| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 255145 | A. BUILDING _____ B. WING _____ | 01/09/2025 |

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| COURTYARD REHABILITATION AND HEALTHCARE | 501 SOUTH LOCUST STREET MCCOMB, MS 39648 |

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| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an Annual Recertification Survey and four (4) Complaint Investigations (CI MS #26789, CI MS #26809, CI MS #26810, and CI MS #27323) at the facility from 01/06/25 through 01/09/25. The SA investigated CI MS #26789 for activities of daily living, transfer notice and dignity, CI MS #26809 for rights, quality of care and dignity, CI MS #26810 for abuse and rights, and CI MS #27323 regarding abuse, resident right and safety. There were no citations related to the CI's.The SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550, F656, F689, F800, F804 and F880 related to the annual survey.<br><br>The census at the time of the survey was 119 and the facility was licensed for 145 beds. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal | F 550 | | 2/19/25 |

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

Electronically Signed | 01/30/2025

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|---|---|---|---|---|
| F 550 | Continued From page 1<br>access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interview and record review, the facility failed to ensure that the dignity and respect of residents are upheld when feeding during mealtimes for one (1) of 26 sample residents reviewed. Resident #3<br><br>Findings includes:<br><br>An observation and interview on 1/06/25 at 1:30 PM, revealed Certified Nursing Assistant #1 (CNA) assisting Resident #3 with lunch. This observation revealed CNA #1 was standing up while feeding the resident. During an interview with CNA #1 stated that she did not know that she | F 550 | Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 1/10/2025 and based on the findings Certified Nursing Assistant #1 and Charge Nurse #1 were educated by the Director of Nursing (DON) on 1/7/2025 on maintaining dignity and respect for Residents ensuring staff are seated when feeding Residents.<br><br>Resident #3 was informed of the right to have dignity and respect when being fed on 1/7/2025 by the Director of Nursing. | |

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| F 550 | Continued From page 2<br>was not supposed to stand up when feeding residents.<br><br>On 01/07/25 at 12:50 PM, Charge Nurse #1 stated during an interview that she was unaware that staff should sit down when feeding residents. She acknowledged that standing while assisting a resident with meals could raise dignity concerns.<br><br>On 1/7/25, at 1:04 PM, during an interview with the Director of Nursing (DON) emphasized that CNAs should always sit at eye level when assisting residents with meals. She explained that sitting down prevents residents from feeling intimidated by staff who are standing over them and this approach enables eye contact which helps residents feel more comfortable. She noted that this practice is important as it maintains the residents' dignity.<br><br>A record review of Resident #3's "Admission Record" revealed the facility admitted the resident on 1/22/24 with diagnoses including Primary Generalized Osteo Arthritis and Cognitive Communication Deficit.<br><br>A record review of Resident # 3's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 10/25/24 revealed a Brief Interview for Mental Status (BIMS) of 03 indicating the resident was severely cognitively impaired. Section GG revealed substantial maximum assistance with eating. | F 550 | Residents requiring Activity of Daily Living (ADL) assistance has the potential to be affected.<br><br>Education was conducted by the Regional Director of Clinical Services (RDCS) on 1/7/2025 with the Executive Director (ED) and Director of Nursing (DON) on Resident Rights and Dignity with emphasis on staff sitting while feeding Residents.Education was initiated by the DON on 1/7/2025 with all staff on Resident Rights and Dignity with emphasis on Resident Rights and Dignity and staff sitting while feeding Residents. Staff will maintain Resident Rights and Dignity by sitting while feeding residents at the level of the resident.New hired staff will be educated during orientation.<br><br>Quality Monitoring through observation was started on 1/10/2025 by the Executive Director and will be conducted with a sample of 10 Residents requiring feeding assistance daily for 2 weeks, then a sample of 5 residents 3 times weekly for 2 weeks; a sample of 5 residents weekly for 2 weeks; then monthly thereafter for 3 months. Findings will be reported to the Quality Assurance Committee monthly beginning 2/12/2025 by the Director of Nursing and 3 months thereafter. | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and | F 656 | | 2/19/25 |

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|---|---|---|---|---|
| F 656 | Continued From page 3 | F 656 | | |

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 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

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| F 656 | Continued From page 4<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, record review, and facility policy reviews, the facility failed to implement care plan interventions related to wound care when a nurse cleaned a resident's pressure ulcer wound without patting it dry for one (1) of 43 resident care plans reviewed (Resident #64)<br><br>Findings included:<br><br>Record review of the facility's policy titled "Plans of Care," revised 9/25/2017, revealed, "The Individualized Person-Centered plan of care may include ...Services are provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ..."<br><br>Record review of Resident #64's comprehensive care plan revealed " ... Interventions/Task ...Cleanse Stage 4 sacrum with wound cleanser and 4 x 4 gauze. Pat dry with 4 x 4 gauze ..."<br><br>During an observation on 1/8/2025 at 12:03 PM, Registered Nurse (RN) #2 did not pat the wound dry with gauze on the sacral region as described in Resident #64's care plan.<br><br>On 1/8/2025 at 2:20 PM, during an interview, RN #2 admitted she did not pat the sacral region dry with gauze as per Resident #64's care plan.<br><br>On 1/9/2025 at 12:00 PM, during an interview, RN #3 Minimum Data Set (MDS/Care Plan) nurse, | F 656 | Root Cause Analysis was conducted on 1/10/2025 and based on findings the Director of Nursing provided wound care according to the comprehensive care plan for Resident #64 on 1/8/2025. Registered Nurse #2 was educated on following Care Plan for providing wound care by the Director of Nursing on 1/8/2025.<br><br>Residents with physician orders for wound care have the potential to be affected.<br><br>Education was conducted by the Director of Nursing on following Care Plan when providing wound care with all nursing staff begining 1/8/2025.Wound Care will be provided according to the physician order and Comprehensive Care Plan. Care plans will be updated in morning clinical meeting with any new wound care orders beginning 1/9/2025.New hires will be educated during orientation.<br><br>Quality monitoring began on 1/10/2025and will be conducted by the Director of Nursing, Unit Manager or Charge Nurse on Care Plans to ensure care plans are updated and followed with emphasis on providing wound care according to the care plan for a sample of 2 residents 3 times weekly for 4 weeks | |

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| F 656 | Continued From page 5<br>stated that care plans are created to inform staff of residents' care needs and should be followed by all staff. She emphasized the importance of adhering to the care plan when providing care.<br><br>Record review of Resident #64's "Admission Record" revealed an admission date of 1/24/2024 with diagnoses including Pressure Ulcer of Right Heel, Stage 2 and Pressure Ulcer of the Sacral Region, Stage 4. | F 656 | and then weekly for 2 months. Findings will be reported Quality Assurance Committee monthly beginning 2/12/2025 and presented by the Director of Nurses for 3 months. | |
| F 689 SS=E | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility policy review, the facility failed to securely safeguard hazardous chemicals in two unlocked janitor's closets for one (1) of four (4) days of survey.<br><br>Findings Include:<br><br>Review of the facility ' s policy, "Overview of Proper Chemical Use," revised 6/2016, revealed, "In order to help prevent accidents from occurring you must follow the following guidelines: 6. If you leave chemicals in the janitor's closet the door must be locked ..." | F 689 | Root Cause Analysis was conducted on 1/9/2025 by the Interdisciplnary Team and based on the findings a new continious lock door handle was installed on the 2 janitor closets doors by the Maintenance Supervisor on 1/9/2025.<br><br>All residents have the potential to be affected.<br><br>Education with the Housekeeping Staff was conducted by the Environmental Services Supervisor on 1/15/2025. All storage areas with chemicals stored will be kept locked at all times. | 2/19/25 |

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| F 689 | Continued From page 6<br>An observation on 01/06/25 at 10:30 AM, revealed the "Janitor Closet" on the 200 hall was unlocked and there was a full bottle of 3M Concentrated Glass Cleaner in the closet.<br><br>An observation on 01/06/25 at 11:19 AM, revealed the "Janitor Closet" on the Intermediate Care (IC) Hall was unlocked and unattended and there were containers of 3M Concentrated Glass Cleaner and 3M Quat Disinfectant.<br><br>On 01/07/25 at 3:19 PM, during an interview, Housekeeping Supervisor #2 confirmed that the "Janitor Closet's" were unlocked. She also confirmed that these rooms were used to store housekeeping carts containing chemicals and cleaning supplies, posing a potential safety hazard, especially for cognitively impaired residents. She disclosed the "Janitor Closet" doors were keyed. However, she did not possess keys to ensure they remained locked. She revealed that maintenance issues are usually given to maintenance verbally, but she had not notified maintenance of these doors being unlocked but would ask a nurse to notify them.<br><br>An interview on 01/07/25 at 3:37 PM, with Maintenance Staff #1 revealed that he was unaware of the problems with janitor closets not locking until today. He confirmed that the janitor closets were used to store carts containing chemicals and cleaning supplies, emphasizing the potential safety concern this posed, particularly for residents that are cognitively impaired.<br><br>An interview on 01/08/25 at 1:45 PM, the Director of Nursing (DON) confirmed that unlocked rooms storing cleaning supplies was a safety issue for | F 689 | Education with all staff was conducted by Director of Nursing, Assistant Director of Nursing and Unit Managers that all chemicals are stored behind locked doors on 1/30/2025.<br><br>Quality monitoring will be conducted by observation by Environmental Services Supervisor, Executive Director, Maintenance Supervisor or Environmental Services Assistant Supervisor daily for 3 months starting 1/10/2025. Findings will be reported to the Quality Assurance Committee starting 2/12/25 and presented by the Environmental Services Supervisor for 3 months. | |

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| F 689 | Continued From page 7<br>residents particularly those that were identified as wanderers and should remain locked.<br><br>An interview on 01/09/25 at 10:00 AM, the Administrator confirmed not properly securing the janitors closets that housed chemicals posed a potential hazard, especially for cognitively impaired residents. She continued by admitting that any maintenance issue should be clearly communicated and corrected.<br><br>A record review of the "Safety Data Sheet", dated 6/5/24, revealed "Glass Cleaner Concentrate" had a "Hazard identification" classification that indicated "Serious Eye Damage/Irritation." Review of "Handling and storage" revealed "Precautions for safe handling" included "Keep out of reach of children ..."<br><br>A record review of the "Safety Data Sheet", dated 10/9/18, revealed "Quat Disinfectant Cleaner Concentrate ' had a "Hazard identification" classification that indicated "Serious Eye Damage/Irritation" and "Skin Corrosion/Irritation" and "May cause chemical gastrointestinal burns." Review of "Handling and storage" revealed "Precautions for safe handling" included "Keep out of reach of children ..." | F 689 | | |
| F 800 SS=E | Provided Diet Meets Needs of Each Resident<br>CFR(s): 483.60<br><br>§483.60 Food and nutrition services.<br>The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.<br>This REQUIREMENT is not met as evidenced | F 800 | | 2/19/25 |

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| F 800 | Continued From page 8<br>by:<br>Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure dietary staff supported and respected a resident's right to make choices about his or her meal preferences for one (1) of twenty-six (26) sampled residents. Resident #40.<br><br>Findings Include:<br><br>Record review of the facility policy "Menus" revised 10/2022, revealed, " ...Procedures...2. Menus will be periodically presented for resident review, including the resident council, menu review meetings, or other review board as indicated by the center. The menu will identify the primary meal, the alternate meal, and any always offered food and beverage items ..."<br><br>An observation on 1/6/25 at 10:52 AM, revealed a menu hanging in both dining areas that did not include alternate options.<br><br>An interview on 01/7/25 at 11:13 AM, with Resident #40 indicated that alternate meals are never posted or available for selection. She stated that this situation upsets her because she feels they have no choice but to eat what is provided. Resident #40 explained that, as a diabetic, she may not particularly like the food being served, but she must eat something to avoid getting sick.<br><br>An interview on 1/8/25 at 7:52 AM, with the Dietary Manager confirmed that the menus were outdated and did not contain alternate options at this time plus their system does not allow them to consider any alternates or individual preferences for the residents. She confirmed that residents | F 800 | Root Cause Analysis was conducted by the Interdisciplinary Team on 1/10/2025 and based on the findings the Dietary Manager (DM) was educated by the Director of Operations on 1/8/2025 on maintaining Resident Rights ensuring alternate meals are offered to residents according to their preference.<br><br>Residents with a Diet order have the potential to be affected.<br><br>Education was conducted on 1/10/2025 by the District Manager with dietary staff on preparing alternate meal to meet Resident Rights. Education was conducted by Director of Nursing, Unit Manager or Charge Nurse on 1/10/2025 with current staff on Resident Rights to receive meals according to their preference. Alternate meals will be prepared by the dietary staff. Alternate meals will be posted on menu board in each dining room beginning 1/10/2025. Food committee meets monthly to discuss menus, preferences and recommendations by residents. The Dietary Manager conducts interviews with Residents for food preferences on admission.New hired staff will be educated in orientation.<br><br>Quality Monitoring through observation was started on 1/10/2025 by the Executive Director, Director of Nursing, Unit Manager or Dietary Manager to ensure alternate meals are prepared, offered and posted. Monitoring will occur 3 | |

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|---|---|---|---|---|
| F 800 | Continued From page 9<br>should have current menus available, however, they do not provide alternate options for residents because the computerized system formulates their menu for the month based on the resident's allergies, likes and dislikes as identified on admission. She continued by admitting since it included so much information then there was no room for alternative or individual preferences. The Dietary District Manager confirmed that the residents should have the choice of an alternate meal by at least providing an "always available" menu.<br><br>A record review of the "Admission Record" reveals the facility admitted the Resident on 12/9/2016 with diagnoses including Type 2 Diabetes and Hypertension.<br><br>A record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/3/25 revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. | F 800 | times weekly for 4 weeks then weekly for 2 months. The findings of the Quality Monitoring will be reported to the Quality Assurance Committee on 2/12/2025 by the Dietary Manager and will continue monthly for 3 months. | |
| F 804 SS=E | Nutritive Value/Appear, Palatable/Prefer Temp<br>CFR(s): 483.60(d)(1)(2)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, record review, | F 804 | Root Cause Analysis was conducted by | 2/19/25 |

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| F 804 | Continued From page 10<br>and facility policy review, the facility failed to provide palatable, appropriately temperature-controlled foods for one (1) of (43) sampled residents. Resident #40<br><br>Findings included:<br><br>A review of the facility's policy titled "Food Quality and Palatability Policy" (HCSG Policy 006), revised February 2023, revealed, "Policy Statement: Food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive, and served at a safe and appetizing temperature. Food and liquids are prepared and served in a manner, form, and texture to meet the residents' needs..."<br><br>During an interview on 1/7/2025 at 11:19 AM, Resident #40 complained the food served was usually cold.<br><br>An observation and interview on 1/7/2025 at 12:09 PM, a meal tray was provided, and temperatures were evaluated by the Dietary Manager. The temperatures were as follows: white rice, 122°F (Fahrenheit); spinach, 122°F; and egg noodles with gravy, 109°F. A sampling of the meal tray revealed that the food was bland and not served at a palatable temperature. During an interview at this time the Dietary Manager agreed that these temperatures were unacceptable and noted that residents might not want to eat food at such temperatures.<br><br>A record review of the "Admission Record" revealed the facility admitted Resident #40 on 12/09/2016 with diagnoses including Type 2 Diabetes Mellitus. | F 804 | the Interdisciplinary Team on 1/10/2025 and based on the findings Resident #40 was informed of her right to have palatable, attractive food at a proper temperature.<br><br>Residents with a Diet order have the potential to be affected.<br><br>Education was conducted on 1/10/2025 by the District Manager with dietary staff on preparing meals according to menu, preparing attractive meal trays and appropriate temperatures for maintaining food on serving line. Food temperature on serving line will be maintained at 135 degrees. New hired staff will be educated during orientation.<br><br>Quality Monitoring will be conducted by the Dietary Manager with a sample of 5 trays alternating meals 3 times weekly for 4 weeks then 5 trays alternating meals weekly for 2 months to ensure attractive, palatable food with proper temperatures beginning 1/10/2025. The findings of the Quality Monitoring will be reported to the Quality Assurance Committee on 2/12/2025 by the Dietary Manager and will continue monthly for 3 months. | |

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| | 255145 | A. BUILDING _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 804 | Continued From page 11<br><br>A record review of the Minimum Data Set (MDS) with an Assessment Reference date of 1/3/2025 revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. | F 804 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other | F 880 | | 2/19/25 |

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| F 880 | Continued From page 12<br>persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, record review, and policy review, the facility failed to prevent the possibility of the spread of infection as evidenced | F 880 | Root Cause Analysis was conducted by the Interdisciplinary Team on 1/10/2025 and based on the findings perineal care | |

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| F 880 | Continued From page 13<br>by improper hand hygiene practices and wound care for three (3) of six (6) direct care observations. (Resident #3, Resident #64 and #66)<br><br>Findings included:<br><br>Record review of the facility's "Handwashing Hand Hygiene" policy, revised August 2019 revealed "Policy Statement The facility considers hand hygiene the primary means to prevent the spread of infection. Policy Interpretation and Implementation ... 2. All personnel shall follow the handwashing hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 3. Hand hygiene products and supplies (sink, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use..."<br><br>Record review of the facility's policy titled "Dressing, Dry Clean," revised September 2013, revealed, " ... Steps in the Procedure ...15. Cleanse the wound with the ordered cleaner. If using gauze, use a clean gauze for each cleaning stroke. Clean from the least contaminated to the most contaminated area (usually, from the center outward). 16. Use a dry gauze to pat dry..."<br><br>Resident #3<br><br>On 1/6/2025 at 11:00 AM, Certified Nursing Assistant (CNA) #1 and CNA #2 both entered the room, applied gloves, and began perineal care for Resident #3 without performing hand hygiene prior to applying clean gloves. CNA #1 pulled six (6) premoistened wipes from the packet and began cleaning the perineal area. When she ran out of wipes, she retrieved additional wipes from | F 880 | was provided with the appropriate Infection Control Techniques for Resident #3, and wound care with appropriate Infection Control Techniques were provided for Resident #64 and #66 by the Director of Nursing on 1/8/2025.<br><br>Resident requiring Activities of Daily Living assistance for incontinence and Residents requiring wound care have the potential to be affected.<br><br>Education with the Licensed Nurses, Certified Nursing Assistance and the Infection Preventionist was conducted by the Director of Nurses or Unit Managers on 1/16/2025 regarding Infection Control practices to prevent the spread of infection while providing wound care and perineal care with emphasis on Hand Hygiene, Clean Dressing changes and Cross Contamination.New hires will be educated during orientation.<br><br>The Director Of Nursing, Unit Managers or Assistant Director Of Nursing will monitor Wound Care and Perineal Care through observation with a sample of 2 residents 3 times weekly for 4 weeks; then weekly for 2 months with emphasis on providing wound care and perineal care in manner to prevent the spread of infection. Findings will be reported to the Quality Assurance Committee by the Director of Nursing monthly starting 2/12/2025 and for 3 months thereafter. | |

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| F 880 | Continued From page 14 | F 880 | | |

the packet twice with unclean gloves, touching the outside of the wipe packet during care.

On 1/6/2025 at 11:29 AM, during an interview, CNA #1 confirmed that she forgot to wash her hands before starting care on Resident #3. She acknowledged that her actions could cause infection for the resident and that her failure to remove all needed wipes before starting care was an infection control issue, as she had touched the container with unclean gloves.

On 1/6/2025 at 11:32 AM, during an interview, CNA #2 confirmed that she forgot to wash her hands before beginning perineal care for Resident #3. She confirmed her actions were an infection control issue.

On 1/7/2025 at 12:52 PM, during an interview, Registered Nurse (RN) #1 stated the CNAs should have washed their hands before providing perineal care for Resident #3. She explained that CNA #1 should not have retrieved additional wipes with dirty gloves. RN #1 stated the CNAs caused cross-contamination and risked the spread of infection.

On 1/7/2025 at 1:07 PM, during an interview, the Director of Nursing (DON) confirmed that the CNAs actions represented an infection control issue. She emphasized that staff must wash their hands prior to care, when transitioning from dirty to clean tasks, and after care. She added that failure to follow these practices could result in the spread of infections

A record review of the "Admission Record" revealed the facility admitted Resident #3 on 1/22/2024 with diagnoses including Primary

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| F 880 | Continued From page 15 | F 880 | | |

Generalized (Osteo) Arthritis and Cognitive Communication Deficit.

A record review of Resident # 3's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 10/25/24 revealed a Brief Interview for Mental Status (BIMS) of 03 indicating the resident was severely cognitively impaired. Section GG indicated the resident was dependent for toileting hygiene.

Resident #64

On 1/8/2025 at 12:03 PM, during an observation, Registered Nurse (RN) #2 was observed providing wound care to Resident #64. RN #2 washed her hands and applied gloves. She removed a soiled dressing from the resident's right heel, did not change her gloves and then cleaned the wound. While cleaning the wound she used normal saline and a gauze in a circular motion five times, alternating between dirty to clean and clean to dirty without changing the gauze. She removed a heavily soiled dressing from the sacral area and placed it in a biohazard bag. She then cleaned the sacral wound in the same circular motion six times with the same gauze, again alternating between dirty to clean and clean to dirty and did not pat dry after cleaning as indicated in the physicians order.

On 1/8/2025 at 2:20 PM, during an interview, RN #2 confirmed that she should have performed hand hygiene and applied clean gloves after removing the soiled dressing. She also confirmed that she should not have cleaned the wound in a circular motion multiple times with the same gauze. She acknowledged that her actions could increase the risk of infection and delay wound

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|---|---|---|---|
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| F 880 | Continued From page 16 | F 880 | | |

healing.

A record review of Resident #64's "Order Listing Report" revealed a physician order dated 12/7/2024, "Wound care: Cleanse stage IV (4) pressure ulcer to sacrum with Dakins, pat dry with 4x4 gauze. Apply silver alginate to the wound bed, and cover with bordered gauze daily and prn (as needed.) Physician orders dated 12/13/2024 revealed "Wound care to Stage II (2) ulcer to R (right) heel with NS (normal saline), apply medi honey to the wound bed, cover with an ABD (abdominal) pad, and wrap with Kerlix. Changed daily and PRN (as needed.)

A record review of the "Admission Record" revealed the facility admitted Resident #64 on 1/24/2024 with diagnoses including Pressure Ulcer of the Right Heel, Stage 2 and Pressure Ulcer of the Sacral Region, Stage 4.

A record review of the MDS with an ARD of 11/28/2024 revealed Resident #64 was severely impaired for cognitive skills for daily decision making.

Resident # 66

An observation and interview on 01/08/25 at 10:59 AM, with RN #2 performing wound care on Resident #66 revealed that she donned clean gloves without performing hand hygiene prior to removing and performing wound care to the resident's right knee abrasion. Upon finishing this wound, she rolled resident to his right side, removed a dressing with a moderate amount of foul-smelling purulent discharge on a sacral unstageable pressure ulcer with the same gloves used to dress and undress the first wound. She

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|---|---|---|---|---|
| F 880 | Continued From page 17 | F 880 | | |

then walked to the resident's door, turned open the doorknob with the soiled gloves. An interview with RN #2 confirmed that she had not changed gloves or performed hand hygiene throughout the two procedures and that she opened the door with unclean gloves. She confirmed that infection could be spread from one wound to the other making it harder to heal and that wearing gloves to open the door could spread infection.

An interview on 01/09/25 at 11:50 AM, with the DON confirmed that hand hygiene should be performed before and after completing wound care and before and after removing gloves. She confirmed that not doing this put the resident at risk of infection as well as increased difficulty in wound healing. She also confirmed that gloves should have been removed before touching a doorknob as that could increase the spread of infection throughout the facility. She further stated that it was her expectation that wound care would be performed according to guidelines for infection control and prevention.

Record review of "Admission Record" revealed the facility admitted Resident #66 on 02/23/23 with medical diagnoses that included Pressure Ulcer of Sacral Region Unstageable.

Record review of Resident #66's MDS with an ARD of 10/19/24 revealed Section M revealed the resident has 2 pressure ulcers.