STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255291	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPIAH LIVING CENTER	806 WEST GEORGETOWN STREET CRYSTAL SPRINGS, MS 39059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 05/05/2025 through 05/08/2025. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F557, F641, F690, F867, and F880. The facility had a census of 54 and was licensed for 60 beds.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure residents' rights for respect and dignity, as evidenced by staff entering resident rooms and providing care while using personal cell phones and wearing earbuds, which residents described as "rude and disrespectful." This deficient practice affected two (2) of 18 sampled residents, Resident #4 and Resident #43. Findings Included: A review of the facility's policy, "Resident's	F 557	A. On 05/08/2025, Resident #4 and Resident #43 were assessed by the Director of Nursing on any adverse effects related to how the facility failed to ensure Resident Rights for respect and dignity. There were no adverse effects noted. B. All current residents of the facility have the potential to be affected by the deficient practice. C. On 5/8/2025,the facility Staffing Coordinator started an in-service on	6/4/25

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

Electronically Signed | 05/22/2025

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F 557	Continued From page 1 Rights," dated 3/24, revealed, "Every resident in this facility has the right to...12. Be treated courteously, fairly and with the fullest measure of dignity..." Resident #4 On 5/8/25 at 9:28 AM, during an interview with Resident #4, she confirmed her concerns shared during the Resident Council meeting and explained that staff often entered her room while on the phone or wearing earbuds. She stated that she felt this was disrespectful and rude. A record review of the "Admission Record" revealed the facility admitted Resident #4 on 3/11/21 with diagnoses including Unspecified Atrial Fibrillation. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/10/25 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact. Resident #43 On 5/8/25 at 9:28 AM, during an interview with Resident #43, she explained that staff frequently entered her room while using phones or earbuds, which she found disrespectful. A record review of the "Admission Record" revealed the facility admitted Resident #43 on 3/13/24 with diagnoses including an Unspecified Fracture of Sacrum. A record review of the Comprehensive MDS with an ARD of 2/21/25 revealed Resident #43 had a	F 557	Resident Rights Policy with an emphasis on not using personal cell phones and wearing earbuds while entering Resident's rooms. The facility Administrator and Director of Nursing will ensure that Resident's Rights are not being violated D. Beginning 05/08/2025 the Licensed Practical Nurse and/or Registered Nurse on duty will check All Staff during her shift for personal cellphones and earbuds usage daily times four weeks then five days/week times three weeks then three days/week thereafter. Areas of concern will be brought to the Quality Assessment and Improvement Committee for review. The Quality Assessment And Improvement Committee will convene on 06/04/2025 to discuss further recommendations as needed. Additional training and/or disciplinary action will be considered as warranted.	

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F 557	Continued From page 2 Brief Interview for Mental Status (BIMS) score of 12, indicating her cognition was moderately impaired. On 5/8/25 at 11:50 AM, during an interview with the Director of Nursing (DON), she explained that she had provided multiple in-services on this issue. She stated that staff should not wear earbuds in resident rooms and acknowledged that it could be irritating to the residents. On 5/8/25 at 12:13 PM, during an interview with the Administrator, she explained that she had also in-serviced staff multiple times regarding not wearing earbuds. She stated that she was unaware the issue was still occurring and emphasized that residents should be given undivided attention because their rooms are their homes.	F 557		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification.	F 641		6/4/25

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F 641	Continued From page 3 §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to accurately code antipsychotic medications on the Minimum Data Set (MDS) for one (1) of eighteen (18) sampled residents, Resident #17. Findings included: A review of the facility's policy, "Resident Assessment," revised 9/19, revealed, "An assessment will be completed on each resident utilizing the MDS...The Registered Nurse is responsible for the completion of the assessment. The completed assessment guide the staffing in identifying key information about the resident and serves as a basis for identifying resident specific issues and objectives in order to develop a care plan. This process assists the resident in reaching the highest practical physical, mental and psychosocial well-being..." A record review of the "Admission Record" revealed the facility admitted Resident #17 on 4/23/21 and she had current diagnoses including Schizoaffective Disorder.	F 641	A. On 05/08/2025, the facility Nurse Case Manager completed a Minimum Data Set (MDS) Modification on Resident #17 and was transmitted to the Internet Quality Improvement and Evaluation System (IQIES). B. All residents that receive Antipsychotic medications have the potential to be affected by this deficient practice. C. Beginning on 05/08/2025, the Director of Nurses and Assessment Nurse reviewed Section N of the Minimum Data Set (MDS) on all Residents that are receiving Antipsychotic medications. Out of 19 records reviewed,4 residents receiving antipsychotic medication was not accurately coded on the Minimum Data Set (MDS).On 5/13/2025, the facility Assessment Nurse completed and transmitted the Minimum Data Set (MDS) Modification on the 4 Residents. On 05/08/2025,the Director of Nurses in-serviced the Assessment Nurse and	

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F 641	Continued From page 4 A record review of the Comprehensive MDS with an Assessment Reference Date (ARD) of 2/10/25, revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated her cognition was moderately impaired. Further review revealed Section N (Medications) indicated that she was not taking an antipsychotic medication. A record review of the "Order Review History Report" revealed Resident #17 had a Physician's Order, dated 11/21/24, for Abilify 2.5 milligrams (mg) at bedtime. A record review of the "Medication Administration Record (MAR)" for February 2025, revealed Resident #17 was administered Abilify 2.5 mg at bedtime during the MDS lookback period. A record review of the web page "Drugs.com" indicated the "Drug Class" of Abilify is "Atypical antipsychotics." On 5/8/25 at 10:13 AM, during an interview with Licensed Practical Nurse (LPN) #1, who also served as the Minimum Data Set (MDS) nurse, she confirmed that completing the MDS for residents was part of her responsibilities. Upon reviewing the physician's order for Resident #17, she acknowledged that while an antipsychotic medication was ordered, it was not coded on the MDS. She stated this was an error. On 5/8/25 at 10:19 AM, during an interview with Registered Nurse (RN) #1, who also functioned as an MDS nurse, she explained that a Utilization Review of the MDS was conducted prior to submission to ensure accuracy. However, upon	F 641	Nurse Case Manager on the Resident Assessment Policy and Section N of CMS's RAI Version 3.0 Manual. D. Beginning on 05/08/2025, the Director of Nurses and/or Nurse Case Manager will review Section N on all completed Omnibus Budget Reconciliation Act (OBRA) Minimum Data Set (MDS) before transmission to Internet Quality Improvement and Evaluation System (IQIES) one time per week for four weeks then two times a month for at least three months. Areas of concern will be brought to the Quality Assessment and Improvement Committee will convene on 06/04/2025 and monthly for at least three months to discuss further recommendations as needed. Additional training and/or disciplinary action will be considered as warranted.	

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F 641	Continued From page 5 reviewing the physician's order from 11/21/24 for the antipsychotic medication for Resident #17, RN #1 acknowledged the current MDS did not reflect this order and confirmed that it was an error requiring correction.	F 641		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690		6/4/25

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F 690	Continued From page 6 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure incontinent residents received appropriate care and services to prevent the possibility of urinary tract infection for two (2) of two (2) residents reviewed for perineal care, Resident #20 and Resident #38. This deficiency was also cited on the last Recertification Survey, therefore the scope/severity was increased to "E" representing a pattern. Findings included: A review of the facility's policy, "Perineal Care," revised 1/24, revealed, "Purpose to cleanse the perineum, eliminate odor, prevent irritation and to enhance the resident's dignity and self-esteem ... Female-without catheter ...5. Wash genital area, moving from front to back, while using a clean portion of the washcloth or pre-moistened wash wipe for each stroke ... Male without catheter ...5. Using the other hand gently cleanse from the tip to the base of the penis. Use a clean portion of the washcloth or pre-moisturized wash wipe after each stroke..." Resident #20 A record review of Resident #20's "Admission Record" revealed the facility admitted the resident on 1/11/21 with diagnoses including	F 690	A. On 05/07/2025,Residents #20 and #38 were assessed by the Director of Nursing on any adverse effects related to how the facility failed to ensure incontinent residents receive appropriate care and services to prevent the possibility of urinary tract infection. There were no adverse effects noted B. All residents that receive incontinent care have the potential to be affected. C. On 05/07/2025, the facility Infection Preventionist Nurse completed one on one in-service with return demonstration on Certified Nursing Assistant #3 regarding Perineal Care Policy. On 05/08/2025, the facility Infection Preventionist Nurse completed a one on one education with return demonstration on Certified Nursing Assistant #2 on Perineal Care Policy. Beginning 05/07/2025, the Infection Preventionist Nurse began in-servicing all Certified Nursing Assistants on the Perineal Care Policy and new hires will be in-serviced with return demonstration upon hire. D. Beginning on 05/07/2025, the Director of Nursing, Infection Preventionist Nurse and/or Registered Nurse Supervisor will observe at least five Certified Nursing Assistants/day times five days/week times	

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F 690	Continued From page 7 Hypertension. A record review of Resident #20's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/7/25 revealed she had a Brief Interview for Mental Status (BIMS) score of 5, which indicated her cognition was severely impaired. Further review revealed she was dependent upon staff for toileting hygiene. On 5/5/25 at 1:55 PM, during an observation of perineal care for Resident #20, Certified Nursing Assistant (CNA) #3 removed Resident #20's pants and brief and began care by wiping only the groin area on each side of the vagina. She did not wipe the vaginal area while providing the care. On 5/5/25 at 2:14 PM, during an interview with CNA #3, she acknowledged that she did not give proper perineal care and stated Resident #20 could get a urinary tract infection by not cleaning the perineal area appropriately. She explained she was supposed to clean both sides and the center of the vaginal area for Resident #20. Resident #38 A record review of Resident #38's "Admission Record" revealed the facility admitted him on 4/5/24 and he had current diagnoses including Dementia. A record review of Resident #38's Quarterly MDS with an ARD of 4/18/25 revealed he required a staff assessment for Mental Status and his cognitive skills for daily decision making were severely impaired. Further review revealed he was dependent upon staff for toileting hygiene.	F 690	four weeks then five Certified Nursing Assistants/day times three days/week times four weeks then five Certified Nursing Assistants one time a week times four weeks on Perineal Care for at least three months. The Quality Assessment and Improvement Committee will convene on June 4,2025 and monthly for at least three months to discuss further recommendations as needed. Additional training and/or disciplinary action will be considered as warranted.	

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F 690	Continued From page 8 On 5/7/25 at 1:20 PM, an observation revealed CNA #2 providing perineal care to Resident #38. CNA #2 removed the resident's brief and wiped the entire penis several times using the same wipe. She folded the wipe one time during perineal care. She did not clean the penis from the tip to the base, using a clean portion of the pre-moisturized wipe after each stroke. On 5/7/25 at 2:13 PM, during an interview with CNA #2, she acknowledged that she did not perform perineal care correctly because she did not clean the penis by starting at the tip and using a clean wipe for each stroke. On 5/7/25 at 3:50 PM, during an interview with the Licensed Practical Nurse (LPN)/Infection Preventionist (IP), she stated CNA #3 should have cleaned both sides and the center of the vagina for Resident #20 and CNA #2 should have cleaned the penis from the tip down using a clean wipe each time for Resident #38. She explained that Resident #20 and Resident #38 could develop a urinary tract infection (UTI) or other infection due to the improper care they received. On 5/7/25 at 4:00 PM, during an interview with the Director of Nursing (DON), she stated CNA #3 should have wiped the vaginal area down both sides and the center for Resident #20 and CNA #2 should have cleaned the penis from the tip downward, folding the wipe or using a clean one each time for Resident #38. She stated that improper care could result in skin breakdown and expressed that she expects staff to perform peri-care and all resident care correctly.	F 690		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)	F 867		6/4/25

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(iii)

§483.75(c) Program feedback, data systems and monitoring.
A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to

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prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms

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F 867	Continued From page 11 that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective	F 867	A. On 05/09/2025 a Quality Assurance and Performance Improvement (QAPI) meeting was conducted.	

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COPIAH LIVING CENTER	806 WEST GEORGETOWN STREET CRYSTAL SPRINGS, MS 39059

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F 867	Continued From page 12 actions to prevent recurrence of previously cited deficiencies, specifically, the facility was cited for failing to ensure an incontinent resident received appropriate care and services to prevent the possibility of a urinary tract infection and failed to ensure infection control measures were consistently implemented to prevent the development and/or transmission of infection during an annual recertification survey on 11/2/2023. The facility was cited again for the same deficiencies during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for two (2) of five (5) deficiencies cited. F690 and F880 Findings included: A review of the facility's policy, "Quality Assurance Performance Improvement Program (QAPI) with a revision date of 11/22 revealed, "This facility shall develop, implement, and maintain an effective, comprehensive, data driven Quality Assurance Performance Improvement (QAPI) program that focuses on indicators of the outcome of care and quality of life. The facility shall have in place a system that continuously strives to improve the quality of care and services received by residents in this facility. This will be achieved through quality management. Quality management will be a systematic, pro-active process of accessing, controlling and improving outcomes. The system will focus on both health care outcomes and operational efficiency ..." Record review of the "Provider History Profile" revealed the facility received a citation for F690-Bowel/Bladder Incontinence, Catheter, UTI (Urinary Tract Infection) and F880-Infection	F 867	B. All residents have the potential to be affected by the alleged deficient practices. C. On 05/09/2025 the Administrator in-serviced the Director of Nurses, Infection Preventionist Nurse, Social Services Director, Dietary Manager, Assessment Nurse, Nurse Case Manager, Registered Nurse Supervisor and Medical Records on Quality Assurance and Performance Improvement (QAPI) Program. The Infection Preventionist Nurse in-serviced all Certified Nursing Assistants on Infection Control Policy, Hygiene Policy and Perineal Care Policy on 05/07/2025. D. Beginning on 05/07/2025, the Infection Preventionist Nurse, Director of Nurses and Registered Nurse Supervisor began monitoring hand hygiene and infection control practices during perineal care by Certified Nursing Assistants five days/week times four weeks, then three days/week times four weeks and once a week times four 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 05/20/2025. The next QAA Committee Meeting will convene on 06/04/2025	

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Prevention & Control on the survey dated 11/2/2023.

Record review of the CMS-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of 11/02/2023, revealed the facility received a citation for F690, " ...Based on observation, interviews, record review, and facility policy review, the facility failed to ensure an incontinent resident received appropriate care and services to prevent the possibility of a urinary tract infection ..." and for F880, " ...Based on observation, interviews, record review, and facility policy review, the facility failed to ensure infection control measures were consistently implemented to prevent the development and/or transmission of infection ..."

During the current recertification survey, the facility failed to ensure incontinent residents received appropriate care and services to prevent the possibility of urinary tract infection for two (2) of two (2) residents reviewed for perineal care and failed to follow infection control practices during the provision of perineal care for two (2) of two (2) residents observed for perineal care.

On 5/8/25 at 11:47 AM, during an interview with the Director of Nursing (DON), she confirmed the facility was cited for the same deficient practices on the previous survey that was identified during the current survey.

On 05/08/25 at 2:00PM, in an interview, the Nursing Home Administrator (NHA) explained that she is aware of the previous annual survey citations, and the facility has new staff, and

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F 867	Continued From page 14 part-time staff could have played a part in the repeat citations.	F 867		
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 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;	F 880		6/4/25

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F 880	Continued From page 15 (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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to follow infection control practices during the provision of perineal care for two (2) of two (2) residents observed for perineal care, Resident #20 and Resident #38, as evidenced by not performing hand hygiene, using gloves	F 880	A. On 05/07/2025,Residents #20 and #38 were assessed by the Director of Nursing on any adverse effects related to how the facility failed to ensure infection control practices during perineal care was being followed. There were no adverse effects noted.	

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F 880	Continued From page 16 inappropriately stored in pockets, continuing care with soiled gloves, and retrieving wipes from the packet with contaminated gloves, placing residents at risk for cross-contamination and infection. This deficiency was also cited on the last Recertification Survey, therefore the scope/severity was increased to "E" representing a pattern. Findings included: A review of the facility's policy, "Infection Prevention and Control Program," revised 8/21, revealed, "This facility has developed and maintains an infection prevention and control program that provides a safe, sanitary and comfortable environment to help prevent the development and transmission of infection ..." A review of the facility's policy, "Hand Hygiene," revised 1/24, revealed, " ...Cleanse hands to prevent transmission of infection or other conditions... Indications for Hand Washing ...2. Hand hygiene should be performed between all contact with residents or when entering and exiting a resident's room 3. Before and after procedures. 4. Before and after applying gloves. 5. When hands are visibly soiled ...Selecting Hand Washing Method ...2. When to wash with soap and water ...d. When hands are visibly contaminated with blood or bodily fluids ..." Resident #20 A record review of Resident #20's "Admission Record" revealed the facility admitted the resident on 1/11/21 with diagnoses including Hypertension.	F 880	B. All residents that receive perineal care care have the potential to be affected by this deficient practice. C. On 05/07/2025, the facility Infection Preventionist Nurse completed an one on one in-service on Certified Nursing Assistant #3 regarding Infection Control Policy and Hand Hygiene Policy. On 05/08/2025, the facility Infection Preventionist Nurse completed a one on one education on Certified Nursing Assistant #2 on Infection Control Policy and Hand Hygiene Policy. Beginning 05/07/2025, the Infection Preventionist Nurse began in-servicing all Certified Nursing Assistants on Infection Control Policy and Hand Hygiene Policy. and new hires will be in-serviced with return demonstration upon hire. D. Beginning on 05/07/2025, the Director of Nursing, Infection Preventionist Nurse and/or Registered Nurse Supervisor will observe at least five Certified Nursing Assistants/day times five days/week times four weeks then five Certified Nursing Assistants/day times three days/week times four weeks then five Certified Nursing Assistants one time week times four weeks for at least three months on Perineal Care with emphasis on Infection Control practices such as hand hygiene, ensure staff not storing gloves in pockets and does not retrieve wipes from the packet with contaminated gloves. The Quality Assessment and Improvement Committee will convene on June 4,2025	

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F 880	Continued From page 17 A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/7/25 revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident's cognition was severely impaired. On 5/5/25 at 1:55 PM, during an observation of perineal care for Resident #20, Certified Nursing Assistant (CNA) #3, assisted by CNA #1, was observed removing gloves from her pocket and applying them without first performing hand hygiene. CNA #3 also handed a pair of gloves to CNA #1, who applied them without washing her hands. CNA #3 then began providing care to Resident #20, who was visibly soiled with feces. During care, CNA #3 moved from dirty to clean areas without removing gloves or washing her hands. She verbalized awareness by stating she should have changed gloves and performed hand hygiene, but continued care without doing so. CNA #3 applied a clean brief while wearing soiled gloves and was observed removing perineal wipes from the package twice with contaminated gloves. On 5/5/25 at 2:14 PM, during an interview with CNA #3, she acknowledged she should not have stored gloves in her pocket or removed wipes from the pack with soiled gloves. She admitted she should have washed her hands before beginning care and during care. She acknowledged she had not provided proper perineal care and stated that the resident could develop a urinary tract infection as a result. On 5/6/25 at 1:18 PM, during an interview with CNA #1, she confirmed she applied gloves taken from CNA #3's pocket without washing her hands.	F 880	and monthly for at least three months to discuss further recommendations as needed. Additional training and/or disciplinary action will be considered as warranted.	

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She acknowledged this was an infection control issue and that gloves should not be stored in pockets, and hand hygiene should be performed prior to donning gloves.

Resident #38

A record review of Resident #38's "Admission Record" revealed the facility admitted the resident on 4/5/24 with diagnoses including Dementia.

A record review of the Quarterly MDS with an ARD of 4/18/25 revealed the resident required a staff assessment for mental status and was documented as having severely impaired cognitive skills for daily decision making.

On 5/7/25 at 1:20 PM, during an observation of perineal care for Resident #38, CNA #2 was observed touching the bed remote control with gloved hands prior to starting care. She continued care by cleaning feces from the resident and removed additional wipes from the package using soiled gloves.

On 5/7/25 at 2:13 PM, during an interview with CNA #2, she acknowledged her actions during care were incorrect. She confirmed that retrieving wipes with soiled gloves could contribute to infection and skin breakdown.

On 5/7/25 at 3:50 PM, during an interview with the Licensed Practical Nurse (LPN)/Infection Preventionist, she confirmed that hand hygiene should be performed before starting care and gloves should never be stored in pockets. She stated CNA #2 should not have touched the bed remote or pulled wipes from the package with soiled gloves. She acknowledged that both

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F 880	Continued From page 19 Resident #20 and Resident #38 were at risk of developing urinary tract infections or other complications from improper care. On 5/7/25 at 4:00 PM, during an interview with the Director of Nursing (DON), she confirmed CNAs are expected to wash hands prior to providing care and should not store gloves in pockets. She acknowledged that the improper perineal care observed placed residents at risk for infection and skin breakdown.	F 880		