #85's PEG tube care to help prevent the spread of germs. She revealed	F 880	hospice house. Prior to discharge on 8/9/24 no adverse outcomes had been documented by the Registered Nursing or Licensed Practical Nursing personnel due to not wearing a gown during percutaneous endoscopic gastrostomy (PEG) tube care. II. All residents requiring enhanced barrier precautions were identified as having the potential to be affected. III. An inservice was initiated on 8/7/24 for Registered Nurses and Licensed Practical Nurses by the Director of Nursing, Assistant Director of Nursing, Infection Preventionist, and Registered Nurse Clinical Coordinators on enhanced barrier precautions. All licensed staff will be inserviced by 8/31/24. IV. The Director of Nursing, Assistant Director of Nursing, or Registered Nurse Clinical Coordinators started conducting five observations a week for four weeks and five observations a month for one quarter to ensure enhanced barrier precautions are being followed on 8/12/24. A Quality Assurance Performance and Improvement (QAPI) committee meeting is scheduled for 8/29/24, 9/12/24, and 9/26/24 to review and revise the plan of correction if additional concerns are identified through the observations. If any issues are identified with the observations, the QAPI plan committee will track and trend any noncompliance and make recommendations that may include further training or corrective actions of employees.	

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F 880	Continued From page 17	F 880		

that enhanced barrier precautions were put in place to protect the nurse and to protect the resident from the spread of infection and she stated, "I knew to do it, I was just nervous." LPN #1 revealed that they followed enhanced barrier precautions when providing care to anyone with a foley catheter, PEG tube, or open wounds.

An interview on 08/07/24 at 9:45 AM with Registered Nurse, Infection Preventionist revealed that LPN #1 should have worn gloves and a gown while providing PEG tube care as part of the enhanced barrier precautions. She revealed residents with open wounds and those with indwelling devices such as PEG tubes were placed on enhanced barrier precautions to protect the resident and the staff member and to help prevent the possible spread of infection. RN Infection Preventionist revealed that bacteria could be passed from the resident to staff on their uniforms and infection could be transmitted to other residents without protective gowns in use.

An interview on 08/07/24 at 9:55 AM, with the Director of Nursing (DON), revealed residents with open wounds, foley catheters and PEG tubes were placed on enhanced barrier precautions to prevent the spread of infection. She agreed that LPN #1 should have worn a gown and gloves when providing PEG tube care for Resident #85 to prevent the spread of potential infection.

Record review of Resident #85's "Order Summary Report" revealed an order dated 04/01/24, "Elder to remain on enhanced barrier precautions with care at all times d/t (due to) presence of PEG tube and Foley catheter."

Record review of Resident #85's "Admission

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F 880	Continued From page 18 Record" revealed an admission date of 12/15/2023 and had diagnoses that included Dysphagia and Encounter for Attention to Gastrostomy.	F 880		