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
	25LI	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND NURSING AND REHABILITATION CENTEI	3680 LAKELAND LANE JACKSON, MS 39216

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and complaint investigations (CIs), MS #27735, CI MS #27678, and CI MS #27680 at the facility from 1/27/25 through 1/30/25. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. The SA investigated CI MS #27735 for medications administration and quality of care and there were no citations regarding this complaint. CI MS #27678 was investigated for concerns regarding staffing, grooming, weight loss, bowel and bladder and falls and M225 were cited. CI MS# 27680 was investigated for concerns of sufficient staffing levels and M225 was cited. Citations regarding the recertification survey included M225, M500, M715, M815, and M1570.	M 000		
M 225	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a	M 225		3/10/25

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M 225	Continued From page 1 registered nurse. b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day shift and be responsible for all nursing services in the facility. c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse. d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency.	M 225		

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M 225	Continued From page 2 This Statute is not met as evidenced by: Level II Based on observation, staff interviews, and record review, the facility failed to ensure sufficient nursing staff to meet the needs of residents for four (4) of 14 staffing days reviewed in January, 2025. (1/19/25, 1/20/25, 1/25/25, and 1/27/25). Findings Include: Record review of a typed document on facility letterhead dated January 30, 2025, and signed by the Executive Director (Administrator) revealed "There is no Staffing policy" A review of anonymous complaints, received 1/20/25 and 1/21/25, revealed "3-11 and 11-7 shifts are always short CNAs" and "there was one CNA working the floor Central Unit by herself on 3-11 Sunday 1/19/25." A record review of the "PBJ (Payroll Based Journal) Data Report" for the 4th Quarter (July 1-September 30) revealed the facility triggered for "One Star Staffing Rating" and "Excessively Low Weekend Staffing." A record review of the "Facility Assessment Tool" dated 1/10/2025, revealed "...There are 3 units: South, Central, and North ...Staffing plan ...Nurse aides ...3-11 CNA (3 South/2 Central/4 North) 11-7 CNA (2-3 south/2 central/ 3 north unit) ..." The facility assessment indicated the resident acuity and population required 9 total CNAs for 3-11 shift and 7-8 CNAs for 11-7 shift. A record review of the staffing grid completed by	M 225	1.Facility ensures that adequate staffing in place with the use of additional as needed staff. 2. All residents in the facility have the potential to be affected by this deficient practice. 3. Staff Development Coordinator, Director of Nursing Services, and nurse manager in-serviced on 1.31.25 by Executive Director regarding maintaining desired staffing level and notifying Executive Director immediately when staffing falls below required levels. 4. Facility will utilize on call, administrative, and agency staff to ensure adequate staffing is maintained. Staff Development Coordinator to provide Executive Director with daily staffing totals and updates regarding call-in and no shows beginning 2.4.25 so that contingency can be arranged. Registered Nurse Supervisor to notify Executive Director on weekends beginning 2.4.25 regarding staffing, call-ins, and no shows so that contingency staff can be arranged. Staff Development Coordinator, Director of Nursing, and Executive Director to have staffing/recruitment beginning 2.10.25 meeting weekly for 4 weeks. Then monthly for 2 months. Minutes to be reviewed in Quality Assurance Committee 3.10.25, then for 2 months	

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the facility revealed on 1/27/24 there were three (3) CNAs on the 11-7 shift (85 census), on 1/25/24 there were three (3) CNAs on the 11-7 shift (87 census), on 1/20/25, there were three (3) CNAs on the 11-7 shift (85 census), and on 1/19/24 there were four (4) CNAs on the 3-11 shift and three (3) CNAs on the 11-7 shift (84 census).

On 01/28/25 at 9:39 AM, during an interview with Licensed Practical Nurse (LPN) #1/Staffing Coordinator, she revealed the facility faces challenges keeping the building staffed on weekends due to frequent call-ins. She noted that while the required number of staff is scheduled appropriately, the high rate of call-ins creates difficulties in maintaining weekend staffing levels. She indicated that this month, January 2025, the facility has had to operate with only one (1) CNA on halls that should have had two (2).

During an interview on 1/28/25 at 5:00 PM, LPN #5 confirmed a resident's medication was left on the resident's table because the resident was slow taking her medication. The nurse stated there was no time to encourage the resident to take her medication because there was only one CNA assigned to the unit to assist with the residents' care, provide showers and meals.

On 1/29/25 at 09:28 AM, during a follow-up interview with LPN #1/Staffing Coordinator, she confirmed the staffing grids accurately reflect all staff that were assigned to the halls, including any agency staff. She said she knows that having one CNA on the units is not appropriate because there should be two on each unit to cover the resident needs.

In an interview with the Administrator on 1/29/25

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M 225	Continued From page 4 at 2:31 PM, she indicated that it was because of illnesses due to COVID-19 and constant call ins as to why they had low staffing on the weekends.	M 225		
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 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	M 500		3/10/25

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M 500	Continued From page 5 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; 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	M 500		

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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 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

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M 500	Continued From page 7 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 Based on observation, interview, record review, and facility job description review, the facility failed to ensure the residents' right to a homelike environment for one (1) of eighteen (18) sampled residents, Resident #5. Findings included: A review of the facility's "Job Description," dated 08/01/2012, for the Director of Maintenance revealed, " ...General Description ...the Director of	M 500	1. Resident #5 was moved to rm#316 on 1.29.25 while floor in residents room was repaired. Laminate was removed and replaced with tile by maintenance director on 1.31.25. 2. All residents that require to maintain homelike environment have the potential to be affected by this deficient practice. 3. Maintenance director was in serviced by Executive Director on 1.30.25 to ensure that all resident rooms will maintain homelike environment. Resident rooms	

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M 500	Continued From page 8 Maintenance ... is accountable for the upkeep of the grounds, Facility, and equipment in a safe and efficient manner ...Essential Duties 1. Provides a safe, clean environment for residents in accordance with Resident Care Policies and Procedures ..." On 01/27/2025 at 3:26 PM, during an observation, Resident #5 was seated in her wheelchair in her room. The resident was confused but able to make simple needs known. The linoleum flooring in the resident's room was torn and folded back under the resident's wheelchair. The flooring was also buckling up under the resident's bed. On 01/27/2025 at 4:00 PM, during an interview, Resident #5's sister stated that the resident's flooring had been torn for several months. She reported that she had complained to the nursing staff and the Administrator because she felt the flooring was a fall risk. On 01/28/2025 at 4:05 PM, during an interview, Certified Nursing Assistant (CNA) #3 stated that the flooring had been in ill repair for at least a month. CNA #3 explained that when housekeeping mopped the floor, they laid the torn flooring back down, but the edges lifted again within a day. CNA #3 also stated that she had reported the issue to the Maintenance Director. On 01/28/2025 at 4:15 PM, during an interview, Licensed Practical Nurse (LPN) #5 stated that the floor had been torn for as long as he could remember. He noted that the sharp edges at the base of the bed continued to rip the flooring each time the bed was moved. He stated that he had placed the information on the clipboard at the nurse's station for the Maintenance Director.	M 500	should be free of hazards related to flooring. 4. On 1.31.25 Maintenance Director and Executive Director conducted room rounds of all resident rooms to ensure no tears in flooring or damages to tile related to flooring existed in any other rooms. Executive Director and Maintenance Director to conduct safety rounds beginning 2.3.25 (2) times per week for 3 weeks and weekly for 4 weeks. Results of round to be reviewed in Quality Assurance Meeting on 3.10.25 then monthly for 2 months.	

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M 500	Continued From page 9 On 01/28/2025 at 4:35 PM, during an interview, the Maintenance Director stated that he had known about the torn flooring for about a month. He reported that he had installed the linoleum flooring approximately a year ago. He stated that he was the only maintenance staff in the facility and had not had the opportunity to repair the floor. The Maintenance Director confirmed that the torn linoleum presented a potential fall hazard for the resident. On 01/28/2025 at 4:40 PM, during an observation and interview, the Administrator confirmed the linoleum in Resident #5's room was torn. The Administrator stated that she was aware of the linoleum coming up and planned to have new tile installed. She reported that she had not had time to complete the repair. The Administrator stated that she expected CNAs to elevate the bed onto its wheels to prevent it from dragging across the floor. She explained that the bed was a crank bed and required staff to manually adjust it. The Administrator confirmed that Resident #5 transferred herself from bed to wheelchair without assistance and was at high risk for falls. A record review of the "Admission Record" revealed Resident #5 was admitted to the facility on 4/21/2017 with diagnoses that included Spinal Stenosis. A record review of Resident #5's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/15/2024 revealed a Brief Interview for Mental Status (BIMS) score of eight (8), which indicated the resident's cognition was moderately impaired.	M 500		

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M 715	Continued From page 10	M 715		
M 715	45.24.4 Labeling of drugs Labeling of drugs. Each facility shall follow the Mississippi State Board of Pharmacy labeling requirements. This Statute is not met as evidenced by: Level II Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were secured and inaccessible to unauthorized residents and staff one (1) of four (4) days of survey observations. Findings included: A review of the facility's policy titled "Medication Storage," dated 01/2015, revealed, " ...All drugs, treatments, and biologicals must be stored securely..." Resident #5 A record review of the "Admission Record" revealed the facility admitted Resident #5 on 04/21/2017 with diagnoses including Spinal Stenosis. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/15/2024 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of eight (8), which indicated the resident's cognition was moderately impaired. On 01/28/2025 at 4:40 PM, during an observation and interview with the Administrator, an	M 715	1. Residents #5,#56, identified as having medications at bedside. Medications immediately removed by Licensed Practical Nurse on 1.28.25. 2. All resident had the potential of being affected by this deficient practice. 3. Nursing staff in-serviced on 2.3.25 by Staff coordinator regarding not leaving medication in residents rooms. Nurse should verify that resident has taken all medications prior to leaving room. Resident cannot have medicated creams in room. 4. Unit Managers and Director of Nursing to make rounds beginning 2.3.25 to ensure no medications are left at bedside 3 times per week for 4 weeks. Then weekly for 3 weeks. Audit tools to be reviewed in Quality Assurance Meeting on 3.10.25, then monthly for 2 months	3/10/25

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unattended medicine cup was observed on Resident #5's bedside table alongside a glass of water. The resident was lying flat in bed, and no staff were present to monitor the resident taking the medication.

On 01/28/2025 at 5:00 PM, during an interview, Licensed Practical Nurse (LPN) #5 confirmed he left the medication on the table because the resident was slow to take her medication. He stated he did not have time to encourage the resident to take her medication as she normally took one pill at a time. He acknowledged that he knew he should not have left the medication unattended because the resident could choke, or another resident could enter the room and take the medication. LPN #5 reported that the medication in the cup included Vitamin C, Multivitamin, Levothyroxine, Metoprolol and Pravastatin.

On 01/28/2025 at 5:15 PM, during an interview, the Administrator confirmed that LPN #5 left the medication in a medicine cup unattended on the resident's bedside table. The Administrator stated she expected nurses to ensure residents swallowed their medications before leaving the room.

Resident #56

A record review of Resident #56's "Admission Record" revealed the facility admitted the resident on 03/05/2024 and currently has diagnoses that include Pruritus.

A record review of the "Order Summary Report" with active orders as of 1/30/2025, revealed Resident #56 had a Physician's Order, dated 10/25/24 for Nystatin External Cream.

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M 715	Continued From page 12 A record review of Resident #56's MDS with an ARD of 11/20/2024 revealed a BIMS score of 15, which indicated the resident was cognitively intact. On 01/28/2025 at 9:08 AM, during an observation and interview with Resident #56, the resident was observed sitting up in bed with two medication dispensing cups containing an unidentified cream on the bedside table. One cup was nearly empty, and the other contained a moderate amount of cream. Resident #56 stated that the weekend nurse gave her the cream to apply as needed for itching. On 01/28/2025 at 9:12 AM, during an observation and interview, LPN #3 acknowledged the medication cups containing some type of cream were left on Resident #56's bedside table. LPN #3 stated that nurses were not supposed to leave any medications at the bedside. After reviewing the physician orders, LPN #3 confirmed the unidentified cream was Nystatin External Cream.	M 715		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation and staff interview, the facility failed to ensure proper food handling and sanitation practices to prevent	M 815	1.Dietary cook in-services 1:1 on 1.28.25 regarding proper sanitation of thermometer when taking food temperatures.	3/10/25

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	25LI	A. BUILDING: _____ B. WING _____	C 01/30/2025

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M 815	Continued From page 13 cross-contamination when Dietary Cook (DC) #2 failed to sanitize the thermometer when checking food temperatures on the tray line for one (1) of two (2) kitchen observations Findings included: On 01/27/2025 at 11:15 AM, during an observation of the tray line, DC 2 was observed checking food temperatures. DC #2 used a brown paper towel to clean the thermometer between food items. DC #2 wiped food residue off onto a brown paper towel and then tested each food item on the tray line without properly sanitizing the thermometer. On 01/27/2025 at 12:10 PM, during an interview, the Dietary Manager (DM) #1 stated that staff should always use an alcohol pad to clean the thermometer when checking tray line temperatures. DM #1 explained that using a paper towel instead of an alcohol pad constitutes cross-contamination. She confirmed that dietary staff had been trained to use alcohol swabs when performing tray line temperature checks. On 01/29/2025 at 1:56 PM, during a phone interview, DC #2 confirmed that she had used a brown paper towel instead of an alcohol pad when checking tray line temperatures on 01/27/2025 at 11:15 AM. DC #2 stated that she had been trained to use an alcohol pad but was nervous and forgot to follow the procedure. She acknowledged that her actions constituted cross-contamination and could cause residents to develop gastrointestinal issues.	M 815	2. All residents that receive meals from dietary services have the potential to by this deficient practice. 3. Dietary staff in-serviced on 1.27.25 by Dietary Manager regarding proper sanitizing of thermometer when taking food temperatures. 4. Dietary Manager to monitor tray line during temperature beginning 2.3.25 once daily for 4 weeks then 2 times weekly for 3 weeks to ensure proper sanitization of thermometer. Monitoring tools to be provided to Executive Director weekly and reviewed in Quality Assurance Meeting 3.10.25, then monthly for 2 months	
M1570	48.58.1 Infection Control	M1570		3/10/25

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M1570	Continued From page 14 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, interview, record review, and facility policy review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were followed while providing care to a resident requiring high-contact precautions for two (2) of three (3) care observations, Resident #27. Findings included: A review of the facility's "Enhanced Barrier	M1570	1.Licensed Practical Nurse #2 and Licensed Practical Nurse #7 provided in-service on 1.29.25 regarding properly donning gown/Personal Protective Equipment when providing direct care to resident on Enhanced Barrier Precautions. 2. All residents requiring Enhanced Barrier Precaution were at risk from this deficient practice. 3. All staff in-serviced 2.3.25 by Staff	

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M1570	Continued From page 15 Precautions" policy, dated 04/2024, revealed, "Enhanced Barrier Precautions are indicated for residents with ...indwelling medical devices, secretions/excretions that are unable to be covered/contained, and are not known to be infected/colonized with any MDRO (Multidrug-Resistant Organism) during high-contact resident care activities, as these residents are at an increased risk of being infected ..." On 01/29/2025 at 8:50 AM, during an observation, Licensed Practical Nurse (LPN) #2, the Nursing Supervisor, was observed administering medications to Resident #27 via percutaneous endoscopic gastrostomy (PEG) tube. LPN #2 did not wear a gown while accessing the resident's PEG tube. On 01/29/2025 at 10:20 AM, during an observation, LPN #7 was observed performing PEG tube care for Resident #27. The nurse entered the resident's room and explained that she was going to clean the PEG tube site. LPN #7 washed her hands and applied clean gloves but did not apply a gown prior to providing care. On 01/29/2025 at 10:27 AM, during an interview, LPN #7 stated that Enhanced Barrier Precautions are used to protect Resident #27 from staff. She acknowledged that she should have donned (put on) a gown before providing care. On 01/29/2025 at 10:35 AM, during an interview, LPN #2, the Nursing Supervisor, stated that she should have worn a gown when administering PEG tube medications to Resident #27. She acknowledged that her actions put the resident at risk for complications, including infection.	M1570	Development Coordinator regarding Enhanced Barrier Precautions. 4. Infection Preservationist and Staff Development to conduct competency training with staff regarding proper donning of Personal Protective Equipment for Enhanced Barrier Resident starting 2.3.25. Completed check offs on 5 staff 3 times per week for 4 weeks then weekly for 3 weeks. Check offs to be provided to Executive Director weekly and reviewed in Quality Assurance Committee on 3.10.25. Then monthly for 2 months	

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M1570	Continued From page 16 On 01/30/2025 at 9:45 AM, during an interview, LPN #6/ Infection Preventionist (IP) stated that nurses should have donned a gown before providing care to Resident #27's PEG site . She explained that the gown protects the resident. She stated that the nurses' failure to follow proper precautions could result in the resident having complications. She explained that her expectation was for staff to don the appropriate Personal Protective Equipment (PPE) when providing care to residents that are at high risk for MDROs. A record review of the "Admission Record" revealed the facility admitted Resident #27 on 6/14/24 with diagnoses including Metabolic Encephalopathy. A record review of the "Order Summary Report" with active orders as of 1/29/2025, revealed Resident #27 had a Physician's Order, dated 6/14/24, to clean the PEG site with soap and water, pat dry, and cover with split gauze every night shift. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/17/2024 revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated the resident's cognition was moderately impaired. A record review of the Enhanced Barrier Precautions signage on Resident #27's door revealed instructions indicating, "Everyone must ...wear gloves and a gown for the following High-Contact Resident Care Activities ...Device care or use ...feeding tube ..."	M1570		