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
	71PM	A. BUILDING: _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 000	Initial Comments The State Agency (SA) conducted an annual re-certification survey with complaint investigations (CI) MS # 27587, CI MS # 28336 and CI MS #28360 at the facility from 3/30/25 through 4/2/25. During the survey, the SA determined the facility was not in compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA identified non-compliance and cited M 500, M 650, and M 1570. There were no deficiencies cited for CI MS # 27587, CI MS # 28336 and CI MS #28360. The census at the time of the survey was 99 and the facility was licensed for 105 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate	M 500		4/29/25

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M 500	Continued From page 1 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 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,	M 500		

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M 500	Continued From page 2 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 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;	M 500		

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M 500	Continued From page 3 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 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 III	M 500	On April 2, 2025, Licensed Practical Nurse	

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M 500	Continued From page 4 Based on observations, resident/staff interviews, medical record review, and facility policy/procedure review, the facility failed to ensure a resident's right to promote dignity during Percutaneous Endoscopic Gastrostomy (PEG) medication administration for (Resident #12) and to ensure a resident's right to be free from involuntary seclusion for (Resident #40) for 2 (two) of 20 residents reviewed for resident's rights. Findings include: Resident #40 Review of facility policy titled, "Incident Investigation & Reporting" dated 11/09/2009, reviewed 1/14/2025, revealed, "...Each resident residing in this facility has the right to be free from any type of abuse ...includes but is not limited to free from...involuntary seclusion...Involuntary Seclusion: Separation of a resident from other residents or from his/her room or confinement to his/her room..." Review of facility policy titled, "Policy for Control of Multidrug-Resistant Organism (MDRO) Infection" dated 6/14 reviewed 1/14/2025, revealed, "It is the policy of this facility to place residents in contact...precautions if they are displaying symptoms of active multidrug-resistant organism (MDRO) infection. Conditions requiring isolation include: ...If the resident has a draining wound that is infected with an MDRO, and the drainage cannot be contained..." Review of facility policy titled, "Resident's Rights Policy" dated 6/94, revised 12/23, reviewed 1/14/2025, revealed, "Every resident in this facility has the right to...Be free	M 500	#1 was in-serviced by the Director of Nursing on Residents Rights to include providing dignity and privacy for Resident #12 by closing residents room door, blinds or pulling the privacy curtain prior to medication administration by way of Percutaneous Endoscopic Gastrostomy (PEG) tube. On April 1, 2025, the Administrator and Social Service Designee (SSD) informed Resident #40 that she was allowed to come out of her room, that she was not in isolation, and apologized to Resident #40 for the misunderstanding/miscommunication from staff that had been telling her otherwise. Resident #40 verbalized understanding of being allowed to come out of room. On April 1, 2025, the Activity Director visited with resident and discussed afternoon activities and going outside, however resident declined to participate in events. All residents receiving medication by way of a Percutaneous Endoscopic Gastrostomy (PEG) tube and all residents who require Transmission Based Precautions have the potential to be affected by this deficient practice. No other residents were identified as being affected by this deficient practice. On April 9, 2025, all Licensed Nurses were in-serviced by the Director of Nursing on providing privacy and maintaining dignity to residents during medication administration by way of Percutaneous Endoscopic Gastrostomy (PEG) tube. Licensed Practical Nurse #1 viewed video titled All Staff Orientation to include Residents Rights on April 22, 2025. On	

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M 500	Continued From page 5 of...psychological...abuse..." During an observation and interview on 3/30/2025 at 3:53 PM with Resident #40 it was revealed that the resident had a red biohazard barrel in her room. The resident reported being in isolation, stating she was informed by numerous staff that she could not leave her room until 4/3/25 after her antibiotics were finished. During the interview the resident expressed frustration and stated, "I'm getting tired of it, I just want to go outside, I don't even care if it's raining." The resident acknowledged that isolation has increased her anxiety and depression, stating, "Just from staying in for that long, anyone would have it!" She emphasized, "I like to go outside and be in the air." A record review of Resident #40's "Order Summary Report" for the month of 3/2025, revealed an order, dated 3/13/2025, for Contact Isolation Precautions due to Methicillin Resistant Staphylococcus aureus (MRSA) of Wound. A record review of a nursing "Progress Note," dated 3/13/2025 at 6:52 PM for Resident #40, revealed, "Dr (proper name) evaluated and reviewed labs...Doxycycline Monohydrate...related to MRSA infection...until 4/3/2025...contact isolation precautions due to MRSA of wound." Observation on 3/31/2025 at 9:00 AM, Resident #40 was observed to be in her room lying in bed. Record review of Resident #40's "Skilled Nursing Facility (SNF) Documentation Record" dated 3/13/2025 through 3/25/2025, revealed no more than a scant amount of drainage to scabbed areas with no drainage observed to the surgical	M 500	April 1, 2025, staff on duty was in-serviced by the Infection Preventionist on Hand Hygiene, Enhanced Barrier Precautions and Contact Precautions. On April 2, 2025, all staff was in-serviced by the Director of Nursing and Infection Preventionist on the Incident Investigation & Reporting Policy addressing Abuse, Neglect and Involuntary Seclusion and the Residents Rights Policy. On April 9, 2025, all Licensed Nurses were in-serviced by the Director of Nursing on Abuse/Neglect, Involuntary Seclusion and Transmission Based Precautions (TBP). A Quality Assurance Meeting was held on April 3, 2025, to discuss findings from survey exit and any systematic changes needed to ensure deficient practice does not reoccur. Beginning April 3, 2025, the Director of Nursing or Quality Improvement Nurse will observe medication administration by way of Percutaneous Endoscopic Gastrostomy (PEG) tube weekly for four weeks, then monthly for 3 months to ensure the residents dignity and privacy are being maintained. Beginning April 7, 2025, the Administrator or Director of Nursing will report any concerns from medication administration observation in the Department Head Meeting weekly for four weeks, then monthly for three months. Beginning April 3, 2025, any resident requiring Transmission Based Precautions (TBP) will be discussed in the Daily Stand-Up Meeting for the duration that the resident requires the TBP. Beginning April 3, 2025, the Social Service Designee (SSD) will visit all residents in Transmission Based Precautions (TBP) to	

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M 500	Continued From page 6 site wound to her back during that timeframe. On 3/31/2025 at 1:20 PM, Resident #40 was observed to be in her room lying in bed. A record review of a psychotherapy "Progress Note" dated 3/12/2025 at 11:59 PM for Resident #40, revealed, "Reason for referral: 68 year old white female with follow up for insomnia, anxiety and depression...Resident's Statement: "I've had my surgery. I had a brown spot come out on the bandages and they sent it (a specimen) off" ...Case Conceptualization...Endorses good sleep...Says she is not depressed and does not feel anxious and thinks medications are working well. Good mood. Laughing and talking freely ..." A record review of Resident #40's psychotherapy "Progress Note" dated 3/20/2025 at 11:59 PM, revealed, "Diagnosis of Anxiety...Visit Summary...She shared she is frustrated as she is currently in isolation due to MRSA...She does report frustration related to isolation. She stated it has made her feel more disoriented ..." A record review of Resident #40's psychotherapy "Progress Note" dated 3/27/25 at 11:59 PM, revealed, "She has now been isolated to her room for two weeks due to MRSA. She stated she is managing but is ready to get out of her room...She has 7 more days. She reported some anxiety and depression due to isolation and shared that her daughter is not supportive of her leaving the facility." During an interview on 4/1/2025 at 8:28 AM, with Certified Nursing Assistant (CNA) #3, she stated she was unsure of the type of isolation but confirmed that Resident #40 had not left her room in two (2) weeks. She confirmed that she has	M 500	assess for any psychosocial needs weekly for the duration of the Transmission Based Precautions and report any concerns to the Director of Nursing. Beginning April 3, 2025, the Director of Nursing or Infection Preventionist will interview three staff members regarding the understanding of Transmission Based Precautions (TBP) with in-servicing provided as needed weekly for four weeks, then monthly for three months. Beginning April 29, 2025, the Administrator or Director of Nursing will report any concerns from medication administration observations, Social Service Designee visits and staff interviews at the Quality Assurance Committee Meeting, then monthly for three months to ensure substantial compliance is achieved with M Tag 500. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with M Tag 500.	

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never seen any drainage on the residents' clothing or bed linen and stated there is always a small dressing covering the area.

During an interview on 4/1/2025 at 8:31 AM, with the Treatment Nurse, she stated Resident #40 had MRSA to her lower left back surgical incision and that the resident has been in isolation for a couple of weeks under contact precautions and is on a 21-day antibiotic regimen. She confirmed that the treatment order included covering the incision with a dressing, and any drainage from the wound has only been a scant amount and contained by the dressings. She also noted that the resident was alert, oriented, and capable of making decisions.

During an interview on 4/1/25 at 8:48 AM, with Infection Control (IC) Nurse, she confirmed the presence of MRSA in Resident #40's surgical incision. She confirmed that she was unaware that the resident has been confined to her room, and stated, "Staff should have gotten her out of her room and allowed her to go out and get fresh air, maybe more staff education is warranted."

During an interview on 4/1/2025 at 8:59 AM, with the Activities Director and Activities #1, confirmed that Resident #40 and other staff informed her that the resident could not come out of her room for 21 days due to being in isolation. Activities #1 went on to reveal that Resident #40 does not attend a lot of activities but enjoys walking around and going outside of the building daily.

During an interview on 4/1/2025 at 9:11 AM, with Director of Nursing (DON) she stated, "Residents are not supposed to come out of their room if they are on contact precautions." She stated we cannot force any residents to stay in their room

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but encourage them to do so. She confirmed her certification in infection control but admitted she did not review Resident #40's isolation status or continued need for isolation, as it is a facility practice for residents on isolation to remain in their rooms until the medication is completed. She acknowledged concerns that isolation could lead to depression and feelings of confinement.

During an interview on 4/1/2025 at 9:16 AM, with the Social Services Director, she stated, "I didn't know Resident #40 was in isolation until just now, I would have increased my visits with her if I had known." She further reported that isolation could lead to increased anxiety and depression.

During an interview on 4/1/2025 at 9:33 AM, with Licensed Practical Nurse (LPN) #2, it was confirmed that Resident #40 was on contact isolation and must stay in her room to prevent contact with other surfaces or residents. She explained that residents placed in isolation are to remain on precautions until their antibiotic therapy is completed.

During an interview on 4/1/2025 at 9:37 AM, with Housekeeping Staff #1, she confirmed she had recently completed in-service training that stated that a resident should remain in their room if they are on contact isolation.

During a follow-up interview on 4/1/2025 at 9:40 AM, with the Infection Control Nurse, she acknowledged that the training was too broad, indicating that staff might interpret it to mean all residents on contact isolation should remain confined to their rooms. She said that she should have been more involved, but she had been teaching a CNA class for the past two (2) weeks, which limited her availability. She mentioned that

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had she been more present to review the infection log, she might have identified the situation sooner. She emphasized the need for treatment protocols for MDRO to be more personalized based on individual resident circumstances rather than applying a blanket policy of keeping residents in contact isolation until their medication regimen is completed. She confirmed that Resident #40 was alert, oriented, and able to follow directions. She noted that the residents' wound displayed only scant to zero drainage and remained covered. Furthermore, she stated that staff should have assisted the resident with hand hygiene and facilitated opportunities for her to go outside, acknowledging the importance of addressing the residents' emotional and mental well-being during isolation.

The Administrator was interviewed on 4/1/2025 at 10:02 AM and confirmed that social isolation could lead to increased anxiety and depression among residents.

An interview with CNA #1 and CNA #2 on 4/1/2025 at 2:10 PM, both verbalized they were trained to ensure that residents on isolation remain in their rooms to prevent the spread of infection. They confirmed that they had never observed any drainage from Resident #40's back as the affected areas were consistently covered. Additionally, they noted that the resident often leaves her room to approach the nurse's medication carts and frequently goes to the doorway, and requires redirection back to her room.

During an interview with LPN #2 on 4/1/2025 at 2:20 PM, she also revealed that Resident #40 was alert, oriented and able to follow directions, additionally she confirmed the area to her back

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was always covered with a dressing and all drainage contained. She verbalized that the resident had never reported to her any increase in depression or anxiety, but stated she was not surprised as the resident has a history of both depression and anxiety.

An interview with Medicare Nurse on 4/2/2025 at 8:00 AM, revealed she is the case manager for Resident #40. She stated she was aware that the resident was on contact precautions but confirmed that the surgical wound was approximately 1 (one) CM (centimeter) in diameter and only presented with scant drainage at times, but most of the time the surgical site was scabbed over and was always covered with a bandage and any drainage would have been contained. She confirmed that the resident should have been allowed to come out of her room for activities and socialization.

A phone interview with Social Services #1 for on 4/2/2025 at 8:10 AM, she revealed she is a psychiatric social worker and has Resident #40 on case load. She confirmed that Resident #40 has a history of anxiety and depression. She confirmed that she saw the resident on several occasions in March and the resident voiced her frustration of being in isolation and confirmed that the resident also spoke of her increased anxiety and depression due to the isolation. She confirmed she gives a visit recap to the nursing staff after every visit and documented her notes in the medical record.

An observation of Resident #40's surgical site on 4/2/2025 at 8:45 AM, with the DON revealed a secured dressing was removed, and revealed approximately a 0.1 CM open area noted with a scant amount of red drainage of the bandage.

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M 500	Continued From page 11 There was no drainage on the bed linens or the residents' clothing noted during this observation. A record review of an "Admission Record" indicated the facility admitted Resident #40 on 11/29/22 with medical diagnoses that included Cerebral Infarction due to Thrombosis of Right Posterior Cerebral Artery, Encounter for Surgical Aftercare following Surgery on the Nervous System, Basal Cell Carcinoma of Skin of Other Part of Trunk, Anxiety Disorder, Depression, Mood disorder and MRSA Infection. Record review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/3/2025, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. Resident #12 Review of the facility policy titled "Dignity and Respect" with a revision date of 7/2022 revealed, "5. Residents will be examined and treated in a manner that maintains bodily privacy. A closed door and/or drawn cubicle curtain should be utilized to maximize the privacy of each resident while rendering care." On 4/01/25 at 8:48 AM, an observation of Licensed Practical Nurse (LPN) #1 revealed, she administered Resident #12's, who was a female resident, Percutaneous Endoscopic Gastrostomy (PEG) tube medications without closing the resident's room door, blinds, or pulling the privacy curtain. The door of the resident's room remained open and anyone passing in the hallway could see that the resident's abdomen area was exposed.	M 500		

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(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) COMPLETE DATE
M 500	Continued From page 12 An interview with LPN #1 on 4/01/25 at 9:10 AM, confirmed she did not ensure the resident had privacy while administering medications through her PEG tube and revealed she should have provided privacy and maintained the dignity of the resident. During an interview with the Director of Nursing (DON) on 4/01/25 at 9:17 AM, she confirmed the nurse should have provided privacy for Resident #12 while administering medications through a PEG tube. Review of the "Admission Record" revealed that the facility admitted Resident #12 on 2/06/25, with a medical diagnosis that included Cerebral Infarction, Unspecified and Attention to Gastrostomy.	M 500		
M 650	45.21.10 Hydration Hydration. Each resident shall be provided sufficient fluid intake to maintain proper hydration and health. This Statute is not met as evidenced by: Level II Based on record reviews, staff interviews, and facility policy reviews, the facility failed to accurately monitor and document fluid intake for one (1) of three (3) residents reviewed for hydration. Resident #25. Findings Include: A record review of the facility policy "Physician Orders," revised 1/2025, revealed, "It is the policy of this facility that all physician's orders will be	M 650	On April 1, 2025, the task to document fluid intake was added to the task list in the computer by the Medical Records Nurse for Resident #25. On April 1, 2025, the Medical Records Nurse was in-serviced by the Director of Nursing on ensuring all tasks pertaining to the residents plan of care and/or needs are initiated in the computer upon admission and as needed if residents condition changes. All residents with a fluid restriction order	4/29/25

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	71PM	A. BUILDING: _____ B. WING _____	04/02/2025

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M 650	Continued From page 13 implemented timely and carried out in a professional manner." A record review of the facility policy "Fluid Restriction," revised 2/2022, revealed, "Fluids will be restricted for residents as directed by physician orders ... Nursing services will document intake and output." A record review of physician orders revealed that Resident #25 was placed on a 2,000-milliliter (ml) fluid restriction, with 120 ml allocated for four (4) medication passes, totaling 480 ml, and 500 ml with meals, totaling 1,500 ml. This order was initiated on 1/30/25. A record review of the electronic Medication Administration Record (MAR) for Resident #25 revealed no documentation of the resident's fluid intake. During an interview on 4/1/25, at 1:00 PM, Licensed Practical Nurse (LPN) #3 confirmed that Resident #25 was on a 2,000 ml per day fluid restriction. She explained that Certified Nursing Assistants (CNAs) document the amount the resident drinks during meals on the meal ticket and give it to the nurse, who then records the total fluid intake for the shift under the task list. A record review of the oral intake task list documentation, with LPN #3, for Resident #24 revealed no documentation of oral intake for over the past 30 days. During a further interview on 4/1/25 at 1:10 PM, LPN # 3 verified that there was no documentation of the resident's fluid intake, making it impossible to determine if the resident was adhering to the prescribed fluid restriction. She stated it was	M 650	have the potential to be affected by this deficient practice. No other residents were identified as being affected by this deficient practice. On April 2, 2025, the nursing staff was in-serviced by the Director of Nursing on documenting accurate intake for a resident with a fluid restriction order. On April 9, 2025 all Licensed Nurses were in-serviced by the Director of Nursing on the policy Fluid Restrictions and documenting intake every shift with a twenty-four hour total to ensure resident is compliant with fluid restriction order. A Quality Assurance Meeting was held on April, 3, 2025, to discuss findings from survey exit and systematic changes needed to ensure this deficient practice does not reoccur. Beginning April 3, 2025, the Medical Records Nurse will audit all residents with a fluid restriction order daily (Monday-Friday) to ensure documentation for intake is complete. Beginning April 7, 2025, the Administrator or Director of Nursing will report any concerns from the daily (Monday-Friday) audit for intake documentation in the Department Head Meeting weekly for four weeks, then monthly for three months. Beginning April 29, 2025, the Administrator or Director of Nursing will report any concerns from the review of physicians orders/care plan intervention tasks at the Quality Assurance Committee Meeting, then monthly for three months to ensure substantial compliance is achieved with M Tag 650. The Quality Assurance Committee will	

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M 650	Continued From page 14 important to monitor fluid intake to prevent fluid overload. During an interview with the Director of Nursing (DON) on 4/1/25 at 2:00 PM, she confirmed that Resident #25 had a fluid restriction ordered by the physician upon admission. She acknowledged that there was no documentation of fluid intake monitoring and confirmed that it should have been recorded. During an interview with the Medical Records Nurse on 4/1/25 at 3:00 PM, she confirmed that she was responsible for triggering documentation tasks upon admission. She admitted that she had failed to initiate a task for the nursing staff to document Resident #25's intake upon admission. A record review of the "Admission Record" showed that the facility admitted Resident #25 on 1/27/25, with diagnoses including End-Stage Renal Disease and Congestive Heart Failure.	M 650	revise the corrective action plan as needed until substantial compliance is achieved with M Tag 650.	
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a	M1570		4/29/25

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M1570	Continued From page 15 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, staff interview, and facility policy review the facility failed to follow Enhanced Barrier Precautions (EBP) for one (1) of three (3) resident care observations. Resident #12. Findings Include: Review of the facility policy titled "Enhanced Barrier Precautions" with a revision date of 3/2024 revealed, "Enhanced Barrier Precautions are indicated for residents with any of the following: ... Wounds and/or indwelling medical devices ..." An observation outside Resident #12's room door on 4/1/25 at 8:42 AM, revealed a sign that read, "Enhanced Barrier Precautions." On 4/01/25 at 9:01 AM, an observation during medication administration with Licensed Practical Nurse (LPN) #1 revealed, she administered medications to Resident #12 via (by) Percutaneous Endoscopic Gastrostomy (PEG) tube without using a gown for EBP.	M1570	On April 2, 2025, Licensed Practical Nurse #1 was in-serviced by the Director of Nursing on the Enhanced Barrier Precautions (EBP) Policy. All residents that require Enhanced Barrier Precautions (EBP) have the potential to be affected by this deficient practice. No other residents were identified as being affected by this deficient practice. On April 1, 2025, staff was in-serviced by the Infection Preventionist on Enhanced Barrier Precautions (EBP). On April 2, 2025, all staff was in-serviced by the Director of Nursing and Infection Preventionist on Infection Control and Enhanced Barrier Precautions (EBP). On April 9, 2025, all Licensed Nurses were in-serviced by the Director of Nursing on Enhanced Barrier Precautions (EBP). A Quality Assurance Meeting was held on April 3, 2025 to discuss findings from survey exit and systematic changes needed to ensure deficient practice does not reoccur.	

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M1570	Continued From page 16 An interview on 4/01/25 at 9:11 AM, with LPN #1, confirmed she did not apply a gown to administer Resident #12's medications. She explained that the gowns were not hanging on the resident's door; therefore, she did not realize she was supposed to wear one. LPN #1 indicated the purpose of wearing a gown was to reduce infection risk to the resident who had an indwelling device. An interview with the Director of Nursing (DON) on 4/01/25 at 9:16 AM, confirmed LPN #1 should have worn a gown to administer medications to Resident #12 via PEG tube to protect the resident from infection. Record review of the "Admission Record" revealed the facility admitted Resident #12 on 2/06/25, with a medical diagnosis that included Cerebral Infarction and Attention to Gastrostomy.	M1570	Beginning April 3, 2025, the Director of Nursing or Infection Preventionist will observe three residents that require Enhanced Barrier Precautions (EBP) to ensure staff is donning appropriate Personal Protective Equipment (PPE) prior to entering room weekly for four weeks, then monthly for three months. Beginning April 7, 2025, the Administrator or Director of Nursing will report any concerns regarding Enhanced Barrier Precautions (EBP) in the Department Head Meeting weekly for four weeks, then monthly for three months. Beginning April 29, 2025, the Administrator or Director of Nursing will report any concerns regarding Enhanced Barrier Precautions (EBP) at the Quality Assurance Committee Meeting, then monthly for three months to ensure substantial compliance is achieved with M Tag 1570. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with M Tag 1570.	