STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41CH	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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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey, from 08/05/24 to 08/08/24 and determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M610 and M1570.	M 000		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II 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,	M 610	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	9/13/24

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M 610	Continued From page 1 dressing, grooming and oral care ..." 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 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	M 610	Nursing Assistants working in the Green 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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M 610	Continued From page 2 #106's ADL care, her expectations were for the aides to include nail care (cleaning, cutting, and 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	M 610		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by:	M1570		9/13/24

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M1570	Continued From page 3 Level II 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 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	M1570	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 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	

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M1570	Continued From page 4 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 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	M1570	training or corrective actions of employees.	

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M1570	Continued From page 5 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.	M1570		