STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255214	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE CO NURSING CENTER	700 JEFFERSON STREET SOUTH MONTICELLO, MS 39654

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 3/30/2025 through 4/2/2025. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F584, F656, F657, F697 F759, F851, F865, and F880 The facility had a census of 56 and was licensed for 60 beds.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		4/28/25

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

Electronically Signed | 04/24/2025

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F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review, the facility failed to ensure proper handling of personal belongings for one (1) of seven (7) residents reviewed for personal property, Resident #49. Findings include: Record review of the facility policy titled "Resident Rights," with a revision date of 03/2024, stated residents have the right to... "11. Receive adequate and appropriate... support services..." On 03/30/25 at 1:09 PM, during an interview, Resident #49 stated he had a pair of jeans missing. He said his son had recently purchased them and that he had only worn them once. He reported notifying staff, who stated they would look for the jeans; however, he said no one followed up or informed him of the outcome. On 03/31/25 at 4:13 PM, during an interview, the	F 584	a. On 4/2/2025, the Social Services Director (SSD) and Administrator immediately searched for residents pants. On 4/2/2025, the Administrator, replaced the missing item and on 4/2/2025, the Social Services Director verified residents personal items and updated his inventory sheet. The SSD audited all inventory sheets of current facility resident. No issues were identified. b. All residents have the potential to be affected by this alleged deficient practice. c. On 4/3/2025, the SSD and Laundry staff were in-serviced by Administrator on Resident belongings and inventory sheet updating. d. On 4/3/2025, the Administrator and SSD began monitoring new admit	

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F 584	Continued From page 2 facility Social Services (SS) staff stated she handles admissions and resident concerns. She explained that when a resident reports a missing item, she searches for it, checks with laundry, and if the item cannot be located or is damaged, a grievance is filed, and the facility replaces the item. On 04/01/25 at 7:48 AM, Resident #49 again stated he had reported the missing jeans to SS, but no one had followed up with him regarding the item. On 04/01/25 at 10:51 AM, during a phone interview, the Resident Representative (RR) stated he had purchased two pairs of Levi jeans for the resident and was made aware of the missing pair by Resident #49. He said he had spoken with staff and the laundry department but had not received any follow-up. He reported this occurred around the end of February 2025. On 04/01/25 at 2:19 PM, Licensed Practical Nurse (LPN) #2 stated Resident #49 regularly received clothing from his son and should have had an inventory sheet in his paper chart. On 04/02/25 at 9:48 AM, SS staff stated Resident #49 never reported missing jeans to her. She added that she had been on medical leave from 01/02/25 to 02/03/25 and had not been informed about the issue. She stated she could not locate the resident's inventory sheet but had completed one on 04/01/25 following State Agency (SA) request. On 04/02/25 at 3:00 PM, during an interview, the Nursing Home Administrator (NHA) confirmed he was unaware of the missing jeans until recently	F 584	residents inventory sheets and long-term residents inventory sheet additions three (3) times a week for four (4) weeks and then two (2) times a week for four (4) weeks and then one (1) time a week for two (2) months. The SSD will perform interviews with a sample of residents from each hall one (1) time a week for four (4) weeks, then one (1) time a month for six (6) months. Any areas of concern will be corrected and forwarded by the Administrator to the quarterly Quality Assessment and Improvement Committee for review and follow up including any needed corrective actions or changes to current plan at least quarterly. Additional training and/or disciplinary action will be considered as warranted. A Quality Assessment and Assurance Committee (QAA) Meeting was held on 4/21/2025. The next QAA Committee meeting will convene on 5/22/2025. By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	

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F 584	Continued From page 3 and had ordered a replacement that day. Record review of Resident #49's Admission Record revealed an admission date of 07/13/24 with diagnoses including Major Depressive Disorder, recurrent, mild. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 01/08/25 revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident was cognitively intact. Record review of the facility grievance log revealed no grievance was filed regarding Resident #49's missing personal item. Record review of the Resident #49's Personal Clothing and Articles Inventory List revealed the sheet was completed on 04/01/25, after the State Agency requested documentation.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		4/28/25

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F 656	Continued From page 4 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to follow the comprehensive care plan for related to Enhanced Barrier Precautions one (1) of seventeen (17) sampled residents, Resident #5. Findings include:	F 656	a. On 4/2/2025, the Certified Nursing Assistant #2 and Licensed Practical Nurse (LPN) #3 were immediately educated by Director of Nursing on following Resident #5's Care plans related to Enhanced Barrier Precautions protocol. On 4/2/2025, Director of Nurses verified residents with	

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F 656	Continued From page 5 Record review of the facility's care plan policy "Care Plan Process" dated 12/24 revealed, " ...The overall care plan should be oriented towards:1. Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence (e.g., palliative approaches in end-of-life situation). 2. Managing risk factors to the extent possible or indicating the limits of such interventions. 3. Addressing ways to try to preserve and build upon resident strengths. 4. Applying current standards of practice in the care planning process ..." Record review of the Resident #5's care plan with an initiation date of 1/27/25 revealed "Focus: The resident has a STAGE 2 pressure ulcer ...Interventions ...Enhanced Barrier Precautions were in place ..." On 04/01/25 at 10:18 AM, Resident #5 was observed during wound care to the sacral area. Licensed Practical Nurse (LPN) #3 and Certified Nursing Assistant (CNA) #2 were present and providing the care. Neither staff member was wearing gowns nor following Enhanced Barrier Precaution protocols as indicated in the Resident #5's care plan. On 04/02/25 at 10:13 AM, the Director of Nursing (DON) stated that care plans must be followed to ensure safe and appropriate care tailored to each resident's condition. She verified the care plan was not followed in this case and emphasized that failure to use Personal Protective Equipment (PPE) as directed could lead to infection. She emphasized that it is her expectation that staff follow care plans for all residents.	F 656	Enhanced Barrier Precautions protocols were care planned. No issues were identified. b. All residents requiring Enhanced Barrier Precautions have the potential to be affected by this alleged deficient practice. c. On 4/2/2025, the Certified Nursing Assistant #2 and LPN #3 were immediately educated by Director of Nursing on following Resident #5's Care plans related to Enhanced Barrier Precautions protocol. On 4/3/2025, facility DON began in-servicing C.N.As and nurses following Resident Care Plans and was completed on 4/6/2025. d. On 4/4/2025, the Infection Preventionist Nurse began monitoring Enhanced Barrier Precautions protocol are being followed on five (5) residents three (3) times a week for four (4) weeks, and then two (2) times a week for four (4) weeks, then monthly for two (2) months. Any areas of concern will be corrected and forwarded by the Director of Nurses to the quarterly Quality Assessment and Improvement Committee for review and follow up Including any needed corrective actions or changes to Current plan at least quarterly. Additional training and/or disciplinary action will be considered as warranted. A Quality Assessment and Assurance (QAA) Committee Meeting was held on 4/21/2025. The next QAA Committee meeting will convene on 5/22/2025.	

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F 656	Continued From page 6 On 04/02/25 at 11:41 AM, during an interview, the Infection Preventionist (IP)/ LPN #1, stated that care plans are critical for infection prevention and must be followed. She explained, "You can't take care of residents properly without following the care plan." She identified potential outcomes of non-compliance including infection, injury, and residents not receiving needed care. On 04/02/25 at 12:34 PM, the Care Plan Nurse (RN #1) stated care plans are individualized and guide staff in providing appropriate care. She confirmed that failing to follow the plan may result in infection or injury. Record review Admission Record revealed Resident #5 was admitted on 07/22/22 with diagnoses that included of Schizoaffective disorder. Record review of the Minimum Data Set (MDS)with an Assessment Reference date of 1/8/25 Section C, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Section M documented a Stage 2 pressure injury.	F 656	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	
F 657 SS=G	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		4/28/25

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F 657	Continued From page 7 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record reviews, and facility policy reviews, the facility failed to review and revise the resident's pain to reflect actual pain instead of at risk for pain for one (1) of seventeen (17) residents reviewed for pain. Resident #44. Findings include: Record review of the facility's "Care Plan Process," with a revision date of 12/24, revealed" The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to review and revise each resident's comprehensive person-centered plan of care." Record review of Resident #44 ' s Care Plan	F 657	a. On 4/2/2025, Resident #44 was assessed for pain by the Director of Nurses (DON) and Nurse Practitioner with resident stating he had no pain and did not want a medication change. The Nurse Case Manager and Director of Nurses modified Resident #44□s Care plan to reflect Actual Pain instead of At Risk for Pain. A medication review was conducted on 4/4/25 by the Nurse Practitioner and a change in the prescribed pain management medication was conducted to provide better pain relief and Resident #44□s care plan was updated to reflect new medication order. The Director of Nurse and Nurse Case Manager reviewed all residents with Pain Care plans with No issues identified.	

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F 657	Continued From page 8	F 657		

Report with a date initiated of 12/5/24 revealed "Focus: The resident IS AT RISK FOR PAIN. This care plan had not been revised to reflect Resident #44's ACTUAL pain.

On 03/30/25 at 11:35 AM, during an observation and interview, Resident #44 stated he is in constant pain due to skin cancer. Resident #44's right arm was wrapped in Kerlix. He stated they only give him Tylenol and that it does not help. He described the pain as feeling like ants are biting him and stated he is in pain all the time. He reported telling the nurse that Tylenol does not help and rated his pain as an eight (8) on a scale of 0-10 with 10 being the greatest pain.

On 04/01/25 at 7:52 AM, during an interview, Resident #44 stated his pain level was at a nine (9). He reported calling for pain medication three times before the nurse finally gave him something for pain the previous night. He stated the nurse told him she could not give him anything because it was not time yet. He said he was in pain all night and had trouble sleeping. He repeated that he is in constant pain and all he receives is Tylenol.

On 04/01/25 at 03:04 PM, during an interview, Licensed Practical Nurse (LPN) #4 stated that Resident #44 has skin cancer and "that's what all the sores are on him."

On 04/02/25 at 10:57 AM, Resident #44 was observed lying in bed watching TV. He stated he had received Tylenol that morning and his current pain level was a 7. He stated that without Tylenol, his pain is typically at an eight to nine (8-9).

On 04/02/25 at 11:02 AM, during an interview,

b. All residents with actual pain have the potential to be affected by this alleged deficient practice.

c. On 4/2/2025, the LPN #4 was immediately educated by Director of Nursing on following Resident #44s updated Care plan to Actual Pain protocols. On 4/2/2025, the Minimum Data Set (MDS) and Case Manager Nurses were educated by Director of Nursing on revision of Care plans to Actual Pain. On 4/3/2025, facility DON began inservicing nursing staff on following Resident Care Plans and was completed on 4/6/2025.

d. Beginning 4/3/2025 the facility Director of Nurses began to monitor all residents requiring pain management care plans three (3) days a week for four (4) weeks and then two (2) times a week for four (4) weeks, then one (1) monthly for two (2) months to ensure ongoing compliance and will report any deficient practice to quarterly Quality Assessment and Improvement Committee for review and follow up including any needed corrective actions or changes to current plan at least quarterly. Additional training and/or disciplinary action will be considered as warranted. A Quality Assessment and Assurance (QAA) Committee Meeting was held on 4/21/2025. The next QAA Committee meeting will convene on 5/22/2025.

By submitting the enclosed materials, we

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LPN #3 stated that when Resident #44 complains about pain, she gives him Tylenol. She confirmed Tylenol is now scheduled. She stated the resident was previously receiving Tylenol as needed and that it was changed to a scheduled dose on 03/19/25 to help manage his pain. She could not recall where she had documented the resident's pain relief.

On 04/02/25 at 11:32 AM, during an interview, the DON stated the comprehensive care plan should have been updated from "at risk for pain" to reflect "actual pain". She stated she expects nurses to follow up with the resident after administering pain medication and to document the outcome.

On 04/02/25 at 12:18 PM, during an interview, Registered Nurse (RN) #1, the MDS/Care Plan Nurse, stated she just noticed the care plan should have been updated. She confirmed that the care plan is used by all staff.

Record review of Resident #44's "Admission Record" revealed an admission date of 09/22/23 with diagnoses of localized infection of the skin and subcutaneous tissue, pain, leukemia (unspecified and not in remission), and basal cell carcinoma of the skin (unspecified).

Record review of Resident #44's Order Summary Report with active orders as of 4/2/25 revealed a physician order dated 03/19/25 "Acetaminophen Tablet 325 mg - Give 2 tablets by mouth three times a day, related to pain."

Record review of Resident #44's Physician Consultation Report from Resident #44's Dermatologist dated 10/29/24 revealed "Findings:

are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.

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F 657	Continued From page 10 Basal cell carcinoma of the left forearm, excised; Spots of concern x 2 right temple, left chest. Referral to plastic surgery for right forearm for squamous cell carcinoma. Review of the Minimum Data Set (MDS) for Resident #44 with an Assessment Reference Date (ARD) of 02/24/25 revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. Section J indicated the resident experienced pain "almost constantly" and that pain affected sleep "almost constantly." Section M documented open skin lesions.	F 657		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record reviews, and facility policy reviews, the facility failed to manage the resident's pain to the extent possible in accordance with professional standards and the resident's goals and preferences for one (1) of seventeen (17) residents reviewed for pain, Resident #44. Findings include: Record review of the facility's "Pain Screen and Management" policy, with a revision date of 12/23, revealed: All residents who experience	F 697	a. On 4/3/2025, Director of Nurses (DON) assessed resident #44 for any adverse findings related to the failed pain management with none noted. A medication review was conducted on 4/4/25 by the Nurse Practitioner and a change in the prescribed pain management medication was conducted to provide better pain relief and Resident #44□s care plan was updated to reflect new medication order. On 4/2/2025, a pain scale requirement was added to the prescribed pain management medication	4/28/25

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LAWRENCE CO NURSING CENTER	700 JEFFERSON STREET SOUTH MONTICELLO, MS 39654

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F 697	Continued From page 11 routine pain receive a comprehensive pain screening and a treatment plan until acceptable level of pain relief is achieved. All residents have the right to treatment for pain. Resident preferences are respected when deciding on methods to be used for pain management. The residents' statements are the most valid measurements of pain. 4.b New or changed medication orders are transcribed per facility standards of practice and a clinical note is documented ....4.d. When the resident is medicated with the prescribed medication or treated as ordered, documentation of medication or treatment is done on the electronic Treatment Administration Record (TAR). 4.e. Documentation using the pain scale of a new type of pain, a pain medication and/or treatment change is completed every shift until the pain is managed effectively... 6.a. A pain scale is completed on the Electronic Medication Administration Record (eMAR)/Electronic Treatment Administration Record (eTAR.)..." During an observation and interview on 03/30/25 at 11:35 AM, Resident #44 stated he is in constant pain due to skin cancer. Resident #44's right arm was wrapped in Kerlix. He stated they only give him Tylenol and that it does not help. He described the pain as feeling like ants are biting him and stated he is in pain all the time. He reported telling the nurse that Tylenol does not help and rated his pain as an eight (8) on a scale of 0-10 with 10 being the greatest pain. During an interview on 04/01/25 at 7:52 AM, Resident #44 stated his pain level was at a 9. He reported calling for pain medication three times before the nurse finally gave him something for pain the previous night. He stated the nurse told	F 697	to allow each assigned Licensed Practical Nurse or Registered Nurse to provide documentation and follow-up documentation of pain management on each resident with pain management orders and each resident with pain management orders care plan was updated to reflect any pain management medication order that had a change. b. All residents with actual pain have the potential to be affected by this alleged deficient practice. c. An In-service was provided to all licensed nurses on 4/3/2025 on the policy entitled Pain Screen and Management by Director of Nurses related to the pain management of any residents actual pain. The facility's medical director reviewed the policy entitled Pain Screen and Management with no recommended changes to the policy on 4/21/25. The Facility Quality Assessment and Assurance (QAA) Committee met on 4/21/25. d. Beginning 4/3/25, the facility Director of Nurses will monitor all residents requiring pain management three (3) days a week for four (4) weeks and then two (2) times a week for four (4) weeks, then weekly for two (2) months to ensure ongoing compliance and will report any deficient practice to quarterly Quality Assessment and Improvement Committee for review and follow up including any needed corrective actions or changes to current plan at least quarterly. Additional	

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F 697	Continued From page 12 him she could not give him anything because it was not time yet. He said he was in pain all night and had trouble sleeping. He repeated that he is in constant pain and all he receives is Tylenol. During an interview on 04/01/25 at 3:04 PM, during an interview, Licensed Practical Nurse (LPN)# 4 stated that Resident #44 has skin cancer and stated "that's what all the sores are on him." She reviewed his diagnoses and confirmed that Resident #44's diagnosis of skin cancer was not in the chart. During an observation, Resident #44 was observed lying in bed watching television on 04/02/25 at 10:57 AM. He stated he had received Tylenol that morning and his current pain level was a 7. He stated that without Tylenol, his pain is typically at eight to nine (8-9). During an interview on 04/02/25 at 11:02 AM, LPN #3 stated that when Resident #44 complains of pain, she gives him Tylenol. She confirmed Tylenol is now routine. She stated the resident previously received Tylenol as needed, and it was changed to routine on 03/19/25 to help with his pain. She could not recall where she documented the resident's pain relief. On 04/02/25 at 11:08 AM, during an interview, the Nurse Practitioner (NP) stated she is in the facility three days a week and sees all residents once a week. She stated she had not seen Resident #44 yet this week but was aware of his skin cancer. She stated he receives routine Tylenol for pain. She added that a pain level of seven (7) while on medication indicates the treatment is not effective.	F 697	training and/or disciplinary action will be considered as warranted. A Quality Assessment and Assurance Committee Meeting was held on 4/21/2025. The next QAA Committee meeting will convene on 5/22/2025. By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	

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On 04/02/25 at 11:32 AM, during an interview, the DON stated that Resident #44 had been seen by a dermatologist. She confirmed that a pain level of 7 with medication is not effective. She stated that when nurses give pain medication, they are expected to reassess the resident's pain level 30 minutes after administration and document the outcome. She stated the eMAR should have a pain scale attached to the order and that it was not attached in April. She stated the pain scale provides a place for nurses to document the effectiveness of pain medication. She also confirmed that there were no progress notes related to pain and stated this documentation is expected. The DON stated that if the pain medication is not effective, staff must document it and notify the NP for a new order.

Record review of Resident #44's "Admission Record" revealed an admission date of 09/22/23 with diagnoses of local infection of the skin and subcutaneous tissue, pain, unspecified leukemia not in remission, and basal cell carcinoma of the skin (unspecified).

Record review of Resident #44's "Order Summary Report with active orders as of 4/2/25 revealed a physician order dated 03/19/25, "Acetaminophen Tablet 325 mg - Give 2 tablets by mouth three times a day, related to pain."

Record review of the March 2025, eMAR revealed that from 03/20/25 to 03/31/25, Resident #44 received Acetaminophen 325 mg (milligrams)tablets three times daily; however, pain levels were not documented. This section was left blank. The previous "as needed" Tylenol order was discontinued on 03/19/25.

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F 697	Continued From page 14 Record review of the April 2025 eMAR revealed that Resident #44 received Acetaminophen 325 mg tablets three times daily on 04/01/25 and 04/02/25. Pain levels were not documented. Record review of Resident #44's "Progress Notes" dated from 03/01/25 to 04/02/25 revealed no documentation related to pain. Record review of Resident #44 's Physician Consultation Report from Resident #44's Dermatologist dated 10/29/24 revealed "Findings: Basal cell carcinoma of the left forearm, excised Spots of concern x 2 right temple, left chest...Referral to plastic surgery for right forearm for squamous cell carcinoma. " Review of the Minimum Data Set (MDS) for Resident #44, with an Assessment Reference Date (ARD) of 02/24/25, revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident is cognitively intact. Section J indicated the presence of pain "almost constantly," with pain affecting sleep "almost constantly." Section M documented open skin lesions.	F 697		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record reviews, and facility policy review, the facility	F 759	a. On 4/3/2025, residents #1, #39, and #50 were assessed by the Director of	4/28/25

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F 759	Continued From page 15 failed to ensure a medication error rate of less than five percent (5%) for three (3) of four (4) medication administrations observed that affected Resident #1, Resident #39, and Resident #50. The medication error rate was 12.9%. Findings include: Record review of the facility's policy titled, "Drug Administration and Documentation," with a revision date of 03/25, revealed, "Obtain for the administration and check the order with resident's Medication Administration Record (MAR). Read the medication label and compare it with MAR. Remembering the five rights...Right Dose..." Record review of the facility's policy titled, "Administering Medications Through Nasogastric or Gastrostomy Tube," with a revision date of 03/18, revealed, "Upon the order of the attending physician, medication will be administered through nasogastric/gastrostomy tube when a patient is unable to swallow medications or has a nasogastric/gastrostomy tube for nourishment...7. Flush feeding tube with at least 5 cc (cubic centimeters) of water between medications..." Resident #50 On 04/01/25 at 8:07 AM, during an observation of medication administration for Resident #50 by Licensed Practical Nurse (LPN) #4, the resident was administered two puffs of Albuterol Sulfate Inhalation by mouth. LPN#4 waited one minute and then gave oral pills with water. LPN #4 then administered one puff of Advair HFA Inhalation Aerosol 45-21 MCG/ACT (milligrams/actuated) (Fluticasone-Salmeterol) but did not rinse the resident's mouth afterward.	F 759	Nurses (DON) for any adverse findings related to medication errors with none noted. Licensed Practical Nurse (LPN) #4 was provided in-service training by the DON related to administration of an inhaled aerosol using the policy entitled Metered Dose Inhaler Inhaled Medications and the administration of medication via Percutaneous Endoscopic Gastrostomy (PEG) using the policy entitled Administering Medications Through Nasogastric or Gastrostomy Tube. Licensed Practical Nurse #2 was provided in-service training by DON related to the administration of eye drops using the policy entitled Eye and Ear Medication, Instillation of. Licensed Nurse #4 and Licensed Nurse #2 were in-serviced by DON on the proper technique to administer medication using the policy entitled Drug Administration and Documentation. b. All residents with prescribed medication have the potential to be affected by this alleged deficient practice. c. An In-service was provided to all licensed nurses on 4/3/25 on the following policies: Metered Dose Inhaler Inhaled Medications, Administering Medications Through Nasogastric or Gastrostomy Tube, Eye and Ear Medication, Instillation of, and Drug Administration and Documentation. The facility's medical director reviewed the policies entitled Metered Dose Inhaler Inhaled Medications, Administering Medications Through Nasogastric or Gastrostomy	

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F 759	Continued From page 16 Record review of Resident #50's "Order Summary Report revealed an order dated 8/16/24 for Albuterol Sulfate HFA Inhalation Aerosol 108 (90 Base) MCG/ACT 16-24 two puff inhale orally two times a day related to COPD, by mouth twice a day. An additional order dated 12/9/24 for Advair HFA Inhalation Aerosol 45-21 MCG/ACT (Fluticasone-Salmeterol) one puff by mouth twice a day. Offer resident to rinse mouth after use. Record review of Resident #50's "Admission Record" revealed an admission date of 08/11/248/16/24 with diagnoses that included Chronic obstructive pulmonary disease (COPD). Record review of Resident #50's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/10/25 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Resident #39 On 04/01/25 at 8:20 AM, during observation of medication administration for Resident #39, LPN #2 instilled two drops of Blink Tears Ophthalmic Solution 0.25% (Polyethylene Glycol 400 Ophth) in each eye, instead of one drop per eye as ordered. On 04/01/25 at 10:12 AM, during an interview, LPN #2 confirmed she administered two drops in each eye and acknowledged the order was for one drop in each. She confirmed that she did not follow the physician's order. Record review of Resident #39's "Admission Record" revealed an admission date of 12/18/24 with diagnoses that included of rash and other	F 759	Tube, Eye and Ear Medication, Instillation of, and Drug Administration and Documentation with no recommended changes to the policy on 4/21/25 The Facility Quality Assessment and Assurance Committee met on 4/21/25 to review the plan of correction. d. Beginning 4/3/25, the facility Director of Nurses will monitor medication pass three (3) days a week for four (4) weeks and then two (2) times a week for four (4) weeks, then weekly for two (2) months to ensure ongoing compliance and will report any deficient practice to the quarterly Quality Assessment and Improvement Committee for review and follow up including any needed corrective actions or changes to current plan at least quarterly. Additional training and/or disciplinary action will be considered as warranted. A Quality Assessment and Assurance (QAA) Committee Meeting was held on 4/21/2025. The next QAA Committee meeting will convene on 5/22/2025. By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	

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F 759	Continued From page 17	F 759		

nonspecific skin eruptions.

Record review of Resident #39's "Physician Orders" revealed: Blink Tears Ophthalmic Solution 0.25%:Instill one drop in both eyes as needed every 6 hours for dry eyes." Order date 1/27/25.

Record review of Resident #39's MDS with ARD 03/04/25 revealed a BIMS score of 15, indicating cognitively intact.

Resident #1

On 04/01/25 at 8:38 AM, during observation of medication pass for Resident #1 via Percutaneous Endoscopic Gastrostomy (PEG) tube, LPN #4 administered multiple medications without flushing the tube with 5 cc of water between medications.

Record review of Resident #1's "Order Summary Report" included orders with a start date of 4/1/25 for Eliquis 5 mg: Give one tablet via PEG tube twice a day. Famotidine 40 mg: Give one tablet via PEG tube twice a day. Fluoxetine 10 mg: One tablet daily via PEG tube. Metoprolol 25 mg: One tablet via PEG tube twice a day. Glycolax (MiraLAX) 17 grams via PEG tube once daily.

Record review of Resident #1's MDS with an ARD of 03/10/24 revealed a BIMS score of 08, indicating moderate cognitive impairment.

Record review of Resident #1's "Face Sheet" revealed an admission date of 4/25/13 with diagnoses including Cerebral palsy.

On 04/01/25 at 10:18 AM, during an interview,

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F 759	Continued From page 18 LPN #4 confirmed she did not wait 5 minutes after administering Albuterol Sulfate before proceeding with oral medications. She also confirmed she did not offer Resident #50 water to rinse the mouth after the Advair inhaler. She acknowledged administering two puffs of Advair instead of one as ordered. LPN #4 further confirmed that she did not flush the PEG tube with 5 cc of water between medications. She stated the purpose of mouth rinsing after inhaler use is to prevent oral thrush, and the purpose of flushing the tube between medications is to prevent clogging and ensure the resident receives the full dosage. On 04/02/25 at 11:22 AM, during an interview, the Director of Nursing (DON) stated that LPN #2 and LPN #4 should have followed physician orders. She stated Resident #50 should have been asked to rinse and spit after using the Advair inhaler. She confirmed the PEG tube should have been flushed with 5 cc of water between medications. She explained that failure to rinse the mouth after inhalers can cause oral thrush, and not flushing the PEG tube can lead to clogging and medication mixing. She emphasized that not following physician orders can cause adverse reactions and that it is her expectation that nurses administer medications accurately and per orders.	F 759		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care	F 851		4/28/25

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staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

§483.70(p)(1) Direct Care Staff.
Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(p)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(p)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care

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F 851	Continued From page 20 staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interviews, facility statement review and Certification and Survey Provider Enhanced Reports (CASPER) data review, the provider failed to ensure their Payroll Based Journal (PBJ)-which includes information on the staffing hours necessary for the appropriate care of the residents-was corrected prior to submission to the Centers for Medicare & Medicaid Services (CMS) for one (1) of four (4) quarters in 2024. (October 1-December 31.) Findings include: Record review of a statement of facility letterhead, undated, and signed by the facility Administrator, revealed "There has been an upgrade to the timeclock system which has created some glitches that may have caused reporting issues." During an interview with the Human Resources Director on April 2, 2025, at 2:30 PM, she stated that nursing hours are automatically sent to the	F 851	a. On 4/2/2023, the Administrative Assistant and Administrator completed an audit of all staff time that was entered automatically from the time clock to Payroll Based Journal (PBJ) database with no discrepancies noted. b. All residents have the potential to be affected by this alleged deficient practice. No issues were identified. c. On 4/3/2025, the Administrative Assistant was in-serviced by the Administrator to verify correct employee times daily for each staff member and contract worker. d. On 4/3/2025, the Administrator began monitoring PBJ entries five (5) days a week for four (4) weeks, then weekly for two (2) months, and once a month for six (6) months. Any areas of concern will be corrected and forwarded	

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F 851	Continued From page 21 Payroll Based Journal (PBJ) when staff clock in. She reported that she only enters agency nursing hours and does not have direct access to the PBJ or receive any notifications regarding submission errors. On April 2, 2025, at 2:45 PM, the Administrator stated that he verifies the accuracy of the PBJ prior to submission. He explained that the corporate office receives notifications about submission errors, such as low weekend staffing. He stated that the facility recently upgraded its time clock system and speculated that ongoing glitches in the system may have contributed to errors in PBJ reporting.	F 851	by the Administrator to the quarterly Quality Assessment and Improvement Committee for review and follow up including any needed corrective actions or changes to current plan at least quarterly. Additional training and/or disciplinary action will be considered as warranted. A Quality Assessment and Assurance (QAA) Committee Meeting was held on 4/21/2025. The next QAA Committee meeting will convene on 5/22/2025. By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis,	F 865		4/28/25

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and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;

§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;

§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a

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LAWRENCE CO NURSING CENTER	700 JEFFERSON STREET SOUTH MONTICELLO, MS 39654

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F 865	Continued From page 23 SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee	F 865		

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F 865	Continued From page 24 except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, facility policy review and Plan of Correction (POC) review, the facility failed to sustain an effective Quality Assurance and Performance Improvement (QAPI) program, as evidenced by repeat deficiencies originally cited during the recertification survey conducted in February 2024, for two (2) of eight (8) deficiencies cited on the current recertification survey. Findings include: A review of the facility policy, "Five Elements of QAPI," revised 11/22, revealed the following: "Element 3: Feedback, Data Systems and Monitoring - the facility puts systems in place to monitor care and services .... It also includes tracking, investigating, and monitoring... and corrective action plans implemented to prevent recurrences..." F851 - Payroll-Based Journal Reporting During this recertification survey, the provider failed to ensure their Payroll Based Journal (PBJ)-which documents staffing hours required to provide appropriate care to residents-was corrected before submission to the Centers for Medicare & Medicaid Services (CMS) for one (1)	F 865	a. On 4/3/2023, a Quality Assurance and Performance Improvement (QAPI) meeting was conducted. b. All residents have the potential to be affected by this alleged deficient practice. No issues were identified. c. On 4/3/2025, the Administrator in-serviced the Administrative Assistant, Director of Nurses, Infection Preventionist Nurse, Social Services Director, Dietary Manager, Assessment Nurse, and Medical Records staff on Quality Assurance and Performance Improvement (QAPI) Program. The Director of Nurses in-serviced Nursing staff and Certified Nursing Assistant (C.N.A) staff on Infection Control policy and Payroll Based Journal (PBJ) protocols. d. On 4/3/2025, the Administrator began monitoring PBJ entries five (5) days a week for four (4) weeks, then weekly for two (2) months, and once a month for six (6) months. On 4/3/2025, The Infection Preventionist Nurse and Director of Nurses began monitoring hand	

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F 865	Continued From page 25 of four (4) quarters in 2024. During the recertification survey in February 2024, the provider failed to ensure PBJ reporting was corrected before submission to CMS for one (1) of four (4) quarters in 2023. F880 - Infection Prevention and Control During this recertification survey, the facility failed to prevent the possible spread of infection by not exercising proper hand hygiene during perineal care for two (2) of three (3) residents observed. During the recertification survey in February 2024, the facility failed to prevent the possible spread of infection by not exercising proper hand hygiene during perineal care for one (1) of fifteen (15) sampled residents observed. On 04/02/25 at 2:27 PM, in an interview with the Director of Nursing (DON), she confirmed that the facility had been cited for the same infection control issue during the previous year's survey. She explained that it is not due to a lack of inservice training but stated they may need to rethink their approach. She suggested implementing more supervision while staff are providing care. She added that although high-risk meetings are held, they do not address infection control tasks like this. On 04/02/25 at 2:31 PM, during an interview with the Staffing Coordinator, she acknowledged that the facility had been cited for the same infection control issues. She stated that while inservices are provided, she believes the frequency of training on hand hygiene and glove use should be increased.	F 865	hygiene during pericare and Enhanced Barrier Precaution Protocol adherence by nursing staff three (3) days per week for four (4) weeks and then once week for eight (8) weeks. Any areas of concern will be corrected and forwarded by the Director of Nurses and Administrator to the quarterly Quality Assessment and Improvement Committee for review and follow up including any needed corrective actions or changes to current plan at least quarterly. Additional training and/or disciplinary action will be considered as warranted. A Quality Assessment and Assurance (QAA) Committee Meeting was held on 4/21/2025. The next QAA Committee meeting will convene on 5/22/2025. By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	

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F 865	Continued From page 26 On 04/02/25 at 2:45 PM, in an interview with the Administrator, he stated that recurring infection control issues are largely due to the need for increased staff monitoring. The Administrator confirmed there were errors in PBJ reporting during the prior recertification survey. He stated that the issue persists due to a recent upgrade to their time clock system. He suggested there may be a transmission problem between the time clock and the PBJ reporting system.	F 865		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		4/28/25

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procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its

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IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and policy review, the facility failed to follow proper infection control guidelines for two (2) of three (3) care observations. Resident# 5 and Resident #44.

Findings include:

Record review of the facility policy Enhanced Barrier Precautions (EBP) last reviewed 03/24 revealed " ...Enhanced Barrier Precautions are indicated for residents with any of the following: wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO (Multidrug Resistant Organisms) ..."

Record review of the facility policy titled "Hand Hygiene" revised 08/14/24 revealed " ...2. Hand hygiene should be performed between all contact with residents, or when entering and exiting a resident ' s room ...4. before and after applying gloves, 5. when hands are visibly soiled ....9. Wearing gloves does not replace the need to perform hand hygiene ...."

Resident #5

On 04/01/25 at 10:18 AM, Resident #5 was observed during wound care to the sacral area. At this time, Licensed Practical Nurse (LPN) #3 and Certified Nursing Assistant (CNA) #2 were present and performing the wound care. Neither staff member was wearing gowns. Prior to the wound care, the resident had soiled her brief with urine. CNA #2 notified the nurse. However,

a. On 4/3/2023, Resident #5 and Resident #44 were assessed by the Director of Nurses and found to be free of any ill effects of improper hand hygiene.

b. All residents have the potential to be affected by this alleged deficient practice. No issues were identified.

c. On 4/3/2025, the Director of Nurses began in-servicing nursing staff on Proper Hand Hygiene, Pericare, Infection Control, and Enhanced barrier Precaution Protocols. On 4/3/2025, the Infection Prevention Nurse began conducting check-offs with all nursing staff on Proper Hand Hygiene, Pericare, Infection Control, and Enhanced barrier Precaution Protocols.

d. On 4/3/2025, The Infection Preventionist Nurse and Director of Nurses began monitoring hand hygiene during pericare and Enhanced Barrier Precaution Protocol adherence by nursing staff three (3) days per week for four (4) weeks and then once a week for eight (8) weeks. Any issues found will be taken by the Infection Preventionist Nurse and Director of Nurses to the quarterly Quality Assessment and Improvement Committee for review and follow up including any needed corrective actions or changes to current plan at least quarterly. Additional training and/or disciplinary action will be considered as warranted. A Quality

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F 880	Continued From page 29 wound care was observed being provided and completed prior to staff changing the resident's brief. After changing the brief, staff did not perform perineal care. On 04/01/25 at 10:30 AM, LPN #3 verified during an interview, that she did not wear a gown. She stated the resident is on Enhanced Barrier Precautions, therefore a gown should have been worn by herself and CNA #2 during care. She also stated that perineal care should have been performed at the time the brief was changed and that the brief should have been changed before wound care was initiated to prevent infection. On 04/01/25 at 10:32 AM, CNA #2 stated that the resident's brief should have been changed prior to performing wound care and that she should have performed perineal care prior to leaving the room, rather than just changing the brief. She acknowledged that this was necessary to prevent infection due to the resident's incontinent episode of urine. She also stated she should have worn a gown before entering the room to provide care. Record review Admission record revealed Resident #5 was admitted on 07/22/22 with a diagnoses that included Schizoaffective disorder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/8/25, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Section M documented a Stage 2 pressure injury. Record review of Order Summary Report with active orders as of 4/1/25 revealed a physician order dated 3/7/25, "Cleanse Stage 2 pressure	F 880	Assessment and Assurance (QAA) Committee Meeting was held on 4/21/2025. The next QAA Committee meeting will convene on 5/22/2025. By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	

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wound to the sacral area with wound cleanser, pat dry, apply Nystatin powder (around the peri-wound), apply Duoderm, and cover with foam dressing daily until healed."

Resident #44

On 04/01/25 at 3:30 PM, Resident #44 was observed receiving perineal care. CNA #1 provided the care. During the process, she was observed cleaning stool from the resident using a brief. She had gloves on. She then wrapped the stool in the brief, placed it in a receptacle, and left the bedside wearing the same soiled gloves. She touched multiple surfaces, turned on the sink faucet, and applied soap to a new towel to clean the resident, all while still wearing the soiled gloves.

On 04/02/25 at 9:25 AM, CNA #1 was interviewed and confirmed that she should have removed her soiled gloves prior to leaving the bedside to avoid possibly spreading contamination from stool to the sink and anything else she touched.

On 04/02/25 at 10:11 AM, the Director of Nursing (DON) revealed that staff should remove gloves and perform hand hygiene prior to touching anything else in the room to avoid spreading infection.

On 04/02/25 at 10:12 AM, the Infection Preventionist (LPN #1) revealed staff should remove gloves to prevent the spread of infection to other surfaces, especially when contaminated with stool.

Record review of the Admission Record revealed Resident #44 was admitted on 09/22/23 with

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F 880	Continued From page 31 diagnoses that included Hypertensive heart disease without heart failure. Record review of the MDS with an ARD of 2/24/25, Section H, revealed that Resident #44 is always incontinent of bowels.	F 880		