STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255158	A. BUILDING _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF HATTIESBURG	10 MEDICAL BOULEVARD HATTIESBURG, MS 39401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 10/21/2024 through 10/24/2024. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F641, F656, F679, F842, and F880. The facility had a census of 95 and was licensed for 120 beds.	F 000		
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 record review, staff interview, and facility policy review, the facility failed to accurately complete a Minimum Data Set (MDS) Discharge assessment for one (1) of nineteen (19) assessments reviewed. Resident #93. Findings Include: A review of the facility's policy titled "Conducting an Accurate Resident Assessment," revised in February 2023 and October 2023, revealed: "Policy: 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." A record review of the "Admission Record" revealed that the facility admitted Resident #93	F 641	1. Immediately upon notification the Minimum Daa Set (MDS) Assessment was corrected by the Minimum Data Set, Director. This corrected Minimum Data Set was transmitted on 11/5/2024. 2. All residents have the potential to be affected by this practice. 3. The Staff Development Nurse will inservice the MDS nurses, Activities, Social Services & Dietary on the importance of accurate coding of the MDS assessments on 11/15/24. The Minimum Data Set (MDS) nurses will verify accuracy of	11/21/24

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

Electronically Signed | 11/07/2024

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F 641	Continued From page 1 on 09/19/24 with diagnoses including Chronic Kidney Disease. A record review of the "Order Summary Report" revealed Resident #93 had a Physician's Order dated 10/4/24 to discharge to home on 10/6/24. A record review of the Discharge (MDS with an Assessment Reference Date (ARD) of 10/06/24 indicated Resident #93 was discharged to a "Short-Term General Hospital." During an interview on 10/22/24 at 11:00 AM, the Director of Nursing (DON) explained that Resident #93 was only at the facility for therapy, and although the discharge was planned, it was sudden due to the resident's insurance status and personal choice. She confirmed that Resident #93 was discharged to his home with his wife. At 1:15 PM on 10/23/24, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed that she completes Section A of the MDS. She initially believed that she coded Resident #93's discharge correctly as "discharged home" but, after reviewing the Discharge MDS, she confirmed it was coded as though the resident discharged to short-term general hospital, which was not accurate. During an interview on 10/24/24 at 09:50 AM, the DON acknowledged awareness of the inaccurate discharge status for Resident #93 and recognized it as a coding error. She stated that she signs off on assessments for accuracy and completion, explaining that she expects all MDS staff, as well as herself, to complete assessments accurately and correctly. The DON confirmed that the discharge status for Resident #93 was completed	F 641	assessments completed by the other MDS team member prior to final submission. 4. The accuracy of the Minimum Data Set (MDS) assessments will be monitored, by the MDS Director, for 3 months beginning on 10/28/24. The findings of each months monitoring will be reviewed, discussed and revisions made if needed at the monthly Quality Assessment & Assurance Committee Meeting beginning on 11/20/24 and continuing for 3 months.	

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F 641	Continued From page 2 in error and emphasized her expectation of accuracy in all assessments conducted by the facility staff.	F 641		
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 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	F 656		11/21/24

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F 656	Continued From page 3 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 observation, interviews, record review, and facility policy review, the facility failed to implement care plan interventions for one (1) of nineteen (19) sampled residents. Resident #6. Findings Include: A review of the facility policy titled "Comprehensive Care Plans", revised 8/24/22 revealed, " ...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 the resident's medical, nursing, and mental and psychosocial needs as identified in the resident's comprehensive assessment ..." A record review of the comprehensive care plan for Resident #6 revealed a "Problem" of "The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs" with "Interventions" including "Provide the resident with materials for individual activities as desired. The resident likes the following	F 656	1. Immediately upon notification the Administrator procured the items which were care planned for the resident. Spanish crossword puzzle books, spanish seek a word books, culturally appropriate adult coloring books as well as a tablet with all the above mentioned apps. In addition apps have been loaded to the tablet for translation and music. 2. All residents who have specific ethnic or cultural needs have the potential to be affected by this practice. 3. Staff Development Nurse will in-service, on 11/15/24,Activities staff on the requirement and importance of providing ethnic and cultural materials and resources in order to implement appropriate care plan interventions. 4. The facility administrator will monitor,	

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F 656	Continued From page 4 independent activities: Spanish word search puzzles ...add content of interest i.e. Spanish speaking programs..." A record review of the "Admission Record" revealed the facility admitted Resident #6 on 03/04/21 with diagnoses including Parkinson's Disease. A record review of the Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 08/20/24 revealed Resident #6's preferred language was Spanish, and she had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated her cognition was severely impaired. On 10/21/24 at 11:01 AM, during an observation, Resident #6 was lying in bed, awake, with the television on an English-language channel. Upon asking Resident #6 if she would prefer the television to be on a Spanish-speaking channel, she nodded affirmatively. On 10/21/24 at 1:16 PM, in an interview, the Activities Assistant explained that the primary in-room activity she engaged in with Resident #6 involved brief visits to chat about family topics, including children and grandchildren. The Activities Assistant noted that the resident preferred staying in her room and did not participate in group activities. She added that Resident #6 enjoyed music, Spanish puzzles, coloring sheets, and watching television; however, she admitted that the television was set to English channels and that no attempts had been made to explore Spanish-language options. She acknowledged that no in-room activities were currently available that catered to Resident #6's	F 656	beginning on 10/28/24 and continue to monitor for three months, to ensure that the needs of residents with specific ethnic or cultural needs are appropriately care planned and materials and resources are provided. This information will be presented at the monthly Quality Assessment & Assurance Committee Meeting for review, discussion and revision if needed beginning on 11/20/24 and will continue for a 3 month period.	

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F 656	Continued From page 5 cultural preferences. On 10/22/24 at 11:25 AM, during an observation and interview, the Activities Director confirmed that the facility had no culturally specific activities for Resident #6, who is Spanish speaking. While in Resident #6's room, she confirmed the presence of a CD player but observed no CDs or materials for the resident to play. The Activities Director stated she knew it was important for the resident to have activities that she specifically enjoyed because this was her home, and it was a part of making her feel loved and considered. On 10/23/24 at 8:13 AM, in an interview, the Administrator stated that she was not aware the activities department was not following the care plan regarding activities for Resident #6. She emphasized the importance of quality and continuity of care for all residents, noting that this is the resident's home, and the facility should cater to Resident #6's preferred activities and cultural preferences to ensure her satisfaction. During an interview on 10/23/24 at 8:45 AM, the Minimum Data Set (MDS) Coordinator explained that the purpose of each care plan is to guide facility staff in providing individualized care to each resident. She stated that not following the care plan for Resident #6's preferred activities was an issue, reinforcing the need for all staff to adhere to the resident's care plan.	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan	F 679		11/21/24

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F 679	Continued From page 6 and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to implement individualized and culturally relevant activities to meet the interests and preferences of one (1) of two (2) Spanish-speaking residents reviewed for activities. Resident #6. Findings Include: A review of the facility's policy, "Activities", dated 10/1/22, revealed, " Policy: It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on the comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident...Policy Interpretation and Implementation ...2. Activities will be designed with the intent to ...g. Reflect cultural and religious interests of the residents ...4. Activities may be conducted in different ways ...b. Person Appropriate - activities relevant to the specific needs, interests, culture, background, etc. for the resident they are developed for ..." During an observation on 10/21/24 at 11:01 AM, Resident #6 was observed lying in bed, awake, with the television on an English-language channel. Upon asking Resident #6 if she would	F 679	1. Immediately upon notification the Administrator procured the items which were care planned for the resident. Spanish crossword puzzle books, Spanish seek a word books, culturally appropriate adult coloring books as well as a tablet with all the above mentioned apps. In addition apps have been loaded to the tablet for translation and music. 2. All resident who have specific ethnic or cultural needs have the potential to be affected by this practice. 3. Staff Development Nurse will in-service, on 11/15/24, Activities staff on the requirement and importance of providing individulized and culturally relevant activities in order to meet the interests and preferences of residents. 4. The administrator, beginning on 10/28/24 and continuing for 3 months, will monitor to ensure that all residents with specific	

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F 679	Continued From page 7 prefer the television to be on a Spanish-speaking channel, she nodded affirmatively. During an interview on 10/21/24 at 1:16 PM, the Activities Assistant explained that the primary in-room activity she engaged in with Resident #6 involved brief visits to chat about family topics, including children and grandchildren. The Activities Assistant noted that the resident preferred staying in her room and did not participate in group activities. She added that Resident #6 enjoyed music, Spanish puzzles, coloring sheets, and watching television; however, she admitted that the television was set to English channels and that no attempts had been made to explore Spanish-language options. She acknowledged that no in-room activities were currently available that catered to Resident #6's cultural preferences. During an observation and interview on 10/22/24 at 11:25 AM, the Activities Director confirmed that the facility had no culturally specific activities for Resident #6, who is Spanish speaking. While in Resident #6's room, she confirmed the presence of a compact disc (CD) player but observed no CDs or materials for the resident to play. The Activities Director stated she knew it was important for the resident to have activities that she specifically enjoyed because this was her home, and it was a part of making her feel loved and considered. During an interview on 10/23/24 at 8:13 AM, the Administrator stated that she was unaware that the activities department was not providing culturally relevant activities. She emphasized the importance of providing quality and consistent care for all residents, acknowledging that	F 679	ethnic or cultural needs, are provided with culturally relevant materials and resources. The results of this monitoring will be presented at the monthly Quality Assessment & Assurance Committee Meeting for review, discussion and revision if needed beginning on 11/20/24 and will be reviewed by this committee for three months.	

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F 679	Continued From page 8 Resident #6's cultural preferences should be respected as part of honoring her home environment. During an interview on 10/24/24 at 9:55 AM, Resident #6's granddaughter, acting as her Resident Representative (RR), shared that in her four years of visiting the facility, she had not observed any activities provided that aligned with her grandmother's cultural background. She expressed that her grandmother would benefit from having television programs or audio content in Spanish, as she believed this would enhance her enjoyment and connection to her heritage. A record review of the "Visual/Bedside Kardex Report" as of 10/22/24 revealed " ...Resident Care ...Activities ...Proved the resident with materials for individual activities as desired. The resident likes the following independent activities: Spanish word search puzzles ..." A record review of the "Admission Record" revealed the facility admitted Resident #6 on 03/04/21 with diagnoses including Parkinson's Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/20/24 revealed Resident #6's preferred language was Spanish and she had a Brief Interview for Mental Status score of 4 which indicated her cognition was severely impaired.	F 679		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is	F 842		11/21/24

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F 842	Continued From page 9	F 842		

resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical

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F 842	Continued From page 10 record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately document a resident's weight in the medical record for one (1) of 19 sampled residents. Resident #49 Findings include: A review of the facility's policy, "Weighing and Measuring the Resident", dated 8/2/22, revealed, " ...The purpose of this procedure are to determine the resident's weight ...to provide ...an ongoing record of the resident's body weight as an indicator of the nutritional status and medical	F 842	1. On 11/5/24 the incorrect weight of 211.4 pounds was struck from the record by the Director of Nursing. The Minimum Data Set (MDS) assessment was modified/corrected and resubmitted. 2. All residents have the potential to be affected by this practice 3. On 11/15/24 an in-service will be presented, to nursing staff, by Staff Development on the procedure of obtaining correct weights,	

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F 842	Continued From page 11 condition of the resident ...Documentation ...The following information should be recorded in the resident's medical record ...2. The ...weight of the resident ...Reporting 1. Report significant weight loss/weight gain to the nurse supervisor ..." A record review of the "Admission Record" revealed the facility admitted Resident #49 on 5/29/2023 with diagnoses including End Stage Renal Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/30/2024 revealed Resident #49 had a weight loss of 5% or more in the last month or loss of 10% or more in last six (6) months. A record review of the "Weights and Vitals Summary" revealed Resident #49 had a "Warning" on 5/17/24 of a significant weight increase in which his weight was recorded as 211.4 pounds. On 5/20/24, there was a "Warning" that Resident #49 had a significant weight loss in which his weight was recorded as 186.5 pounds. On 10/22/2024 at 3:29 PM, in an interview with the Director of Nursing (DON), she explained she was unaware that Resident #49 had triggered a warning for weight loss as it had not been on the weekly weight reports. The DON expressed she believed the weight entered for Resident #49 on 5/17/24 was entered in error and that the resident's weights have been between 175-192 pounds since his admission by the facility. In an interview on 10/23/24 at 2:20 PM, with the Dietary Manger, she explained she was responsible for entering the information to	F 842	review and input of weights and immediate reporting of any significant changes found. This will be monitored by the Resident Care Coordinator beginning on 10/28/24 and will be monitored for 3 months. 4. Weight changes will be reviewed at the weekly high risk meeting beginning on 10/25/24 for 3 months. These findings will be taken to the Quality Assessment & Assurance Committee Meeting beginning on 11/20/24. These findings will be reviewed, discussed and revisions made if needed for 3 months.	

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BEDFORD CARE CENTER OF HATTIESBURG	10 MEDICAL BOULEVARD HATTIESBURG, MS 39401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 12 complete Section K of the Minimum Data Set (MDS). She stated that she entered the residents' weights that are given to her from the weight team. She said that she if she saw a weight that looked inaccurate, she would question the weight team. The Dietary Manager expressed that having accurate resident weight information was important because the one inaccuracy can have a negative effect on other parts of the MDS. On 10/23/24 at 3:10 PM, in an interview with Registered Nurse (RN) #1, she explained there were several factors that could contribute to a change in a resident's weight. She further explained that any major weight gains or losses would be triggered by the computer system and the resident would be re-weighed to ensure accuracy. RN #1 reviewed the weights entered into the medical record for Resident #49 and expressed that the weights were not accurate, and she was unsure as to why the resident was not re-weighed.	F 842		
F 880 SS=E	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	F 880		11/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 13 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 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.	F 880		

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F 880	Continued From page 14 §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, interview, and facility policy review, the facility failed to store reusable medical equipment in a manner to prevent the possible spread of infection as evidenced by mechanical lift batteries stored in the biohazard room on the rehabilitation hall for one (1) of two (2) biohazard storage rooms reviewed. Findings include: A review of the facility's policy, "Infection Prevention and Control Program", revised 6/15/23, revealed, " Policy: This facility has established and maintained an infection prevention and control program to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines ...Policy Explanation and Compliance Guidelines ...10. Equipment Protocol ...a. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with current procedures ..."	F 880	1. Immediately upon notification, 10/24/24, the lift batteries were cleaned and sanitized by the facility Infection Preventionist. 2. All residents have the potential to be affected by this practice. 3. The lift batteries and all charging devices were removed from the bio-hazard room on the Rehabilitation Hall on 10/28/24. These batteries and charging devices were relocated to the alcove outside the rehabilitation supply room. Sanitizing wipe holder/wipes were also installed in Rehabilitation Hall supply room for sanitizing batteries prior to use. Infectionn Control inservice will be provided on 11/15/24 by Staff Development. 4. The placement of these batteries and	

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F 880	Continued From page 15 During an observation on 10/24/24 at 10:11 AM, of the biohazard room located on the Rehabilitation Hall, there was two (2) mechanical lift batteries on charging stations and two (2) batteries stored in the room. On 10/24/24 at 11:00 AM, in an interview and observation with Certified Nurse Aide (CNA) #1, the mechanical lift battery charging station and batteries were in the biohazard room on the Rehabilitation Hall. CNA #1 explained that the biohazard room was considered a "dirty area" and where she would place batteries that needed to be charged and would get the charged batteries as needed. There were no cleaning supplies available in area for sanitizing the batteries before using them on the mechanical lifts. On 10/24/24 at 11:08 AM, in an interview and observation with the Director of Nursing (DON), Registered Nurse (RN) #2, and RN #3 (Infection Control Team) they confirmed the mechanical lift charging stations and batteries were stored in the biohazard room on the Rehabilitation Hall and that any items retrieved from the contaminated room should be cleaned before re-using. The infection control team also confirmed there were no cleaning supplies in the area for the staff to clean the batteries before using. On 10/24/24 at 11:14 AM, in an interview with the Administrator, she stated she expected the facility staff to not store clean items in an area that is considered contaminated.	F 880	charging devices will be monitored for 3 months by the Maintenance Director beginning on 10/28/24.The results of this monitoring be taken to the Quality Assessment & Assurance Committee Meeting for review, discussion and revision if needed beginning on 11/20/2024.These findings will be taken to this committee for 3 months.	