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	255092	A. BUILDING _____ B. WING _____	04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYINGTON HEALTH AND REHABILITATION	1530 BROAD AVE GULFPORT, MS 39501

(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 conducted an annual recertification along with five complaints (CI MS #17576, CI MS #17635, CI MS #17647, CI MS #17673, and CI MS #17682) from 04/20/21 to 04/23/21. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated CI MS #17576 for leaving residents soiled for extended period of time and cited F-600. The SA did not substantiate CI MS #17647 for misappropriation, CI MS #17682 for unqualified personnel, CI MS #17673 for failing to provide appropriate wound care, and CI MS #17635 for medical records and staffing with no citations related to the complaint. The SA also cited F-687, F-812, F-850, and F-880 during the survey.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		6/13/21

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

Electronically Signed | 06/13/2021

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F 600	Continued From page 1 Based on observation, interviews, record reviews, and facility policy review the facility failed to provide the residents who were unable to carry out Activities of Daily Living (ADL's) the necessary services to maintain good personal hygiene for four (4) of 103 residents observed. (Resident #17, Resident #101, Resident #16, and Resident #55). Resident #17 Findings Include: Review of the facility's "Abuse, Neglect and Exploitation Policy", dated 11/2019, revealed: It is the policy of this facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of residential property. The policy also revealed the definition of neglect as "Neglect means the failure of the center, its associates or service providers, to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress". Review of the facility's "Covid-19 Temporary Nurse Aide Skills Competency Checklist" dated 1/20/20 revealed Personal Care Attendant (PCA) #1 was in-serviced on providing Activities of Daily Living (ADL's). Review of the facility's Vulnerable Persons Act dated 01/22/2021 revealed PCA #1 was in-serviced on Abuse and Neglect. Review of the facility's In-service sign in sheet dated 3/26/21 revealed PCA #1 was in-serviced on Resident Rights and Abuse and Neglect.	F 600	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly This Plan of Correction is submitted to meet the requirements established by the State and Federal Law. 1. On April 20, 2021, Residents #17, #16 and #101 were provided incontinent care and Resident #55 was provided a bath on April 23, 2021. Director of Nursing educated Licensed Practical Nurse (LPN)#2 and LPN #4 on rounds, responsibility of nurse overseeing certified nursing assistants (CNA) and staff assignments on April 26, 2021. Director of Nursing educated Personal Care Assistant (PCA)#1 on Incontinent Care and making rounds on April 23, 2021. Director of Nursing educated CNA#6 and CNA#3 on resident showers and residents appearance on April 28, 2021. 2. On April 28, 2021, incontinent residents were observed for incontinent needs and addressed by LPN and Risk Manager Registered Nurse (RN)for any patients identified. 3. Staff Development RN and Risk Manager RN educated staff on Abuse Neglect, Following Resident Care Plan, Elder Justice Act, Incontinent Care and	

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F 600	Continued From page 2 Review of the facilities comprehensive care plan Resident #17 has a self-care deficit related to limited mobility, general weakness often declines to change her clothes and often wears same clothes multiple days. Resident #17 is high risk for infection as evidenced by history of urinary tract infection and neurogenic bladder, and high risk for impaired skin integrity related to decreased mobility. During an observation on 04/20/21 at 11:40 AM, revealed Resident # 17 lying on her back in her bed on two reusable incontinent pads with her eyes closed. The incontinent pads Resident # 17 was lying on and the sheets were visibly wet. Resident #17's gown was also saturated in urine. Observation revealed the incontinent pads Resident # 17 was lying on and the sheets had yellow circular stains with brown rings around the edges of the yellow circular stains. Resident # 17's room had a very strong urine odor. During an interview 04/20/21 at 11:40 AM, with Resident # 17 revealed she was confused and displayed difficulty answering questions. Resident #17 confirmed she had urinated and her clothes and linen were wet. Resident # 17 stated "it would be good to be dry". On 04/04/20/21 at 11:43 AM, the State Agency (SA) notified Licensed Practical Nurse (LPN)#2 that Resident # 17 was requesting assistance. LPN #2 went down the hall and spoke to the LPN #4. On 04/20/21 at 12:06 PM, observation of Resident # 17 sitting on the side of the bed wearing the same clothes with both incontinent	F 600	providing showers beginning April 23, 2021 and ending April 28, 2021. The Local Ombudsman educated facility staff on Residents' Rights, Abuse / Neglect on May 20, 2021. The Facility Administrator educated facility staff on Abuse / Neglect, Incontinent Care and bathing residents on May 20, 2021. On April 28, 2021, incontinent residents were observed for incontinent needs and addressed by Licensed Practical Nurse and Risk Manager, Registered Nurse for patients identified. 4. Director of Nursing, Administrator, Assistant Director of Nursing or Risk Manager will monitor incontinent care for providing timely and showers are provided timely, to include off hours visits weekly times three weeks then monthly times three months and quarterly thereafter. Monitoring began May 5, 2021. Adverse findings will be brought to the monthly Quality Assurance / Performance Improvement Committee by Director of Nursing for continued compliance quarterly. ADHOC Quality Assurance Meeting was held on April 30, 2021.	

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pads folded back. Both wet pads and both wet sheets remained on Resident #17's bed.

Observation on 04/20/21 at 12:15 PM, revealed Resident # 17 was sitting on the bed wearing the same clothes with both wet pads and both wet sheets still on the bed. Resident #17's lunch tray was set up in front of her. Resident #17 was eating lunch. The smell of urine continued to be very strong in Resident # 17's room. The odor was strong enough to be evident in the hallway.

On 04/20/21 at 12:20 PM, an observation revealed Certified Nursing Assistant (CNA) #5 entered Resident # 17's room with linens in a clear plastic bag. CNA #5 closed the door to Resident # 17's room.

On 04/20/21 at 12:25 PM, observation revealed CNA #5 exited Resident # 17's room with the full clear plastic bag. Resident # 17 was sitting on the bed eating lunch wearing the same saturated clothes. The linens on the bed were clean and the bed was clean and neat.

On 04/20/21 at 12:30 PM, during an interview Resident #17 confirmed she was still wearing wet, urine-soaked clothes and saturated disposable brief. When asked if the CNA had left the same dress on but changed the brief, the resident pushed the lunch tray aside, stood up, pulled her dress up and stated "No she didn't" revealing a disposable brief which sagged down between Resident # 17's thighs almost to the resident's knees. The brief was saturated with urine.

On 04/20/21 at 12:40 PM, an observation revealed LPN #4 entered Resident # 17's room

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and removed the lunch tray while Resident # 17 sat on the bed wearing the wet dress and saturated brief. The strong odor of urine remained in the room.

On 04/21/21 at 02:47 PM, an observation of Resident #17 sitting on the side of the bed. Resident #17's brief and gown was saturated in urine. The urine had a strong odor. Resident #17 had three pink incontinent pads with dark brown stains.

During an interview on 04/21/21 at 02:47PM, with Resident #17 confirmed her brief was saturated in urine. Resident #17 said she does normally call the staff when she needs assistance. Resident#17 said the staff will stick their head in the room sooner or later. Resident #17 said "I know I stink but it's ok." Resident #17 said I do not get around like I used too. Resident #17 confirmed her incontinent pads had not been changed for several hours. Resident #17 said she did not want to bother the staff.

During an observation on 04/22/21 at 05:35 AM, with PCA #1 revealed Resident #17 lying in bed. Resident #17's gown and pink incontinent pad was saturated in brown urine. Resident #17 removed her brief and threw it in the garbage can. The room had a strong urine odor.

During an interview on 04/22/21 at 05:45PM, with PCA #1 confirmed Resident #17's pad was saturated with urine and dried brown stains. PCA #1 said the resident is a heavy wetter. PCA #1 said the resident took herself to the bathroom and removed her brief sometimes during the night. PCA #1 said she did not know the resident had removed her brief and laid down on the saturated

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pads.

During an interview on 04/22/21 at 10:24 AM, with LPN #2 revealed she made the CNA assignments for the 11-7 shift CNA's/PCA's. LPN #2 said PCA #1 was assigned to the front of the hall. LPN #2 said she worked on that hall earlier that night on the medication cart. she thought PCA #1 was making rounds. LPN #2 said another nurse came in at 11:00 PM. LPN #2 went to the 200 hall until 1:00 AM. LPN #2 said it is her responsibility to make sure the PCA's and CNA's provide ADL care to the residents. LPN #2 said she has been on the medication cart for the last three weeks and is unable to monitor the staff. LPN #2 confirmed the residents could develop pressure ulcers, UTI's and other complications for laying in urine for a long period of time. LPN #2 also confirmed the residents' incontinent briefs and incontinent pads should not have brown stains on them.

During an interview on 04/22/21 at 11:40 AM, with the Director of Nurses (DON) confirmed the resident's incontinent briefs and pads should not be saturated in brown tea colored urine. The DON said the resident could develop pressure ulcers, UTI's and other complications from laying in urine for several hours. The DON said this is unacceptable and will not be tolerated. The DON said the staff were educated to provide ADL care every 2 hours and as needed.

Record review of the Face Sheet revealed the facility admitted Resident #17 on 1/08/18 with the diagnoses that included Major Depressive Disorder, Neuromuscular Dysfunction of bladder and Congestive Heart Failure. The admission Minimum Data Set (MDS) with an Assessment

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Reference Date (ARD) of 02/14/21 revealed Resident#17 had a Brief Interview for Mental Status (BIMS) of 15 that indicated Resident #17 is cognitively intact.

Resident #16
Findings Include:

Review of the facility's Comprehensive Care Plan revealed Resident #16 has an increased risk for infection as evidenced by recent history of urinary tract infection, high risk for impaired skin integrity related to bowel and bladder incontinence and limited mobility. Resident #16 is also at risk for incontinence of bowel and bladder related to confusion, dementia, and impaired mobility.

During an Observation with PCA#1 on 04/22/21 at 05:37 AM, revealed Resident #16 was lying in bed with a saturated tea colored brief and incontinent pad. The room had a strong urine odor.

In an Interview with PCA #1 04/22/21 at 05:38 AM, confirmed the brief and pad was saturated in urine with dried brown stains on the brief and pads. PCA #1 said the resident is a heavy wetter. The PCA said Resident #16 was changed 2 hours ago.

In an interview on 04/22/21 at 10:24 AM, with LPN #2 revealed she made the CNA assignments for the 11-7 shift CNA's/PCA's. LPN #2 said the PCA #1 was assigned to the front of the hall. LPN #2 said she worked on that hall earlier that night on the medication cart.She thought the PCA was checking on the residents. LPN #2 said it is her responsibility to make sure the PCA's and CNA's provide ADL care to the residents. LPN #2 said

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she has been on the medication cart for the last three weeks and is unable to monitor the staff. LPN #2 confirmed the residents could develop pressure ulcers, UTI's and other complications for laying in urine for a long period of time. LPN #2 also confirmed the residents' incontinent briefs and incontinent pads should not have brown stains on them.

Record review of the Face Sheet revealed the facility admitted Resident #16 on 1/29/2010 with diagnoses that included Mixed incontinence, Benign prostatic hyperplasia, and Dementia. The admission MDS with an (ARD) of 01/14/21, revealed Resident#16 had a BIMS score of 6 which indicated Resident #16 is cognitively impaired.

Resident #101
Findings Include:

Review of the facility's comprehensive care plan revealed Resident #101 has increased risk for infection as evidenced by recent history of Pseudomonal urinary tract infection, benign Prostatic Hyperplasia with lower urinary tract symptoms, Urinary Retention and Impaired skin integrity related to bowel and bladder incontinence.

On 04/22/21 at 05:40 AM, an observation revealed Resident #101 lying in bed with head of the bed elevated. Resident #101 was non- verbal and confused and unable to make needs known. PCA #1 and SA observed Resident #101 lying in bed with a saturated brief. The brief and incontinent pads were saturated with tea colored urine and brown stains.

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In an interview on 04/22/21 at 05:41 AM, with PCA #1 said Resident #101 is a heavy wetter. PCA #1 said she tries to get to them as soon as she can. PCA #1 said the resident hit her in the mouth a few days ago so she did not provide care for him. "That's on me, I'll take that one."

During an interview on 04/22/21 at 05:46 AM, with Resident #101's roomate (Resident #85) confirmed the staff did not come in the room during the night to provide ADL care. Residents #85's last quarterly MDS dated 3/17/21, revealed a BIMS score of 15 indicating Resident #85 is cognitively intact. Resident #85 reported Resident #101 does not get ADL care often. Resident #85 stated Resident # 101 is unable to make his needs known. Resident #85 said he calls the staff often to clean Resident #101 and to assist with his meals. Resident #85 is the Resident council President for this facility.

In an interview on 04/22/21 at 10:24 AM,during an interview with the LPN#2 revealed she made the CNA assignments for the 11-7 shift CNA's/PCA's. The UM said the PCA #1 assigned to the front of the hall. LPN #2 said she worked on the 100 hall earlier that night on the medication cart. she thought the PCA's were making rounds. LPN #2 said another nurse came in at 11:00 PM. LPN #2 went to the 200 hall until 1:00 AM. LPN #2 said it is her responsibility to make sure the PCA's and CNA's provide ADL care to the residents. LPN #2 said she has been on the medication cart for the last three weeks and is unable to monitor the staff. LPN #2 confirmed the residents could develop pressure ulcers, UTI's and other complications for laying in urine for a long period of time. LPN#2 also confirmed the residents' incontinent briefs and incontinent pads should not

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have brown stains on them.

During an interview on 04/22/21 at 11:40 AM, the DON confirmed the resident's incontinent briefs and pads should not be saturated in brown tea colored urine. The DON said the residents could develop pressure ulcers, UTI's and other complications from lying in urine for several hours. The DON also said this is unacceptable and will not be tolerated. The DON said the staff were educated to provide ADL care every 2hrs and as needed.

Record review of the Face Sheet revealed the facility admitted Resident #101 on 4/25/17, with diagnoses that included Pseudomonal Urinary Tract Infection, Benign Prostatic Hyperplasia with lower urinary tract symptoms, Urinary Retention, and Impaired Skin Integrity. The admission MDS with an ARD of 3/25/19 revealed Resident#101 had a BIMS of 3 indicating Resident #101 is cognitively impaired.

Resident #55
Findings Include:

A record review of the MDS with ARD dated 2/25/21 section G revealed resident requires extensive assistance with ADL's.

A record review of Resident #55's Admission Record revealed diagnoses of Contracture right hip and Abnormal posture.

On 4/23/21 at 10:00 AM, in an interview and observation with Resident #55 revealed Resident #55 initially stated that staff had not given him a bath in 2 months. Resident #55 then stated that he had a bed bath last week by a night time CNA.

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A record review of the resident bath schedule revealed resident should get a bath on Monday, Wednesday and Friday. A record review of residents bath task shows resident did not get a bath in the last 7 days.

On 04/23/21 02:14 PM, in an interview with Resident #55 stated he did not get a bath before going to the hospital for surgery on 4/22/21.

On 04/23/21 02:40 PM, in an interview with CNA #2, stated that she helped CNA #6 get resident ready to go to the hospital. She stated she did not give resident bath that she help change resident brief and dress resident. She denied knowing if CNA#6 gave a bath to Resident #55.

On 04/23/21 02:48 PM, the SA phoned CNA #6 and did not get an answer. The SA was unable to leave a message.

On 4/23/21 at 3:07 PM, in an interview with LPN #2 stated the the nurses are supposed to check behind the CNA's and sign off behind the CNA's. She stated CNA#6 was supposed to give Resident # 55 a bath Wednesday morning. She looked at the sheet and confirmed there was no documentation of Resident #55 receiving a bath. She stated the nurses are responsible for checking behind the CNA's.

On 4/23/21 at 3:10 PM, in an interview with CNA #6 stated that she did not give Resident #55 a shower or bed bath. She stated Resident #55 refused a shower. She stated she just wiped his bottom, face, and under the arms. She stated she did not document in the computer because she got locked out of the system and was unable to

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F 600	Continued From page 11 chart. She stated she tried to notify the the nurse but was unable to. On 04/23/21 04:10 PM, in an interview with the DON stated residents should get a bath. He stated it is very important for residents to get a bath. He stated it can cause skin breakdown or infection. He stated CNA #6 did not come to him about being locked out of the system to chart.	F 600		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and facility nursing service procedure review the facility failed to provide podiatry services for three (3) of 23 residents. (Resident #26, Resident #35, and Resident #103). Findings include The facility's, "Fingernails/Toenails, Care of" procedure, dated 11/2001, revealed "The purposes of this procedure are to clean the nail bed, to keep nails trimmed/ to prevent infections.	F 687	1. Resident #26, #103 and #35 were assessed for nail care on April 23, 2021 by Assistant Director of Nursing, LPN Unit Manager and RN Unit Manager. On April 23, 2021, Wound Care Nurse Practitioner, provided nail care for Resident #26, #103 and #35. 2. On April 26, 2021 all residents were observed for need of nail care. Residents	6/13/21

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F 687	Continued From page 12 Key Procedural Points: (1). Nails can be cleaned during bath care. (2). Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments". Resident #26 Findings Include: Review of Resident #26's Admission Record revealed Resident #26 was admitted on 8/3/2017 with diagnoses of Heart Disease, Dementia, Anemia, Thrombocytopenia, Hypertension, and Type 2 Diabetes Mellitus. Resident #26 was admitted to Hospice services on 10/13/20 for Alzheimer's disease, early onset. Review of Resident #26's Quarterly Minimum Data Set (MDS), dated 1/20/2021, revealed Resident #26 required extensive assistance with one-person physical assist for personal hygiene and resident was unable to complete a cognitive assessment because resident was not interviewable. Review of Resident #26's Comprehensive Care Plan intervention initiated 2/12/2018 revealed an intervention for "Podiatrist consult prn" (as needed) and "Podiatry at in house clinic for thick toenails". Review of Resident #26's Physician Orders revealed a current order for "Xarelto 20 milligrams(mg) every (q) hour of sleep (hs)", and "Metformin 1000 mg two times daily". On 04/20/21 at 11:57 AM, Resident #26 was lying in bed. Resident #26's toenails were visible and were long and thick and had a yellow appearance noted to the toenails.	F 687	that need nail care will be arranged to see a podiatrist. 3. Facility obtained Podiatry Contract on May 20, 2021 to begin services on May 28, 2021. Director of Nursing educated CNA#3, LPN#2, LPN#1 on facility policy "Foot Care" on May 11, 2021. Staff Development RN educated nursing staff on facility policy "Foot Care" beginning April 23, 2021 and ending April 28, 2021. 4. Director of Nursing or Assistant Director of Nursing will monitor five (5) residents weekly for proper toe nail care times three (3) weeks then monthly times three (3) months and quarterly thereafter. Monitoring for proper toe nail care began on May 5, 2021. Any Adverse findings will be brought to the monthly Quality Assurance / Performance Improvement Committee for re-evaluation of action plan by Director of Nursing for continued compliance quarterly. ADHOC Quality Assurance Meeting was held on April 30, 2021.	

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On 04/23/21 at 9:50 AM, Resident #26 was lying in bed on his/her right side with her feet uncovered. Her toenails remain untrimmed, with yellow discoloration noted.

Review of Resident #26's paper chart revealed a Podiatry Progress Note dated 11-15-19 that indicated resident with "elongated/deformed/thickened/fungus nails with yellow nail plates".

During an interview with Licensed Practical Nurse (LPN) #1 on 4/23/21 at 9:50 AM, regarding Resident #26's toenails, LPN #1 stated "Usually podiatry does the nails. I have no time to do nails."

During an interview with LPN #2 on 4/23/21 at 9:50 AM, regarding toenail care, LPN #2 stated nails are evaluated on Wednesday and Sunday by the Certified Nursing Assistants (CNAs) and they report any issues with skin or nails on a Body Audit Form that is kept in a binder at the nurse's station. LPN #2 stated a Licensed Nurse Weekly Skin Observation is performed by nurses in the electronic health record and nurses perform all toenail care for all residents. LPN #2 stated the CNA's can do toenail care for all nondiabetic residents and Registered Nurses (RNs) are required to perform diabetic nail care for those residents. LPN #2 stated there is no routine schedule or physician order for nurses to perform resident nail care. LPN #2 stated all requests for physician appointments including Podiatry are sent to the transportation aid and they schedule all appointments.

Review of Resident #26's Body Audit Form dated

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3/18/21 revealed one (1) Change in Skin Condition Notification Form completed by assigned CNA and did not indicate any issues with toenails. There were no other recent Body Audit Forms noted.

Review of Resident #26's Licensed Nurse Weekly Skin Observation dated 3/26/21 revealed the resident does have skin issues, "no new; just already existing" completed by assigned Nurse. There were no other recent Licensed Nurse Weekly Skin Observations noted.

In an interview with the Director of Nursing (DON) on 4/22/21 at 1:19 PM, the DON stated nail care is performed one time weekly on a certain day but is unsure of the exact day of the week. The DON states he will let State Agency (SA) know which day nail care is performed. The DON stated the facility has recently received a contract with a Podiatrist and the DON will let SA know if Podiatrist has begun visits to facility or when the Doctor is scheduled to begin in house visits. The DON stated the CNA's can do nail care unless the resident is a diabetic. If diabetic, an RN, usually the treatment nurse, performs toenail care. The DON stated he will have to check to see where the records indicating completed nail care are located and he will provide a copy when located.

During a follow up interview on 4/23/21 at 12:43 PM with the DON regarding toenail care documentation, he stated there is no documentation of weekly nail care recorded as they do not record or document on resident nail care.

During an interview with the Administrator on

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4/22/21 at 02:00 PM, she stated the facility does not currently have a signed contract with a podiatrist. The Administrator stated the facility is in the process of securing a signed contract and the facility will set up an outside appointment with podiatry for residents as needed.

In an interview with the Social Services Director on 4/22/21 at 2:07 PM, she states nurses give her Physician's orders to set up podiatry appointments as needed. The Social Services director stated she has only set up one appointment recently for a podiatry visit, but the resident has since been discharged from the facility. The Social Services director stated there are no pending appointments for podiatry at this time. The Social Services director stated if a resident complains of nail issues, she will ask an RN to cut resident's toenails She stated sometimes residents will let the physician know during rounds when nail care is needed. The Social Services director also stated CNA's look at nails during baths.

Resident #103
Findings Include:

Review of Resident #103's Admission Record revealed she was admitted on 2/12/2017, and has diagnoses of Heart Disease, Anxiety Disorder, Epilepsy, Hypertension, and Chronic Embolism and Thrombosis of Unspecified Vein.

Review of Resident #103's Quarterly MDS, dated 3/27/2021, revealed the resident required supervision and setup assistance for personal hygiene. Her Brief Interview for Mental Status (BIMS) summary score was 15 indicating Resident #103 was cognitively intact.

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Review of Resident #103's Comprehensive Care Plan revealed an intervention initiated 1/18/2018 for "Follow up appointment with (Podiatrist)".

Review of Resident #26's Physician Orders dated 2/27/21 revealed an order for "Xarelto."

On 4/20/21 at 10:15 AM, Resident # 103 was noted sitting in her wheelchair in her room. The Speech Therapist was in the room working with Resident # 103 on cognition puzzles on a tablet. During an interview with Resident # 103 on 4/20/21 at 10:15 AM, the resident voiced concern about needing a podiatry physician because her toenails are long, and it is hard to put her shoes on her feet.

On 4/20/21 at 4:45 PM, Resident # 103 was sitting in the resident's room in the wheelchair. During an interview with Resident #103 on 4/20/21 at 4:45 PM, the resident stated her toenails are long and cause discomfort. Resident # 103 removed her shoes and SA observed the resident's toenails to be long, thick, and yellow.

On 4/21/21 at 2:30 PM, Resident #103 was sitting in her wheelchair in her room. During an interview on 4/21/21 at 2:30 PM, Resident #103 stated her nails have not been trimmed and voiced concern related to when a podiatrist will be able to come into the facility. The resident stated the shoes she is wearing are wide and her nails are still causing discomfort. She removed her shoes and her right great toenail was long and curving to the side. The resident stated the reason her shoes are causing discomfort is because the nails grow long and turn/curve to the

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F 687	Continued From page 17	F 687		

side. Resident #103 also stated she has a history of ingrown toenails.

During an interview with Resident #103 on 04/22/21 at 11:29 AM, the resident stated no one has trimmed her nails and she has to sleep with her feet out from under the sheet because her nails are so long, they get caught on the covers. On 4/22/21 at 11:29 AM, Resident #103's nails were observed to be long and thick.

During an interview with Resident #103 on 4/23/21 at 9:44 AM, the resident stated that a CNA came into her room last night to perform fingernail care. Resident #103 stated she refused the fingernail care, and told the aide she needed toenail care. The resident stated the aide left her room and did not return. The resident stated that she did not receive toenail care. The resident voiced concern regarding her history of ingrown toenails and if an aide would be qualified to deal with ingrown toenails.

During an interview with LPN #2 on 4/23/21 at 9:50 AM, regarding toenail care, LPN #2 stated nails are evaluated on Wednesday and Sunday by the Certified Nursing Assistants (CNAs) and they report any issues with skin or nails on a Body Audit Form that is kept in a binder at the nurse's station. LPN #2 stated a Licensed Nurse Weekly Skin Observation is performed by nurses in the electronic health record and nurses perform all toenail care for all residents. LPN #2 stated the CNA's can do toenail care for all nondiabetic residents and Registered Nurses (RNs) are required to perform diabetic nail care for those residents. LPN #2 stated there is no routine schedule or physician order for nurses to perform resident nail care. LPN #2 stated all requests for

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F 687	Continued From page 18	F 687		

physician appointments including Podiatry are sent to the transportation aid and she schedules all appointments.

Review of Resident #103's Body Audit Form dated 3/16/21 revealed one (1) change in skin condition notification form dated 3/16/21 completed by assigned CNA and indicated Resident # 103's "middle toe is black and blue" but no other toenail issues addressed. There were no other recent Body Audit Forms noted.

Review of Resident #103's Licensed Weekly Skin Assessment dated 2/23/21 and completed by assigned LPN revealed "no issues". There were no other recent Licensed Nurse Weekly Skin Observations noted.

In an interview with the Director of Nursing (DON) during a follow up interview on 4/23/21 at 12:43 PM, with the DON regarding toenail care documentation, he stated there is no documentation of weekly nail care recorded as they do not record or document on resident nail care.

Resident #35
Findings Include:

At 08:30 AM on 04/22/2021, observed CNA #3 providing activities of daily living care SA observed Resident # 35 with very dry skin to lower extremities, two toes on right foot missing, and left great toenail broken down into a quick. All other toenails of Resident #35's are long and curved.

On 04/22/2021 at 8:50 AM, in an interview with Resident # 35, she explained that her toenail got

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F 687	Continued From page 19 caught in the bed or something and broke. She complained of toe pain when touched. On 04/22/2021 at 08:40 AM, in an interview with CNA #3, she explained CNAs do not clip toenails and CNAs do nail care on Sundays unless residents are diabetics. On 04/23/2021 at 12:00 PM, in an interview with the DON regarding toenails or nail care in general, he explained nails can be done by anyone including nurses or CNAs unless the residents are diabetic. He further explained nail care is mostly done on Sundays and the Nurse Practitioner and Wound Care Nurse can also do nail care. When ask how often toenails are trimmed by Nurse Practitioner and Wound Care Nurse, he explained he does not know for sure but if the aides see a problem the nurse is notified. A record review of Resident #35's Face Sheet revealed the facility initially admitted Resident #35 on 07/16/2019 and readmitted on 1/30/2020 with diagnoses that included End Stage Renal Disease, Type 2 Diabetes Mellitus, High Blood Pressure, and Tubulo-interstitial Nephritis. A record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 2/07/2021, Section C revealed Resident #35 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #35 is cognitively intact. Section G of the MDS revealed Resident #35 required two (2) persons assist with transfer and one person assist with eating, hygiene, bathing, and toilet use.	F 687		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		6/13/21

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F 812	Continued From page 20 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review the facility failed to distribute meals in a safe manner for one (1) of 23 residents. (Resident #26) The facility's, "Principles of Safe Food Handling" policy, dated 11/2017, revealed "... 4.) Chill. Bacteria spread fastest at temperatures between 41 F and 135 F, so chilling food properly is one of the most effective ways to reduce food-borne illness..." Observations on 4/22/21 at 7:30 AM, revealed meal trays being delivered to the 100 hall on a tall, open metal rack. All trays except Resident #26 were delivered to the rooms. The tray for	F 812	1. Resident #26 - the milk and mighty shake were immediately replaced on April 22, 2021. 2. Rounds were made by the Administrator to identify any other issues with milk temperatures on April 22, 2021, Dietary Department maintains the milk and mighty shakes on ice while on the serving line to ensure proper temperature. 3. Staff Development Registered Nurse educated staff on facility policy "Food Storage, Sanitation and Principle of Safe Food Handling" to include timely passing of resident meal trays beginning April 23,	

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F 812	Continued From page 21 Resident #26 was left on the tall, open metal rack, with food in three (3) individual bowls with plastic lids, no insulating dome was noted covering food on tray with a milk and a mighty shake. Observed Resident #26 lying in bed. State Agency (SA) asked resident how she is doing, and she was noted to be non-interviewable. An observation on 4/22/21 at 7:54 AM, revealed Licensed Practical Nurse (LPN) #3 walked down the hallway and into Resident # 26's room. LPN #3 walked out of Resident #26's room and another resident stopped her and asked for coffee. At 7:58 AM, LPN #3 returned to the hallway, retrieved Resident #26's tray from metal rack and took it in to the Resident #26. At 7:59 AM, SA went into Resident #26's room and used a food thermometer to acquire the temperature of Resident #26's milk, as LPN #3 was setting up Resident # 26's meal tray. On 4/22/21 at 7:59 AM the temperature of Resident #26's milk was 53 degrees Fahrenheit (F) and the temperature of the mighty shake was 54 degrees (F). The milk and mighty shake temperature was in the "Danger Zone" indicating temperatures were above 41 degrees Fahrenheit (F). SA asked LPN #3 to confirm temperature readings and she verified readings. During an interview with Registered Nurse (RN) #1 at 8:01 AM, the SA advised RN #1 of the temperature findings and was asked what the harm could be and he states, " if its' not cold enough, bacteria can grow in it or it can spoil ."	F 812	2021 and ending April 28, 2021. Certified Dietary Manager (CDM) educated Dietary employees on facility policy "Food Storage, Sanitation and Principle of Safe Food Handling" to include timely passing of resident meal trays on April 23, 2021. 4. Beginning April 28, 2021, Certified Dietary Manager or Administrator will test temperature of the milk or mighty shake on the last tray served on different halls weekly times three (3) weeks, then monthly times three (3) months and quarterly thereafter. Administrator will bring adverse findings to the monthly Quality Assurance / Performance Improvement Committee for review of plan and make necessary changes for continued compliance quarterly. ADHOC Quality Assurance meeting was held on May 5, 2021.	
F 850 SS=D	Qualifications of Social Worker >120 Beds CFR(s): 483.70(p)(1)(2)	F 850		6/13/21

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F 850	Continued From page 22 §483.70(p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is: §483.70(p)(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and §483.70(p)(2) One year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to employ a Licensed/Qualified Social Worker for four (4) days of four (4) days of survey. Findings include: Review of the facility's, "Social Services" policy, dated 11/2001 revealed, "The Director of Social Services is a qualified social worker." During an interview with the Social Services Director on 4/22/21 at 2:30 PM, the State Agency (SA) asked for a copy of her social worker qualifications/license. The Social Services Director stated she would provide a copy to the SA. During an interview with the Administrator on 4/22/21 at 3:00 PM, to discuss qualifications and license of Social Worker, the Administrator advised SA the previous social worker had been	F 850	1. A qualified social worker was hired on April 28, 2021 and began employment on May 19, 2021. Beginning May 19, 2021 and ending May 25, 2021, Licensed Social Worker made rounds to identify any psychosocial concerns with the residents. This social worker Is a licensed social worker with a Masters Degree in Social Work. Rounds were made to identify psychological issues or concerns with the residents by Risk Manager RN on April 23, 2021. No concerns identified. 2. Rounds were made to identify psychological issues or concerns with the residents by Risk Manager RN on April 23, 2021. No concerns identified. At the time of survey, the social workers had a Bachelors Degree in Social Science and Public Health and a Masters Degree in	

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F 850	Continued From page 23 terminated and the facility has recently made a job offer to an applicant who declined the job. The Administrator stated the Social Services Director has two master's degrees and a copy of the degrees were provided to the SA. The Administrator states the current Social Services Director does not have a degree in Social Work and is not a Licensed Social Worker. There is no Licensed Social Worker supervising the current Social Services Director. The facility is licensed for 180 beds and currently has a census of 111 residents.	F 850	Healthcare Administration with emphasis on Public Health 3. Administrator received training on April 23, 2021 by Director of Operations to describe the qualifications of a Social Worker for a center 120 beds or more. 4. Administrator will monitor the Social Workers Qualifications beginning May 19, 2021, Administrator will monitor Social Worker's qualifications monthly times three months, then quarterly thereafter. Any adverse findings will be brought to the Quality Assurance / Performance Improvement Committee to ensure continued compliance.	
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,	F 880		6/13/21

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staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) 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 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.

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F 880	Continued From page 25 §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 observations, interviews, record reviews, and policy review the facility failed to prevent the possible spread of infections for one (1) of six (6) incontinence care observations, one (1) of four (4) pressure ulcer observations, and two (2) of three (3) residents oxygen therapy observations. (Resident #21, Resident #65, Resident #20, Resident #55). Resident #55 Findings Include: A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated 2/25/21 section G revealed Resident #55 requires extensive assistance with Activities of Daily Living (ADL). A record review of the Admission Record revealed diagnoses of Contracture Right Hip and Abnormal Posture. A record review of the Physician orders revealed wound care to right great toe and 3rd digit as follows: Clean with normal saline (NS) pat dry AG to nail bed and cuticle. Wrap with gauze and secure with tape. Change on Tuesday/Friday (T/F) if soiled or not intact, dated 4/12/21. Wound care to buttock as follows: Clean with cleanser of	F 880	1. On April 23, 2021, Resident #55 - assessed by Risk Manager RN with no adverse findings identified. Resident #55 bed linens were changed on April 23, 2021. Wound Care RN#2 was educated by Director of Nursing on facility Policy "Infection Control and Handwashing" on April 23, 2021. CNA#1 was educated by Director of Nursing on facility policy "Infection Control and Handwashing" April 23, 2021. The oxygen tubing for Residents #20 and #21 were replaced by RN#4 on April 21, 2021. Resident #21 assessed by Risk Manager and no adverse finding identified. CNA#4 and RN#4 were educated by Director of Nursing on April 21, 2021 on facility policy "Respiratory Therapy Equipment" CNA#5 was educated by Director of Nursing on April 27, 2021 on facility policy "Infection Control, Perineal Care." 2. Assistant Director of Nursing or Director of Nursing observed residents with oxygen tubing to ensure proper use	

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F 880	Continued From page 26 choice, pat dry, apply hydrogel dressing to open areas, no tape or adhesive to skin on T/F and as needed (prn). A record review of the Treatment Administration Record (TAR) revealed care was given per Physician orders. A review of the MDS with an ARD dated 2/25/21, revealed in Section M, Resident #55 did not have a pressure wound on 2/25/21 and in Section G, Resident #55 required extensive assistance with ADL's. 04/22/21 at 01:35 PM, in an interview with LPN#2 stated Resident #55 is noncompliant with staff at times. He complains of leg pain and back pain. She stated he is usually nice. She stated resident prefers a bed bath over shower. On 4/23/21 at 9:30 AM, an observation of wound care been performed by RN #2 at the beginning of wound care she moved the remote and call light with gloved hands. She did not remove gloves and wash hands after removing the remote and call light. She removed the dressing with the same gloved hands. She removed her gloves after removing the dressing and continued wound care. On 4/23/20 at 9:30 AM, CNA #1 was assisting RN #2 with wound care. RN #2 asked CNA #1 to go get protective barrier cream. CNA#1 removed her gloves and left the room. She did not wash or sanitize her hands after removing her gloves. She returned to the room, washed her hands and applied gloves. RN #2 asked CNA #1 to go get a incontentint blue pad. CNA #1 removed her gloves but did not wash hands. She left the room.	F 880	and baggage on April 26, 2021 - no further issued identified. Director of Nursing and / or Risk Manager RN observed resident rooms to ensure soiled linen was handled properly on April 26, 2021 - no concerns identified. 3. Staff Development RN educated staff on facility policy, "Respiratory Therapy Equipment - regarding oxygen tubing, Perineal Care, Infection Control beginning on April 23, 2021 and ending April 28, 2021. Director of Nursing and / or Risk Manager RN educated staff on Principles of Transmission based precautions and hand hygiene from online prevention training courses offered by CDC beginning June 8, 2021 and ongoing. Staff will not work until they have been inserviced. r. Director of Nursing, Assistant Director of Nursing or Risk Manager RN will monitor proper storage of oxygen tubing when not in use and proper Infection Control to include handwashing once weekly times three (3) weeks then monthly times three (3) months and quarterly thereafter. Monitoring for proper storage of oxygen tubing when not in use and proper infection control to include handwashing began on May 5, 2021. Risk Manager RN will report results of the monitoring monthly to the Quality Assurance / Performance Improvement Committee for three (3) months and quarterly thereafter to discuss findings	

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F 880	Continued From page 27 When she returned to the room she washed her hands applied gloves and removed the soiled pad from under Resident #55. She placed the soiled pad in a clear garbage bag and tied the bag and put it on the floor. She picked up the bag off the floor and placed it on Resident #55's bed. She then left the room with the bag. On 4/23/21 at 10:30 AM, in an interview with RN #2 stated she should have removed gloves after touching remote and call light, before she removed wound dressing. She stated that she should have changed her gloves and washed her hands prior to removing the wound dressing. She stated her actions could have caused the Resident #55 to get bacteria infection, Streptococcus infection, and Methicillin Resistant Staphylococcus Aureus (MRSA). She stated that her actions could have caused Resident #55 to get an infection. On 4/23/21 at 10:45 AM, in an interview with CNA #1, stated she should have washed her hands after removing her gloves twice. She stated she have not placed the dirty trash bag on the floor and Resident #55's bed. She stated it can cause infection. It could make the resident sick. On 4/23/21 at 10:55 AM, in an interview with the Director of Nursing (DON), stated that RN #2 should have changed her gloves and sanitized her hands after removing the remote and call light from Resident #55's bed. He stated her actions had the possibility of spreading infection. The DON stated CNA #1 should have washed her hands after removing her gloves, before leaving Resident #55's room. He stated CNA #1 should have not placed the bag on the floor and then on Resident #55's bed. He stated that her actions	F 880	and make changes as needed for continued compliance. ADHOC Quality Assurance meeting was held on May 5, 2021 to review the plan for improvement.	

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had the potential to expose the resident to infection. He stated she should have discarded the bag and not placed it on the floor at all.

Resident #20
Findings Includ:

In a record review of the facility's, "Respiratory Therapy Equipment", section of the "Infection Control Policy," with a date November 2019, noted the purpose is to provide guidelines to help prevent nosocomial infection associated respiratory therapy equipment...5. Change oxygen cannulas and tubing every 7 days and date 6.) Keep oxygen cannulas and tubing used PRN in a plastic bag when not in use."

A record review of facility's, "Perineal Care" section of "Infection Control Policy" with a date of November 2019, noted the policy's purpose is to provide cleanliness and comfort to the resident to prevent infections and skin irritation. The policy explained the steps in the procedure including to removed gloves and discard then reposition the covers and make the resident comfortable.

A record review of the facility's "Hand Hygiene" section of "Infection Control Policy" with a date of November 2019, noted the policy's purpose is hand hygiene is a means of preventing the spread of infections. The policy explains in detail when associates must perform appropriate handwashing procedures including after removing gloves purpose is to provide guidelines to prevent nosocomial infections associated with respiratory equipment to residents and staff.

On 04/21/2021 at 2:35 PM, in observation with

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RN #4, Resident #20 was not in his room and oxygen tubing was laying on the floor. A plastic bag was noted to the oxygen machine for the oxygen tubing. The oxygen tubing and bag dated for 04/21/2021.

At 03:00 PM on 04/21/2021, observed RN #4 replace the nasal cannula for Resident #20 and labeled the oxygen tubing with a date of 04/21/2021.

On 04/23/2021 at 2:00 PM, observed resident sitting in chair with oxygen in use at 2 liters/min (minute) via nasal cannula. The oxygen tubing and a bag hanging on the oxygen concentrator was labeled with a date of 04/21/2021 and Resident #20's formal name.

In an interview with RN# 4, on 04/21/2021 at 02:25 PM, when asked what should be done with a nasal cannula when the resident it not using oxygen, she explained the cannula should be placed in the bag hanging on the oxygen concentrator. When ask if the cannula is left lying on the floor does that cause any issues, she explained it is an infection control issue and if the cannula is placed back on the resident without replacing the cannula it could cause the resident a respiratory infection. She further explained that the oxygen tubing, water bottles, and new bags are replaced weekly on Sundays by the night shift nurse, when ask how the facility knows this is done, she explained there is a duty book at the nurse station.

04/21/2021 at 02:35 PM, in an interview with RN #3, when ask for records and documentation of weekly nurse duties completed for oxygen tubing changes, he reported the facility has a new

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system to start on Monday 4/26/2021 that the nurses will fill out when duties are completed. When ask for documentation for previous dates, no documentation was provided. He further explained the facility did do rounds on 04/20/2021 to check all oxygen tubing and changed any that needed changing.

04/23/2021 at 2:00 PM, in an interview with Resident #20, he explained that he has been told by the nurses that he needs to put his oxygen tubing in the bag when not in use and not put it in the floor. When ask how often the oxygen tubing is changed, he explained that he really does not know and that he has not really paid attention to the tubing.

A record review of Resident #20's Face Sheet revealed the facility admitted Resident #20 on 4/13/2020, with the medical diagnoses of Chronic Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease (COPD), Obstructive Sleep Apnea, Essential Hypertension, Hypothyroidism, Chronic Venous Insufficiency, and History of Pneumonia.

Review of the Annual Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 4/09/2021, for Resident #20, revealed for Section C, Resident #20 has a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Section O of the MDS revealed oxygen therapy and Continuous positive airway pressure (CPAP).

Record review of Physician Order's dated 1/25/21 revealed an order for 0xygen at 2L/min as needed.

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F 880	Continued From page 31 Resident #21 Findings Include: On 04/21/2021 at 09:15 AM, an observation of Resident #21 lying in bed with eyes closed. State Agency (SA) observed oxygen concentrator running at 2 liters/min, nasal cannula laying on the floor and no date noted on oxygen tubing and no bag to place oxygen tubing in. On 04/21/2021 at 11:00 AM SA observed nasal cannula laying on the floor and no bag noted to place tubing in. At 02:10 PM on 04/21/2021, SA observed nasal cannula laying on the floor. Resident awake asking for a straw and began cursing SA for not getting her a straw. A Certified Nursing Assistant (CNA) was notified to assist Resident #21. While in the room, CNA# 4 walked into room with a straw and assisted Resident #20 with drinking water. At 02:35 PM on 04/21/2021, SA observed oxygen nasal cannula in Resident #21's nostrils, the oxygen tubing was not labeled with a date. At 03:05 PM on 04/21/2021 observed RN #4 replace oxygen tubing for Resident #21 and labeled tubing for 04/21/2021. At 02:15 PM on 04/21/2021, in an interview with CNA #4, when asked does Resident #21 ever have behaviors and maybe take off oxygen. CNA #4 explained Resident #21 can be very sweet and then she can curse you out. She further explained Resident #21 takes oxygen off all the times and sometimes she will let you put it back on her and other times she will curse you out.	F 880		

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When asked does Resident #21 throw the oxygen tubing on the floor, she explained Resident #21 does throw the oxygen tubing on the floor many times a day.

At 02:25 PM on 04/21/2021, in an interview with RN #4 when ask how often oxygen tubing is changed, she explained the tubing is changed weekly on 11-7 shift by the nurse. She further explained oxygen tubing is labeled and a bag is placed for the oxygen tubing when not in use. When asked RN #4, what should be done when oxygen tubing is on the floor, she explained that the tubing should be replaced and if not that it is an infection control issue and could cause problems with infections if it is not replaced. While standing at the nurse's station talking with RN #4, CNA #4 came up to the station and reported to nurse, Resident #21's oxygen was off and, in the floor, but she got the oxygen nasal cannula placed back on Resident #21.

In an interview at 02:30 PM on 04/21/2021 with CNA #4 she explained that she picked the cannula off the floor and replaced it back on Resident #21.

Attempted to speak to Responsible Party for Resident #21 several times. Left several messages to return SA calls to discuss Resident #21, no return calls made.

Record review of Resident #21's Face Sheet revealed Resident #21 was initially admitted on 1/07/2011 and readmitted on 7/14/2020 with the diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease Stage 3, Pleural Effusion, Hypoxemia, Terminally Ill, and Obstructive Uropathy.

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Physician Orders for Resident #21 revealed an order was written on 1/08/2021 admit to Hospice with diagnoses of COPD and Respiratory Failure with Hypercapnia, Oxygen at 2L/min every 24 hours as needed related to COPD to keep oxygen saturation greater than 92%, and monitor oxygen saturation every shift and report drop in oxygen readings to physician and DON.

Review of a significant change MDS with an ARD dated 1/14/2021, Section C revealed resident had a BIMS score of 05 which indicated Resident #21 had severe cognitive impairment. Section G revealed resident #21 requires total assistance with dressing/bathing and extensive assistance with bed mobility, transfers, and eating.

Resident #5
Findings Include:

At 02:40 PM on 04/21/2021, SA and RN #1 observed Resident #5's oxygen in use via nasal cannula. The oxygen tubing and bag labeled with a date of 04/21/2021.

At 02:45 PM in an interview with Resident #5, she explained the oxygen tubing was changed last night 04/21/2021 on 11-7 shift and was the first time it had been changed in months.

At 03:10 PM on 04/21/2021, in an interview with the Assistant Director of Nurses (ADON) explained the facility has a new nurse duty book and a schedule in place to start on Monday April 26, 2021 after nurses are all in-serviced.

At 03:30 PM on 04/21/2021, in an interview with DON, he explained that on Tuesdays he has a

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nurse doing Quality Assurance to check oxygen tubing and if the tubing is not labeled or dated, a new tubing is replaced.

A record review of Resident #5's Face Sheet revealed the facility admitted Resident #5 initially on 01/04/2018 and readmitted on 07/15/2021 with the diagnoses of COPD, High Blood Pressure, Acute Kidney Failure, and Schizoaffective Disorder, Bipolar Type.

A review of Resident #5's Physician Orders dated 8/7/19, revealed orders for Oxygen at 2L/min via nasal cannula with humidification every shift and obtain oxygen saturation every shift and report drop in oxygen readings to Physician and DON.

A record review of the Quarterly MDS with an ARD date of 1/19/2021, Section C revealed Resident #5 had a BIMS score of 15, which indicated Resident #5 was cognitively intact. Section G of the MDS revealed resident is set up only with dressing, eating, and resident is independent with toilet use, bed mobility, transfers, and locomotion. Section E of the MDS revealed no behaviors noted or no rejection of care. Section O of the MDS revealed oxygen therapy.

Resident #65
Findings Include:

A record review of facility's, "Perineal Care" section of "Infection Control Policy" with a date of November 2019, noted the policy's purpose is to provide cleanliness and comfort to the resident to prevent infections and skin irritation. The policy explained the steps in the procedure including to removed gloves and discard then reposition the

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covers and make the resident comfortable.

A record review of the facility's "Hand Hygiene" section of "Infection Control Policy" with a date of November 2019, noted the policy's purpose is hand hygiene is a means of preventing the spread of infections. The policy explains in detail when associates must perform appropriate handwashing procedures including after removing gloves.

On 04/22/21 at 05:45 AM, SA observed perineal care by CNA #5 with Resident #65. During peri care SA observed old, dried bowel movement on Resident # 65's left thigh. While SA observed perineal care on Resident #65, Resident #65 had a bowel movement. CNA #5 was observed not changing gloves after cleaning the bowel movement and continue to apply a clean brief on Resident #65 and touched the clean linen with the same gloves he had used to wipe the bowel movement from Resident #65. After perineal care, CNA #5 walked out of Resident # 65's room with gloves on and trash from the perineal care and did not wash his hands. CNA #5 was observed taking his gloves off in the hall and then took the trash into soiled laundry room.

On 04/22/2021 at 05:50 AM, in an interview with Resident # 65, when asked did she have a bowel movement earlier tonight, she explained she did have a small bowel movement around 03:00 AM and was changed. She further explained" I know that he did not clean me right." When asked did she say anything to anyone, she reported "No, because it does not matter, the staff does what they want."

On 04/22/2021 at 06:00 AM in an interview with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYINGTON HEALTH AND REHABILITATION	1530 BROAD AVE GULFPORT, MS 39501

(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 36	F 880		

CNA #5 when asked to explain how the peri care that was observed and if he knew of anything he did wrong, he explained that after cleaning Resident # 65's bowel movement, he should have changed gloves and washed his hand and applied new gloves. He further explained that he did think about changing his gloves, but he had already touched the brief and linen. When ask what would have been the best thing to do after he realized he did not change his gloves, he replied he should have stopped and started back over. He also explained that after completing care and tying up the bags of dirty linen and garbage that he should have removed his gloves and washed his hands.

At 08:00 am on 04/22/2021, in an interview with Infection Preventionist, when ask about peri care and when to change gloves with peri care, she explained, "CNAs should change gloves after cleaning a resident, wash hands, and reapply gloves to finish the care." She further explained "gloves must be changed when going from dirty to clean and hands washed in-between glove change or use of hand sanitizer. She further explained CNA #5's actions could have caused cross contamination.

A record review of Resident #65's Face Sheet revealed the facility admitted Resident #65 on 10/15/2021 with the diagnoses of Weakness, High Blood Pressure, COPD, and Type 2 Diabetes Mellitus. Resident #65 was also diagnosed with Urinary Tract Infection and Escherichia Coli in urine on 03/02/2021.

A Record review of Resident #65's Physician Orders revealed an order for contact isolation for e-coli urine dated for 03/29/2021 and contact

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F 880	Continued From page 37 isolation for Extended Spectrum Beta-Lactamase in urine for 7 days started on 04/23/2021. A record review of the annual MDS with an ARD of 3/9/2021, for Resident #65, revealed Section C Resident #65 had a BIMS score of 15, which indicated she was cognitively intact. Section G of the MDS dated for 3/09/2021 revealed Resident #65 required extensive assistance of one (1) person with toilet use and personal hygiene. Section H of the MDS revealed Resident #65 was always incontinent of bowel and bladder. A record review of In-Service Sign in Sheet for 4/19/21 for Infection Control revealed CNA #5 was in-serviced on that day.	F 880		