STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A123	A. BUILDING _____ B. WING _____	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINALD P WHITE NURSING FACILITY	1451 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 5/27/25 through 5/29/25. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F658, F867, and F880. The facility had a census of 64 and was licensed for 70 beds.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, the facility failed to ensure nursing services were provided in accordance with professional standards of practice by not verifying Percutaneous Endoscopic Gastrostomy (PEG) placement prior to administering medications for one (1) of four (4) residents observed for medication administration. Resident #13. Findings included: A review of the facility's policy titled "Tube Enteral Nutrition," revised 10/24, revealed, "The purpose of this protocol is to establish general guidelines for the use of tube enteral feedings for residents/Individuals Receiving Services (IRS) with a functioning Gastrointestinal Tract... "	F 658	"Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. On 6/2/25 Registered Nurse(RN)#2 was in-serviced by the Director of Nursing (D0N) on the proper procedure relating to correct verification on Percutaneous Endoscopic Gastrostomy (PEG) tube placement prior to administering fluids, feedings, nutritional supplements, and/or medications to the residents with a PEG tube. Resident #13 was clinically assessed by acting Director of Nursing (DON)on 5/29/25. No problems were noted. Address how the facility will identify other residents having the potential to be	7/11/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/12/2025

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F 658	Continued From page 1 On 5/29/25 at 9:23 AM, during an observation of medication administration via PEG tube, Registered Nurse (RN) #2 administered MiraLAX, potassium chloride, and ibuprofen to Resident #13 without verifying PEG tube placement prior to administration. On 5/29/25 at 10:40 AM, during an interview, RN #2 confirmed she had not verified PEG tube placement before administering medications. RN #2 acknowledged that placement verification is necessary to ensure the tube is in the correct position and stated that medications delivered into the body cavity could lead to complications. On 5/29/25 at 1:40 PM, during an interview with the acting Director of Nursing (DON), she stated that RN #2 should have verified PEG tube placement prior to medication administration. The DON confirmed that failure to verify placement could result in complications A record review of the "Face Sheet" revealed the facility admitted Resident #13 on 8/5/24. A record review of the "Physician Order Report" revealed Resident #13 had diagnoses including Gastrostomy Status. Further review revealed Resident #13 had Physician Orders for Pro-Stat via PEG tube two (2) times daily (start date of 8/15/24); Potassium Chloride liquid 20 milliequivalent (mEq)/15 milliliter (mL), 15 mL via PEG tube daily (start date of 1/23/25); Ibuprofen suspension 100 milligrams (mg)/5 mL, 30 mL per tube; oral tube twice daily (start date of 9/18/24); MiraLAX powder 17 grams per PEG tube (start date of 8/9/24).	F 658	affected by the same deficient practice. All residents who have a peg tube have the potential to be affected by the deficient practice of failing to adhere to guidelines for verifying PEG tubes are in the correct location prior to administering fluids, feedings, nutritional supplements, and/or medications. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; and, On 6/5/25, all licensed nurses received an in service by the nurse educator (RN) on the importance of verifying Percutaneous Endoscopic Gastrostomy (PEG) placement on both shift assessment and prior to administering fluids, feeding, nutritional supplements, and/or medications to the residents with PEG tube Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. On 6/9/25,a quality assurance meeting was held to address the identified deficiency of RN #2 who failed to verify PEG tube placement prior to administering medication. Beginning 6/16/25, the nurse supervisors will observe all medication nurses administering PEG tube fluids, feeding, nutritional supplements, and/or	

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F 658	Continued From page 2 A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/2/25 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of eleven (11), which indicated the resident's cognition was moderately impaired.	F 658	medications weekly to ensure verification of correct placement of the PEG tube. These observations will be conducted once a week for four weeks." If a deficiency is noted during any observation, corrective action will be achieved by retraining immediately on the proper protocol. Beginning 6/25/25, the Quality Assurance Nurse will conduct weekly observations of 30% medication nurses administering PEG tube fluids, feeding, nutritional supplements, and/or medications to ensure proper verification of PEG tube placement. Observations will occur once per week for a total of four weeks." If a deficiency is noted during any observation, corrective action will be achieved by retraining immediately on the proper protocol. The monitoring will be done weekly for four weeks for 100% compliance. Thereafter, observations will be monthly for three months or until 100% compliance is met compliance is met for 3 consecutive months. These monitoring observations completed by the Nursing Supervisor will be forwarded to the Quality Assurance committee Nurse for review. The Quality Assurance Nurse will discuss all findings in the monthly Quality Assurance meeting beginning 07/11/25 The Quality Assurance Committee will continue reviewing the monitoring observations and reporting the findings in the monthly quality assurance meeting until 100% compliance is met for three consecutive months.	

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F 658	Continued From page 3	F 658	Effective June 16, 2025, the Quality Assurance Nurse or designee will monitor four (4) nurses per month to ensure proper PEG tube placement verification. Findings from this monitoring will be reported monthly to the Quality Assurance Committee on a permanent, ongoing basis. The findings will be reported in the June 2025 monthly Quality Assurance meeting and in each monthly QA meeting thereafter.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(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	F 867		7/11/25

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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 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.

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F 867	Continued From page 5 §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 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	F 867		

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F 867	Continued From page 6 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 actions to prevent recurrence of previously cited deficiencies, specifically, the facility was cited for failing to maintain infection control practices during an annual recertification survey on 1/11/2024 and was cited again for the same deficiency during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of three (3) deficiencies cited. (F880) Findings Include: A review of the facility's Quality Assurance document (undated) revealed, " ...The Outcome Services Division will ...Periodically assess information based on established indicators, taking action to solve problems and pursue opportunities to improve quality ..." Record review of the "Provider History Profile" revealed the facility received a citation for F880-Infection Prevention & Control for the survey date of 1/11/2024.	F 867	"Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1st tag On 6/2/25 Director of Nursing (RN) conducted a 1:1 in service with Registered Nurse (RN) #2 on the proper infection control practices relating to performing hand hygiene, glove changing protocol, and donning/doffing appropriate Personal Protective Equipment (PPE) while administering medications through a Percutaneous Endoscopic Gastrostomy (PEG) tube. On 6/2/25, Director of Nursing (RN) conducted a 1:1 in service with Licensed Nurse (LPN) #1 on the proper infection control practices relating to performing hand hygiene, glove changing protocol, and donning/doffing appropriate PPE on residents who require Enhanced Barrier Precautions during wound care. On 6/10/25, the Administrator conducted a 1:1 in-service with the Quality Assurance Infection Preventionist (QAIP) nurse on the importance of sustaining corrective actions to prevent recurrence of licensed	

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F 867	Continued From page 7 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 1/11/2024, revealed the facility received a citation for F880, " ...Based on observation, staff interviews, record review, and facility policy review, the facility failed to prevent the possibility of the spread of infection ... during wound care for one (1) of five (5) wounds observed ..." During the current recertification survey, the facility failed to ensure staff followed appropriate infection prevention and control practices for two (2) of 18 sampled residents, Resident #13 and Resident #45. Specifically, the facility failed to ensure Registered Nurse (RN) #2 performed hand hygiene and donned appropriate personal protective equipment (PPE) while administering medications through a Percutaneous Endoscopic Gastrostomy (PEG) tube for Resident #13 who required enhanced barrier precautions (EBP) and failed to ensure Licensed Practical Nurse (LPN) # 1 followed EBP and glove-changing protocols during wound care for Resident #45. On 05/29/25 at 2:43 PM, in an interview, the Nursing Home Administrator (NHA) confirmed he was aware that during the prior annual survey, a Licensed Practical Nurse (LPN) was cited for failure to perform hand hygiene during wound care. He stated that since the prior citation, nurses had been retrained, and QAPI had focused on correcting the issue. He stated that QAPI meets monthly and that after three months of focused wound policy correction and achieving what they considered 100% compliance, the QAPI committee shifted focus to other issues. He further stated that follow-up may now occur only	F 867	nurses failing to comply with proper hand hygiene during wound care and Enhanced Barrier Precautions (EBP) protocols to prevent the possibility of the spread of infection. On 5/29/25, Resident #13 and Resident #45 were assessed by the Acting Director of Nursing (RN). No harm was noted. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the deficient practice of the facility's Quality Assurance and Performance Improvement (QAPI) Committee failing to sustain corrective actions to prevent recurrence of previously cited deficiencies of failing to maintain infection control practices relating to hand hygiene during wound care and EBP protocols which will prevent the possibility of the spread of infection. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; and, On 6/5/25, all licensed nurses were in serviced by the Nurse educator on the proper infection control practices relating to performing hand hygiene, glove changing protocol, and donning/doffing appropriate PPE while administering medications through a PEG tube and on residents who require EBP during wound care. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction	

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F 867	Continued From page 8 one to two times per year. He acknowledged that recent in-services focused on infection control had been conducted in the past few months.	F 867	is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. On 6/9/25, a quality assurance meeting was held to discuss the deficient practice of the facility's Quality Assurance and Performance Improvement (QAPI) Committee failing to sustain corrective actions to prevent recurrence of previously cited deficiencies relating to hand hygiene and Enhance Barrier Precautions protocols to prevent the possibility of the spread of infection Beginning 6/16/25, The nurse supervisors will perform weekly observation of licensed nurses for the proper use of hand hygiene and EBP protocols to ensure proper infection control practices are followed. If a deficiency is noted during any observations, corrective action will be achieved by retraining immediately on the proper protocol. Beginning 6/25/25, the Quality Assurance Infection Preventionist Nurse will perform weekly observation of 30% of licensed nurses for the proper use of hand hygiene and EBP protocols to ensure proper infection control practices are followed. If a deficiency is noted during any observations, corrective action will be achieved by retraining immediately on the proper protocol. The monitoring will be done weekly for four weeks for 100% compliance. Thereafter, observations will be monthly for three months or until 100%	

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F 867	Continued From page 9	F 867	compliance is met for 3 consecutive months. These monitoring observations completed by the Nursing Supervisor will be forwarded to the Quality Assurance Infection Preventionist Nurse for review. The Quality Assurance infection Preventionist Nurse will discuss all findings in the monthly Quality Assurance meeting beginning 07/11/2025. The Quality Assurance Committee will continue reviewing the monitoring observations in the monthly quality assurance meeting until 100% compliance is met for three consecutive months. Effective June 16, 2025, the Quality Assurance Infection Preventionist Nurse or designee will monitor four (4) nurses per month to ensure proper hand hygiene and donning/doffing PPE when caring for resident who are on Enhanced Barrier Precautions while performing wound care and administering medication through a PEG tube. Findings from this monitoring will be reported monthly to the Quality Assurance Committee on a permanent, ongoing basis. The findings will be reported in the June 2025 monthly Quality Assurance meeting and in each monthly QA meeting thereafter.	
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	F 880		7/11/25

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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;
(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

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F 880	Continued From page 11 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 ensure staff followed appropriate infection prevention and control practices for two (2) of 18 sampled residents, Resident #13 and Resident #45. Specifically, the facility failed to ensure Registered Nurse (RN) #2 performed hand hygiene and donned appropriate personal protective equipment (PPE) while administering medications through a Percutaneous Endoscopic Gastrostomy (PEG) tube for Resident #13 who required enhanced barrier precautions (EBP) and failed to ensure Licensed Practical Nurse (LPN) # 1 followed EBP and glove-changing protocols during wound care for Resident #45.	F 880	"Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. On 6/2/25 Director of Nursing (DON) conducted a 1:1 in service with Registered Nurse (RN) #2 on the proper infection control practices relating to performing hand hygiene, glove changing protocol, and donning/doffing appropriate Personal Protective Equipment (PPE) on residents who require Enhanced Barrier Precautions (EBP0 while administering medications through a Percutaneous Endoscopic Gastrostomy (PEG) tube. On 6/2/25, Director of Nursing (DON)	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 The scope/severity for F880 was increased to "E" due to previous citation on the annual recertification survey on 1/11/24. Findings included: A review of the facility's "Enhanced Barrier Precautions Protocol" (undated), revealed, "1. Enhanced Barrier Precautions (EBP) are required for certain resident categories ...3. For residents for whom EBP is indicated, EBP is employed when performing the following high-contact resident care activities ...Device care or use ...feeding tube ...Wound care: any skin opening requiring a dressing ..." A review of the facility's policy, "Hand Hygiene," revised 9/23, revealed: "It is the policy ...that employees will use proper hand hygiene techniques to prevent the spread of infectious diseases... Procedure ...C. Employees must always wash hands ...(4) Before performing invasive procedures ...(7) Before and after touching wounds. (8) After removing gloves ..." Resident #13 On 5/29/25 at 9:23 AM, during an observation of a medication pass for Resident #13, RN #2 administered medications via a PEG tube. RN #2 wiped down the bedside table with an antibacterial wipe while wearing gloves, then removed her gloves without performing hand hygiene. She applied a new set of gloves, placed a barrier on the bedside table, removed her gloves again, and applied a second clean pair without hand hygiene. She failed to don a gown at any point during the procedure, despite the resident requiring EBP.	F 880	conducted a 1:1 in service with Licensed Nurse (LPN) #1 on the proper infection control practices relating to performing hand hygiene, glove changing protocol, and donning/doffing appropriate PPE on residents who require EBP during wound care. On 5/29/25 Resident # 13, and Resident #45 were assessed by the Acting Director of Nursing (DON). No harm was noted. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the deficient practice of failing to perform proper infection control practices relating to hand hygiene and donning/doffing appropriate PPE while performing wound care and administering medication via PEG tube to residents who require enhanced barrier precautions. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; and, On 6/5/25, all licensed nurses were in serviced by the Nurse educator on the proper infection control practices relating to performing hand hygiene, glove changing protocol, and donning/doffing appropriate PPE while administering medications through a PEG tube and on residents who require EBP during wound care Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must	

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	25A123	A. BUILDING _____ B. WING _____	05/29/2025

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F 880	Continued From page 13 On 5/29/25 at 10:40 AM, during an interview, RN #2 stated she should have performed hand hygiene initially and between glove changes. She also stated she should have worn a gown to protect the resident from potential contamination. She acknowledged these failures put the resident at risk for infection and noted she had received prior training on hand hygiene and EBP but forgot to follow protocol. On 5/29/25 at 11:05 AM, during an interview, RN #3, the Infection Preventionist stated nurses are expected to perform hand hygiene before starting care and between glove changes. She stated that gowns should be worn before initiating care under EBP protocols and confirmed that failure to do so could lead to infection. She stated staff received recent training on hand hygiene and EBP. On 5/29/25 at 1:40 PM, during an interview, the Acting Director of Nursing (DON) confirmed that RN #2 should have worn a gown before starting care and performed hand hygiene between glove changes. She stated the nurse could have used hand sanitizer or washed her hands, and that failing to do so risked transmitting germs or bacteria to the resident. A record review of the "Face Sheet" revealed the facility admitted Resident #13 on 8/5/24. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/2/25 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated her cognition was moderately impaired.	F 880	be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. On 6/9/25, a quality assurance meeting was held to discuss the deficient practice of licensed nurses not following the proper infection control practices relating to performing hand hygiene, glove changing protocol, and donning/doffing appropriate PPE while administering medications through a PEG tube and performing wound care on residents who require EBP. Beginning 6/16/25, The nurse supervisors will perform weekly observations of licensed nurses for the proper use of hand hygiene and EBP protocols to ensure proper infection control practices are followed. If a deficiency is noted during any observation, corrective action will be achieved by retraining immediately on the proper protocol. Beginning 6/25/25, the Quality Assurance Infection Preventionist Nurse will perform weekly observations of 30% of licensed nurses for the proper use of hand hygiene and EBP protocols to ensure proper infection control practices are followed. If a deficiency is noted during any observation, corrective action will be achieved by retraining immediately on the proper protocol. The monitoring will be done weekly for four weeks until 100% compliance. Thereafter, observations will be monthly or until 100% compliance is met for 3 consecutive months.	

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F 880	Continued From page 14 A record review of the "Physician Order Report" for 5/1/25 through 5/31/25 revealed Resident #13 had diagnoses including Gastrostomy status and had medications required to be administered via a PEG tube. Resident #45 On 5/28/25 at 12:58 PM, LPN #1 was observed performing wound care for Resident #45. Prior to initiating care, she failed to don a gown, despite the resident being on EBP. During the procedure, she cleansed a dirty wound bed and then applied a new dressing without removing or changing her gloves, thereby applying the clean dressing with contaminated gloves. On 5/28/25 at 1:35 PM, during an interview, LPN #1 acknowledged that she should have worn a gown and changed gloves during the wound care procedure to prevent infection. She confirmed that the resident was on EBP, and her actions did not follow protocol. On 5/28/25 at 1:38 PM, during an interview, the DON confirmed that LPN #1 should have worn a gown before entering the room and should have changed gloves during the procedure. She stated gowns were available in the room and that failure to change gloves risked spreading infection. A record review of the "Nurse Competency Skill Assessment for Wound Care" revealed that gloves should be removed, and clean gloves donned four times during wound care-specifically after cleansing a dirty wound and before applying a new dressing, in accordance with physician orders and manufacturer instructions.	F 880	These monitoring observations completed by the Nursing Supervisor will be forwarded to the Quality Assurance Infection Preventionist Nurse for review. The Quality Assurance Infection Preventionist Nurse will discuss all findings in the monthly Quality Assurance meeting beginning 7/11/2025 The findings will be reported in the June 2025 monthly Quality Assurance meeting and in each monthly QA meeting thereafter. The QA Committee will determine if substantial compliance is obtained.	

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F 880	Continued From page 15 On 5/29/25 at 1:08 PM, during an interview, the facility's Infection Preventionist (IP Nurse) stated that LPN #1 should have worn a gown and changed gloves prior to applying the new dressing. She stated failure to do so contaminated the dressing and placed the resident at risk of infection. A record review of the "Face Sheet" revealed the facility admitted Resident #45 on 12/21/22. A record review of the "Physician Order Report" revealed Resident #45 had diagnoses including Venous Insufficiency and had a treatment with a start date of 4/25/25 to " ...Venous wound left anterior superior lower leg: Clean with normal saline, pat dry, apply Xeroform gauze and cover with dry dressing daily and PRN (as needed) ..." A record review of the Quarterly MDS with an ARD of 4/11/25 revealed Resident #45 had a BIMS score of three (3), which indicated his cognition was severely impaired.	F 880		