MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41LM	A. BUILDING: _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO NURSING AND REHABILITATION CENTER	1901 BRIAR RIDGE ROAD TUPELO, MS 38804

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M 000	Initial Comments The State Agency (SA) conducted an annual re-certification survey along with a Complaint Investigation (CI) MS #24972 at the facility from 9/9/24 through 9/11/24. During the survey, the SA determined that the facility was not in compliance with Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500, M610, M1020 and M1570. The SA determined the facility was not in compliance with CI MS# 24972 and cited M610 for failure to provide incontinent care and personal hygiene care.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or	M 500		10/25/24

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M 500	Continued From page 1 nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;	M 500		

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M 500	Continued From page 2 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately	M 500		

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M 500	Continued From page 3 with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II	M 500	1.Resident #74 was interviewed by Administrator (Adm) on 9/11/2024	

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M 500	Continued From page 4 Based on observation, resident and staff interview, record review and facility policy review the facility failed to ensure a resident received coffee, as desired, for one (1) of 24 residents sampled. Resident #74 Findings included: Record review of facility policy titled, "Resident Bill of Rights", dated 1/23, revealed, "Each resident has a right to a dignified existence, self-determination...in an environment that promotes maintenance or enhancement of (his or her) quality of life...15. Self determination, which the facility must promote and facilitate through support of resident choice, consistent with his or her interests, assessments and plan of care and make other choices about aspects of his or her life in the facility that are significant to the resident. Including but not limited to: activities...and how she or he spends time, both in and outside the facility should be supported to the extent possible." During an interview on 9/9/24 at 12:05 PM, Resident #74 revealed she loved to have coffee each morning, but for the past month, she had not received coffee due to the coffee machine in the kitchen being broken. She stated she received coffee this morning for the first time in weeks, but she was unsure if that would continue. She stated this had also been mentioned in the Resident Council meeting and they were told the coffee machine was being repaired. She revealed that coffee was something that she and many other residents enjoyed and it was a social activity for her and others and not having it had "been awful". She stated the facility could have gone to Walmart and bought a coffee pot to make	M 500	regarding concerns with coffee. Resident # 74 confirmed issues with coffee not being ready prior to her going to church on Sunday. Resident #74 had no ill effects from this alleged deficient practice. On 9/13/2024 an outside vendor delivered a new coffee maker for the dietary department. On 9/16/2024, the Administrator ordered an additional coffee dispenser to be set-up in the dining room for pre and post meal services. 2. All residents who drink coffee have the potential to be affected. 3. An in-serviced was initiated 9/11/2024 by the Administrator with Dietary staff to have coffee readily available and set-up in the dining room pre and post meal services. An in-service was initiated 9/20/2024 by Staff Development Coordinator (SDC) with all nursing staff regarding the set-up of the additional coffee dispenser in the dining room available for residents who desire coffee pre and post meal services. A 100% audit of Residents who want coffee was completed on 9/12/2024 by the Dietary Manager. An updated food preference sheet was completed with Residents coffee preference. 4.Beginning the week of 9/16/2024 the Dietary Manager will visit with ten residents daily times five days a week	

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M 500	Continued From page 5 coffee for those residents who wanted it and to go for so long without it was not right or fair for the residents. She stated a lot of money was paid to live at the facility and a basic enjoyable thing like coffee should be given. An interview on 09/10/24 at 11:00 AM, with the Dietary Manager revealed that the facility's coffee maker that was used to make the coffee for the residents had been broken for about two months. She stated that they had been boiling water on top of the stove and using a filter to make some coffee, but there was a delay in getting the coffee to the residents because it was a slow process. She confirmed she had complaints about the coffee machine being broken and understands the residents' frustration. She stated that the Administrator had known about it, and they tried to get someone to repair it, but they never came. She stated someone finally came yesterday and brought a coffee pot as a replacement and this one was working fine. During an interview on 09/10/24 at 11:24 AM, the Administrator confirmed that the coffee pot for the residents had been broken for a while, but she was thinking it had only been a month. She stated she thought someone had already been out to look at the coffee pot before yesterday. She stated that they had a back-up method for making coffee for the residents, but did not realize there was a delay in getting it out to the residents. During the Resident Council on 9/10/24 at 3:15 PM, all of the residents present stated the coffee machine had been broken for several weeks and they were not consistently receiving their coffee and this had been mentioned in the last Resident Council meeting.	M 500	times two weeks, then two times week times two weeks, then monthly times two months. All the results will be reviewed by the Administrator weekly for accuracy and completeness. Any concerns will be immediately addressed. The Administrator will forward audits to Quality Assurance(QA) Committee monthly times three months for review beginning 10/23/2024. The Quality assurance Committee (QA) will make recommendation for the continuation of audits or discontinuation based upon results achieved.	

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M 500	Continued From page 6 Record review of "Admission Record" revealed the facility admitted Resident #74 on 10/13/20. Record review of Resident #74's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/13/24, revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated the resident was cognitively intact.	M 500		
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 Pattern Based on observation, staff and resident interview, record review and facility policy review the facility failed to provide assistance with Activities of Daily Living (ADL's) for residents that were dependent on staff, as evidenced by not being shaved (Resident #43), missed bath (Resident #59), not performing timely incontinent care (Resident # 68, 351 & 352) and long dirty nails (Resident #151) for six (6) of seven (7) residents reviewed for ADL's. Resident #43, 59, 68, 151, 351 and 352.	M 610	1.On 9/10/2024 Resident #43 was shaved by assigned CNA. On 9/10/2024 the Unit Manager cleaned and trimmed Resident #151 fingernails. On 9/10/2024 Resident# #59 received full bath from CNA #2. On 9/9/2024 the assigned CNA for Resident #68 on 9/7/2024 was terminated. On 9/9/2024 the assigned CNA for Resident #68 on 9/8/2024 received disciplinary action and in-service on providing ADL-Care, responding to call-lights, and customer service. On 9/9/2024 the assigned CNA provided	10/25/24

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M 610	Continued From page 7 Cross Reference F725 Findings include: Record review of facility policy titled, "Shaving - Male and Female" dated 1/15, revealed, "Residents will be free of facial hairs - both male and female. If the resident is alert and oriented and requests not to be shaved, this will be noted in the Care Plan." Review of the facility policy titled "Bath/Shower-Dependent" with a revision date of 8/11 revealed, "Policy: A bath (shower/tub) for cleanliness and comfort is scheduled at least weekly for each resident." Also revealed under, "Responsibility: Nursing Assistants or Licensed Nurses monitored by Charge Nurse." Review of the facility policy titled "Incontinent Care" with a review date of 1/15 revealed, "Policy: To provide routine, preventative skin, perineal care to residents after an incontinent episode." Also revealed under, "Responsibility: All Nursing Personnel." Record review of facility policy titled, "Fingernails/Toenails Care", dated 1/15, revealed, "The purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections". Resident #43 On 9/9/24 at 10:50 AM, during an interview and observation , Resident #43 revealed her preference was to have her facial hair removed by shaving, and she had asked staff to assist her with this, but they had not. Facial hair was noted on resident's face.	M 610	incontinence care to Resident #351. On 9/9/2024 Resident # 352 received incontinent care by the assigned CNA. On 9/11/2024, the Unit Managers and Certified Nursing Assistant (CNA) made observation of all residents fingernails and completed 100% audit on all residents residing in the facility. Any issues identified was corrected upon observation. On 9/16/2024, the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers made observation rounds and completed 100% audit on all residents residing in the facility to identify if any issues with Activities of Daily Living (ADL), any issues found was updated to residents plan of care and corrected. On 9/18/2024, the Unit Managers updated residents bath preference. 2. All residents who require staff assistance with Activities of Daily Living (ADL) have the potential to be affected. 3. On 9/9/2024, an educational in-service was initiated by Staff Development Coordinator (SDC) with all Licensed Nursing personnel regarding weekly skin assessments to include if nail care and facial hair shaving is needed. On 9/9/2024, an educational in-service	

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M 610	Continued From page 8 An interview and observation of Resident #43 on 9/10/24 at 11:50 AM, revealed facial hair on chin and lower jaw area. She stated she had a shower yesterday afternoon and she wanted her facial hair to be removed, but the staff did not do it. During an interview and observation in Resident #43's room on 9/10/24 at 12:05 PM, the resident informed the Director of Nursing (DON) that she wanted her facial hair shaved, but staff had not done this. The resident informed the DON she had a shower yesterday afternoon, but shaving was not done. The DON confirmed the resident, who required assistance with care, had facial hair present and did not receive the Activity of Daily Living (ADL) care for shaving, which was part of the grooming process, especially for a female resident. Record review of Task Record revealed Resident #43 had a bath on 9/9/24 at 8 PM. Record review of Resident #43's "Admission Record" revealed the facility admitted the resident on 12/18/2020. Diagnoses included Type 1 diabetes mellitus and arthritis. Record review of Resident #43's quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/26/24, revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had a mild cognitive impairment. Resident #151 On 9/9/24 at 10:50 AM, an observation and interview with Resident #151 revealed fingernails	M 610	was initiated by SDC with all Licensed Nursing personnel and Certified Nursing Assistants (CNA) on call lights, incontinent care, nail care and facial hair with residents bathing and grooming care. On 9/11/2024 the DON in-serviced and educated Unit Managers on making proper rounds and observation, and monitoring residents ADL-care, On 9/20/2024, the SDC in-serviced Physical Therapy Assistant (PTA) on reporting resident care issues and concerns to nursing supervisors and Director of Nursing (DON). On 9/20/2024, the SDC initiated in-service and educated all staff on answering call lights, and reporting residents needs to nursing supervisors when services can not be rendered. 4.Beginning week of 9/16/2024, the Unit Managers will make observation rounds on all residents on their unit, checking residents ADL Care for proper grooming, nail care, and baths weekly for eight weeks, then monthly for two months utilizing the ADL audit tool and bathing assessment tool. Beginning 9/23/2024, the audits will be given to the DON weekly for review, any issues and concerns will be immediately addressed. The DON will forward weekly audits to the ED for further review. The ED will present the audit tools to the monthly Quality Assurance Committee beginning 10/23/2024 for four months for review and recommendation.	

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M 610	Continued From page 9 were long (approximately one-half inch from nail bed) with a brown substance noted under nails. The resident stated she would love for her nails to be trimmed but no one had done it. On 9/10/24 at 4:15 PM, during an observation and interview with the DON and Resident #151 , the resident stated she wanted her nails to be trimmed. The DON confirmed the nails were long with a brown substance under each nail and nails were to be trimmed and cleaned to ensure skin was not scratched and to prevent infections and the facility failed to do this. Record review of Resident #151's "Admission Record" revealed the facility admitted the resident on 8/23/24. Diagnoses included Metabolic Encephalopathy, Type 2 Diabetes Mellitus, and Need for assistance with personal care. Record review of Resident #151's admission MDS with ARD of 8/30/24 revealed a BIMS score of 9 which indicated the resident was moderately impaired cognitively. Resident #59 An observation and interview on 9/9/2024 at 12:18 PM, with Resident #59 who stated, "I'm not going to lie on them or for them... I have not had a bath of any type since last Tuesday; They will wash my face, but that's it." He revealed he would love to be really cleaned up. This observation revealed the resident was a double above the knee amputee and stated he needed assistance with his baths. An interview on 9/10/2024 at 10:17 AM, with Certified Nurse Assistant (CNA) #1 confirmed that she was assigned to Resident #59, and he had	M 610	The Quality assurance Committee (QA) will make recommendation for the continuation of audits or discontinuation based upon results achieved.	

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M 610	Continued From page 10	M 610		

told her he only gets a bath when she was on duty. She stated she knew that the resident complained to Licensed Practical Nurse (LPN) #1 last week about it, but was not sure what happened.

In an interview on 9/10/2024 at 12:10 PM, with LPN #1, confirmed that Resident #59 had complained to her about not receiving a bath on 8/31/24, but she did not report it to anyone, that she just discussed it with the resident.

Record review of documented baths for Resident #59 confirmed that the resident did not receive a bath on 8/31/2024. This documentation revealed the resident received a bed bath on 8/29/2024 with the next bath on 9/3/2024.

Record review of the "Admission Record" revealed the facility admitted Resident #59 on 11/14/2023 with a medical diagnosis of chronic venous insufficiency.

Record review of the Quarterly MDS with an ARD of 7/24/2024 revealed, under section C, a BIMS summary score of 13, which indicated Resident #59 was cognitively intact and in Section GG that the resident needs assistance with Activities of Daily Living (ADL's).

Resident #68

An observation and interview on 9/9/2024 at 10:20 AM, with Resident #68 revealed, she was sitting in her wheelchair in her room. The resident explained that both Saturday (9/7) and Sunday (9/8) she rang her call light and told the aide who came in that she was wet and needed to be changed. She revealed on both days the aide turned the call light off, said she would be back,

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and left the room without ever coming back. She revealed, last night, her sister called the facility and spoke with the nurse to report that the aide never came back. The resident explained that the nurse and another aide later came to change her. She revealed, "I sat in that urine for an hour."

On 9/10/2024 at 8:50 AM, in an interview with the DON revealed she was aware of both incidents that happened over the weekend with Resident #68. She explained that she met with the resident and her son yesterday. She revealed the aide who cared for the resident on Saturday (9/7) had been terminated. The DON revealed she spoke with the aide, and the aide stated that she changed the resident after breakfast and that every time she went back into the resident's room, the resident was asleep. The aide reported that she did not wake the resident to check her or provide incontinent care. The DON revealed that she terminated the aide because this was her second occurrence of not making rounds and leaving the residents soiled. She explained that the resident had a different aide on Sunday (9/8). The DON revealed that she met with the aide, and the aide stated that she answered the call light, cut it off, and told the resident she would be back, but never went back. She revealed the resident called her sister, who then called the facility and reported the issue. The DON revealed that during that time the aide had gone to break, and the aide stated that she had changed the resident before supper. The DON revealed the aide was written up and counseled on answering the call lights and rendering the care when needed, as this was her first offense. The DON confirmed her expectations were for the aides to make rounds on the residents every two (2) hours and as required, and render the necessary care needed.

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M 610	Continued From page 12 An interview with Resident #68 on 9/10/2024 at 9:25 AM, revealed the aide assigned to her on Sunday (9/8) did not toilet or change her before supper. She explained that she waited until after supper and the trays were all picked up and pushed her call light to be changed. She stated the aide came in, turned the light off and said she would be back. The resident explained that after the aide did not return, she called her sister around 7:30 PM, who called the facility. She stated, "They don't come check on me every 2 hours; They say they do, but they don't." She stated, "They can't be lying on me because I have my mind." An interview with the DON on 9/10/2024 at 1:21 PM, confirmed staff did not provide the necessary care for Resident #68. She revealed her expectations were for staff to answer the call lights and render the care that the resident needs in a timely manner. She explained that the aides were to make rounds every 2 hours and as needed to ensure the residents were clean and dry and to prevent skin breakdown. An interview with Certified Nurse Aide (CNA) #4 on 9/10/2024 at 3:20 PM, revealed she had been employed at the facility for eight (8) months and worked 3-11 shift. She revealed on Sunday (9/8) she was assigned to Resident #68. She revealed she had the split section which included her working the top section of A and B hall. CNA #4 revealed she was in the middle of cleaning up another resident on another hall at the time Resident #68's light went off. She explained that she had stepped out of the other resident's room to get some clean linen when she answered Resident #68's light, turned it off, and told the resident she would be back. She stated she	M 610		

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forgot to go back.

Record review of the "Admission Record" revealed the facility admitted Resident #68 on 8/19/2024 with a medical diagnosis of Chronic Combined Systolic and Diastolic Heart Failure.

Record review of the Admission MDS with an ARD of 8/26/2024 revealed, under section C, a BIMS score of 13, which indicated Resident #68 was cognitively intact.

Resident #351

On 9/9/2024 at 10:45 AM, observation of Resident #351 and interview with a family member revealed, he was sitting in a reclining wheelchair in his room. His eyes were open, and he was non-verbal. The resident was wearing a gray pair of jogger pants that were saturated through the groin area and in between the legs with urine. The family member revealed he was brought back from therapy like this, and nobody had been there since to check on him. The family member revealed the resident's bed was always wet with urine. She revealed the bed was soaked out this morning and had to be changed after they got him up. She stated, "They say they are changing him every 2 hours, but they are not because I am here, and they do not enter the room." She explained that the resident was wetting out his clothes and the bed with urine through a brief. The family member revealed when he was in bed, she positioned a pillow under his stroke affected arm, and it even got soaked with urine. She reiterated, "They are not changing him like they should be." She revealed she had been waiting on the resident's nurse to come back since 10:15 AM because she had some questions regarding the resident's fluid

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medication, but she had yet to come back.

On 9/9/2024 at 10:51 AM, an interview with CNA #5 revealed she got Resident #351 up this morning, but she was unsure what time. She stated the resident had been to therapy, and she did not realize he was back. She revealed therapy did not come and let her know he was back or that he was wet. CNA #5 revealed she makes rounds every 2 hours to see if the residents need changing. She confirmed the resident's bed linen had to be changed because it was wet this morning.

An interview with the DON on 9/10/2024 at 11:10 AM revealed, Resident #351 should be checked and changed every 2 hours and more if he needed it. She explained that he may be a heavy wetter and needed to be changed more frequently. The DON revealed if the resident was a heavy wetter, she could see that the resident could wet the bed. She revealed she was not aware of the family members' concerns regarding the resident's care, and stated those concerns were just brought to her attention yesterday.

Record review of the "Admission Record" revealed the facility admitted Resident #351 on 8/23/2024 with diagnoses including cerebral infarction.

Resident #352

On 9/9/2024 at 10:58 AM an observation and interview with Resident #352 revealed, he was lying in bed. There was a foul odor around the resident. The resident revealed, after he ate breakfast and took his morning medicine, it was 2 hours before someone could come to clean him up and change him. He stated, "They tell me they

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are working with somebody and will get to me when they can." He revealed the therapy man will even come to his room to take him to therapy, and he must tell him that he cannot go right now because he needs changing. The resident stated, "He (the therapy man) wouldn't want to sit like that, so he should understand." The resident stated he was still waiting to be changed today.

On 9/10/2024 at 11:50 AM, interview with the Physical Therapy Assistant (PTA) revealed, Resident #352 not being changed had been an issue since he had been working with him. He revealed he had only done about 4 sessions with the resident, and each time the resident would be dirty. The PTA revealed it took 2-3 hours before the resident got changed by the staff. He stated he usually goes down to the resident's room about 8:00-9:00 in the morning to start his session, but after the resident reports being soiled, he will push the resident's call light. He stated he also goes to hunt down someone to help change the resident, but nine times out of ten he cannot find anybody. The PTA stated yesterday he pushed the call light, and nobody ever came, so he went to the nurse and told her, and she went to change the resident.

An interview with the DON on 9/10/2024 at 2:52 PM, revealed she was not aware Resident #352 was not being changed in a timely manner. She stated that therapy had not reported anything to her. She revealed when an issue was brought to her attention, she would address it. The DON confirmed that the aides should be rounding on the residents every 2 hours and the residents should be changed in a timely manner.

Record review of the "Admission Record" revealed the facility admitted Resident #352 on

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M 610	Continued From page 16 9/3/2024 with diagnoses that included Osteomyelitis of vertebra, thoracic region. Record review of the Admission MDS with an ARD of 8/13/2024 revealed under section C, a BIMS score of 15, which indicated Resident #352 was cognitively intact.	M 610		
M1020	45.35.3 Resident Bedrooms Resident Bedrooms. Resident bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance. All sweeping should be damp sweeping, all dusting should be damp dusting with a good detergent or germicide. This Statute is not met as evidenced by: Level II Based on observation, staff interview, and facility review, the facility failed to provide housekeeping services necessary to maintain a clean home-like environment for one (1) of 55 rooms observed for a clean environment. Findings include: A review of a document on facility letter head dated 9/10/24 and signed by the Executive Director revealed the facility does not have a policy on cleaning floor mats. An observation of D5 B room on 9/9/24 at 10:20 AM, revealed a light gray fall protection floor mat that was a length of 72 inches by width of 24 inches on the left side of the bed covered in black and brown dried stains. A quarter size clump of a brown leaf tobacco product was observed on the	M1020	1.On 9/9/2024 the fall mat assigned to Resident in room D5B was cleaned by floor tech. Resident in D5B had no ill effects from this deficient practice. 2. All Residents with fall mats has the potential to be affected. 3.On 9/9/2024 a 100% audit of Residents with fall mats was completed by the Assistant Director of Nursing (ADON), and all Residents with fall mats were giving new fall mats by the Maintenance Assistant. On 9/16/2024 the Executive Director in-serviced Environmental Staff (Housekeeping, Floor tech and	10/25/24

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M1020	Continued From page 17 floor next to the floor mat, with a dried brown ring around the tobacco. An observation of room D5 B on 9/09/24 at 2:30 PM, revealed the tobacco product that was lying on the floor had been cleaned up but the floor mat on the left side of the bed remained completely covered in black and brown dried stains. In an observation of the fall mat next to the bed in room D5 B with Certified Nurse Assistant (CNA) #3 on 9/9/24 at 2:30 PM, she revealed the floor mat was filthy and covered with brown and black stains and the floor mat needed to be cleaned. In an interview with the Director of Nursing (DON) on 9/9/24 at 3:10 PM, she revealed the floor mats should be cleaned daily to prevent the spread of infections when staff step on the dirty fall mat. In an interview with Housekeeper #1 on 9/10/24 at 7:45 AM, she revealed the resident's rooms are cleaned daily, and the floors are mopped as well and more often if needed. She stated if a resident has a fall protection floor mat, they should be moved to mop under the mat, and the top of the mat should be sanitized daily to reduce bacteria growth. In an interview with the Assistant Director of Nursing/Infection Control Nurse on 9/10/24 at 10:44 AM, she revealed that the resident's fall mat should be cleaned and sanitized every day along with the room to reduce the risk for spread of infection.	M1020	Maintenance) on removing and deep cleaning fall mats along with the general cleaning of daily room assignments. On 9/16/2024 the Executive Director in-serviced all members of the Quality Improvement (QI) team on making proper rounds utilizing the Quality Assurance and Quality Improvement rounding audit tool. 4.Beginning 9/16/2024, each member of Quality Improvement (QI) team will monitor for dirt and debris of fall mats seven days a week ongoing. All results of the daily audits will be reviewed by the Executive Director in the morning meeting ongoing, beginning 9/17/2024 five days a week for accuracy and completeness to ensure fall mats are clean or replaced. The Executive Director will present daily rounds to Quality Assurance Committee monthly times three months beginning 10/23/2024 for review. The Quality assurance Committee (QA) will make recommendation for the continuation of audits or discontinuation based upon results achieved.	
M1570	48.58.1 Infection Control	M1570		10/25/24

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M1570	Continued From page 18 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: Level II Based on observation, resident and staff interview, record review, and facility review the facility failed to help prevent the transmission of infections when a resident returned from the hospital with a treatment for Clostridium Difficile Colitis (C-Diff) infection was not placed on contact isolation precautions for one (1) of 14 residents being treated for an infection. Resident #83 Findings include:	M1570	1. On 9/9/2024 Resident #83 was switched from Enhanced Barrier Precautions and immediately placed on contact isolation. Resident #83 received no ill effects from this deficient practice. On 9/9/2024 Licensed Practical Nurse (LPN) #2 and assigned LPN nurse on 9/8/2024 was in-serviced on contact isolation precautions. 2. All Residents residing in the facility have the potential to be affected.	

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M1570	Continued From page 19 A review of Centers for Disease Control (CDC) document revealed Contact Precautions: Contact precautions are intended to prevent transmission of infectious agents, which are spread by direct or indirect contact with the patient or the patient's environment.(Example: C. Difficile) ... C-diff is a germ (bacterium) that causes diarrhea and colitis (an inflammation of the colon). ...Key Points: Most cases of C. Diff occur when you have been taking antibiotics or not long after you have finished..." A review of the facility policy titled, "Contact Precautions," revealed Policy: Contact precautions are a transmission-based precaution that will be utilized to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. In an interview with Resident # 83 on 9/9/24 at 10:00 AM, he revealed he had just returned from the hospital the day before with bad diarrhea. He stated the diarrhea was C-Diff. Observation of the resident's room revealed there were no isolation barrels in the room. There was no signage on the resident's door alerting the staff that the resident was on contact precautions. A review of the diagnosis information on the "Admission Record" for Resident #83 revealed on 8/30/24 he received a diagnosis of long-term use of antibiotics. A review of the "Order Details" revealed a physician's order for Resident # 83 dated 9/8/24 "Fidaxomicin Oral Table 200 MG(milligram) Give 1(one) tablet by mouth every morning and at bedtime for C-Diff until 9/13/24."	M1570	3. On 9/20/2024, the Staff Development Coordinator initiated an in-service with all licensed nursing staff on contact precaution, and preventing transmission of infections, and notifying the Infection Preventionist Nurse of a new admissions or newly diagnosis of infection(s) to ensure resident(s) are placed on correct isolation. On 9/11/2024 the Infection Preventionist Nurse completed an audit to ensure any resident(s) on Enhanced Barrier Precautions was on appropriate isolation. 4.Beginning 9/11/2024 the Infection Preventionist Nurse and Director of Nursing will monitor all new admits and readmits for isolation precaution ongoing daily based on admissions and readmission. The Infection Preventionist Nurse will submit reports to the Executive Director monthly for review. The Executive Director will present the monthly reports to the monthly Quality Assurance Committee beginning 10/23/2024 for three months. The Quality assurance Committee (QA) will make recommendation for the continuation of audits or discontinuation based upon results achieved.	

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M1570	Continued From page 20 Review of hospital lab values for Resident #83 dated 9/3/24 revealed C. Difficile results was positive. In an interview with Licensed Practical Nurse (LPN) #2 on 9/9/24 at 1:20 PM, she revealed Resident #83 was not on contact precautions for C-Diff. She stated she asked the night nurse if the resident was supposed to be on isolation because he was on medication for C-diff, and the nurse told her no because he was treated in the hospital. LPN #2 stated she should have questioned this further. In an interview with the Director of Nursing on 9/9/24 at 1:50 PM, she revealed that Resident #83 did come back from the hospital with orders to treat C-Diff and confirmed staff should have placed him on contact isolation to reduce the risk of infection transmission. In an interview with Assistant Director of Nursing/Infection Control nurse on 9/10/24 at 11:38 AM, she confirmed Resident #83 should have been placed on contact isolation when he returned from the hospital the evening of 9/8/24 to reduce the spread of the infection. Review of the "Admission Record" revealed the facility admitted Resident #83 on 6/09/23 with a diagnosis of Chronic Obstructive Pulmonary Disease. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/9/24 revealed a Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact	M1570		