STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255145	A. BUILDING _____ B. WING _____	C 03/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD REHABILITATION AND HEALTHCARE	**501 SOUTH LOCUST STREET MCCOMB, MS 39648**

(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 the Complaint Investigations (CI), CI #17590 from 3/2/2021 to 3/4/2021 and the SA did not substantiate the complaint for failure to follow Professional Standards of Practice for passing the medication cart from one shift to another and nurses being responsible for more than 50 residents at once. Unable to substantiate nurses punching out medications in advance. Unable to substantiate facility less than 2.8 ratio of staffing per shift. Unable to substantiate short staffed for Certified Nursing Assistant (CNA) and working more than 16 hours per day. Unable to substantiate facility using green bedspreads for incontinent pads. Unable to substantiate any residents being allowed to smoke in their rooms. Unable to substantiate resident on resident physical abuse. Unable to substantiate residents with wounds not being sent to a Long-term Treatment Center (LTAC) unit as ordered by the physician. Unable to substantiate residents in need of Hospice services not being placed on Hospice. The SA did cite F880 at an "E" for failure to practice best infection control practices by failure to clean an overbed table during wound care for one (1) of four (4) wound care observations, Resident # 3, failed to clean scissors prior to cutting tape and gauze for Resident # 1 and Resident # 2, for two (2) of four (4) wound care observations, and by placing a red bag with contaminated supplies onto the floor during one (1) of four (4) wound care observations, for Resident #1. The census was 111 with a license for 145 beds.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		4/1/21

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

Electronically Signed | 03/26/2021

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F 880	Continued From page 1	F 880		

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(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

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F 880	Continued From page 2 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to practice best infection control practices by failure to clean an overbed table during wound care for one (1) of four (4) wound care observations, Resident # 3, failed to clean scissors prior to cutting tape and gauze for Resident # 1 and Resident # 2, for two (2) of four (4) wound care observations, and by placing a red bag with contaminated supplies onto the floor during one (1) of four (4) wound care observations, for Resident #1.	F 880	1. Root Cause Analysis (RCA) was conducted by the Inter Disciplinary Team (IDT) on 3/04/2021, and based on the results scissors for wound care were cleaned and stored in an appropriate sealed container between uses, a clean barrier for wound care supplies was provided, and biohazard bag placed in biohazard receptacle. Director of Clinical Services (DCS) completed a satisfactory competency review with Registered Nurse(RN) #1 on 3/04/2021.	

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F 880	Continued From page 3 The facility's, "Dressings, Dry/Clean" policy, revised September 2013, revealed the "Steps in the Procedure, listed first to clean the bedside stand and establish a clean field then place the clean equipment on the clean field. The facility's, "Dressings, Soiled/Contaminated" policy, revised August 2009, revealed soiled/contaminated dressings must be handled in a safe and sanitary manner and be disposed of upon completion of any procedure. The facility's, "Cleaning and Disinfection of Resident-Care Items and Equipment", revised October 2018, revealed all reusable items are cleaned and disinfected or sterilized between residents to include durable medical equipment. Resident #1 On 3/3/21, at 10:56 AM, observed wound care for Resident #1 with Registered Nurse (RN) #1. RN #1 obtained scissors from cart but did not clean prior to cutting dressing. Scissors were in the top right drawer of the treatment cart and were not in a bag or anything to protect them from being contaminated by the other supplies on the cart. During care, RN #1 picked up the red bag with the contaminated supplies and sat it on the floor. The red bag was picked up off the floor and placed in the red bag on the treatment cart. The scissors were cleaned with a disinfectant wipe with Bleach and placed on the unclean top of the treatment cart and later placed in the top right drawer of the cart, on top of contaminated supplies. Record review for Resident #1 revealed the facility admitted Resident #1 on 12/30/20. The Admission Minimum Data Set (MDS) with the	F 880	2. Current residents with wounds have the potential to be affected. 3. Education and skills competency related to wound care with current licensed nurses began on 3/18/2021 on providing wound care in a manner to prevent the spread of infection with emphasis on cleaning scissors before and after use, storing scissors in an appropriate sealed container between use, and placing biohazard bag in biohazard receptacle by the DCS, RN Supervisor, and Unit Managers. 4. Quality Observation of infection practices pertaining to wound care began on 3/18/2021 and will be conducted by the DCS, RN Supervisor, or Unit Managers with 5 nurse competencies to be completed weekly for 4 weeks then, 3 nurse competencies to be completed weekly for 4 weeks then, 1 nurse competency to be completed monthly and PRN. The findings of the quality review will be reported in the Quality Assurance/Performance Improvement (QAPI) Committee monthly for 6 months and reviewed by the IDT. RCA will be used by the committee and updates made to the performance improvement plan as indicated by findings.	

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Assessment Reference Date (ARD) of 12/20/20 revealed in section M0210 was marked Yes, for unhealed Pressure Ulcers with multiple pressure ulcers listed.

Resident #2

On 3/3/21, 11:15 AM, observed wound care for Resident #2 for a Stage III Pressure Ulcer to the left hip. Wound Care provided by RN #1. Licensed Practical Nurse (LPN) #1 assisted with care. Tape was cut with scissors from treatment cart that was on top of other contaminated supplies without cleaning. No other concerns observed during this care observation.

Record review revealed the facility admitted Resident #2 on 2/23/19. The most recent Annual MDS with the ARD of 2/8/21 revealed Resident #1 had one (1) Stage III Pressure Ulcer.

Resident #3

On 3/4/21, at 10:15 AM, during a wound care observation for Resident #3, RN #1 placed all the wound care supplies and clean gloves on the overbed table without cleaning the table and did not use a barrier to place the supplies on. No other concerns identified during this wound care observation.

Record review revealed the facility admitted Resident #3 on 6/22/20 per the Quarterly MDS with the ARD of 1/2/21.

On 3/4/21, at 10:32 AM, in an interview with RN#1/Wound Care Nurse, stated she has been the Treatment/Wound Care Nurse since November 2020. She denied having any

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additional training for Wound Care but wants to go to a class when there are available spots to attend. She confirmed she had not cleaned the overbed table for Resident #3. She confirmed she should have cleaned the overbed table with the disinfectant wipe with bleach and placed a barrier down before putting supplies on the overbed table. She also confirmed she cut the tape with the scissors from the treatment cart without cleaning prior to using them when providing care for Resident #1 and Resident #2. She stated they are cleaned with the disinfectant wipes with bleach and placed back in the top drawer of the cart on top of other supplies that have been touched with bare hands and confirmed that means they are contaminated. She confirmed that puts residents at risk for infections and was not aware of the exact process for cleaning them other than wiping them down. RN#1 confirmed by nodding her head that she should not have placed the red bag on the floor because it was an infection control concern, when providing care to Resident #1.

On 3/4/21, at 10:40 AM, during an interview with the Director of Nursing (DON)/Infection Preventionist (IP), revealed the facility trains staff when hired, during the annual competency evaluation and as needed. She confirmed by not cleaning the supplies per policy and not cleaning the overbed tables by the directions of the disinfectant wipes with bleach, this could possibly cause infections for the residents. She confirmed she is the acting IP and keeps a log of all infections in the facility. The DON confirmed the treatment nurse should not place any bag with soiled supplies, linens, or anything else on the floor and stated it should go directly into the bag it needs to go into. Soiled linens in the soiled linen

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F 880	Continued From page 6 barrels and soiled dressing supplies into a biohazard bag or container. Review of the facility's, "Clean Dressing Competency Skills Checklist", dated 11/20/2020, revealed RN #1 passed the annual training.	F 880		