STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255095	A. BUILDING _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF LAUREL	935 WEST DR LAUREL, MS 39440

(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 Survey and four (4) complaint investigations at the facility from 1/3/22 through 1/6/22. Complaint Investigations (CI) MS # 17654 related to verbal abuse, CI MS #18036 related to Activities of Daily Living (ADL) care and abuse, and CI MS #18184 related to ADL care, medications not being given, and personal property missing were unsubstantiated. CI MS # 17957 was substantiated related to incontinent care. During the survey, the SA determined that the facility was not in compliance with the requirements for participation for Medicare and Medicaid. The SA cited deficiencies at F644, F657, F689, F690, and F880. The facility census was 77 and they were licensed for 119 beds.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible	F 644		2/7/22

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

Electronically Signed | 01/28/2022

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F 644	Continued From page 1 serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and facility policy review, the facility failed to complete a Level II Preadmission Screening and Resident Review (PASARR) for a resident with a new major mental illness diagnosis for one (1) of three (3) residents reviewed for PASARR completion. Resident #28 Findings include: Record review of the facility's policy "Preadmission Screening PAS/PASRR (MS only) with a revision date of 10/18 revealed "...The Level II evaluation must occur prior to admission and whenever the resident has a significant change in status... A change in status referral for Level II Resident Review Evaluations is also required for individuals who may not have previously been identified by PASRR to have mental illness..." Record review of the Face Sheet revealed the facility originally admitted Resident #28 on 05/07/15 and readmitted him on 05/05/20 with diagnoses that included Bipolar Disorder current episode depression, severe without psych features, Major Depressive Disorder recurrent, severe and Anxiety and Auditory Hallucinations. Record review of the medical record for Resident #28 revealed a Level I PAS was completed on 05/6/15. There was no Level II PASARR evaluation for Resident #28 in the medical record.	F 644	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. A Mississippi Pre-admission Screening and Resident Review Level II Change In Status Form was sent to the agency who reviews Pre-admission Screening and Resident Review's on 1/11/2022 by the admissions coordinator for Resident # 28. On 1/13/2022 response was received from the agency who reviews Pre-admission Screening and Resident Review's stating " your level I screen remains valid during your stay at the nursing facility , you require no Level I screening unless you experience a significant change in serious mental illness treatment needs that suggests neurocognitive disorder/dementia is no longer the primary condition requiring treatment". 82 out of 82 Residents have the potential to be affected by this deficient practice The Admissions Coordinator, Social Services Director, and Registered Nurse Case Manager were in serviced on 1/6/2022 on the Pre-admission Screening	

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F 644	Continued From page 2 Record review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/05/2021, revealed Resident #28 had a diagnosis of Depression and Bipolar disorder. Record review of Physician Orders for January 2022 for Resident #28 revealed a physician order for Remeron 30 milligram tablet, give one tablet by mouth every hour sleep for Depression. The order start date was 05/05/20. Record review of the Behavioral Health Service note for 12/30/21 revealed use of antipsychotics, antidepressants, and medication for Dementia. Resident #28 was seen for Anxiety, Insomnia, and Depression. The current medication on 12/30/21 included Aricept (which is used for Dementia), Remeron (which is used for Depression), Risperdal (which is used for Bipolar), and Doxepin (which is used for Dementia). The recommendations were to discontinue Risperdal due to resident is without psychosis and may benefit from med discontinued. Record review of Resident #28's Care Plan with a problem onset date of 12/28/17 revealed resident has a history of hearing voices/auditory hallucinations with a diagnosis of Bipolar disorder. On 01/05/22 at 3:30 PM, during an interview with the Director of Nursing (DON), she explained Resident #28 had a PAS Level I completed prior to his admission on 05/6/2015 and reported no PASARR Level II has been competed since admission. The DON reviewed Resident #28's medical diagnoses and confirmed a diagnosis of Bipolar disorder and Depression. She further reported Resident #28 had not been out to	F 644	and Resident Review policy and the Mississippi Pre-admission Screening and Resident Review Level II Change In Status Request form by the Administrator. On 1/6/2022 the facility held a Quality Assurance meeting with no changes to current policies related to pre-admission screening Pre-admission Screening and Resident Review Policy. On 1/10/2022 The Admissions Coordinator and/or The Social Services Director started the process of auditing Pre-admission Screening and Resident Reviews on at least 10 charts twice a week for 4 weeks to ensure that each resident has the appropriate Pre-admission Screening and Resident Review on their chart. Facility Admissions Coordinator will then continue to audit at least 10 charts once a month to include new admissions and readmissions for 3 months. The Director of Nursing and/or Medical Records Nurse will review Physicians Orders and diagnosis lists daily for 5 days for 4 weeks to monitor for any new medications and/or diagnosis that will warrant the need for a Mississippi Pre-admission Screening and Resident Review Level II Change In Status Request form. On 1/24/2022 The Quality Assurance Committee began evaluating audits/documentation completed monthly 3 for months and make recommendations and changes to ensure compliance.	

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F 644	Continued From page 3 Geri-psych since she became the DON in February 2019, but Resident #28 does see psychiatric services related to his diagnosis.	F 644		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to ensure a comprehensive person-centered care plan was	F 657	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We	2/7/22

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F 657	Continued From page 4 revised to accurately reflect the Resident's continence status for one (1) of (23) care plans reviewed. Resident #42. Findings include: Review of the facility's "Comprehensive Care Plan Policy", revealed it is the policy of this facility to develop, revise and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The facility's policy also revealed the comprehensive care plan will be reviewed and revised periodically, on an ongoing basis to reflect the services provided or arranged and must be consistent with each resident written plan of care. The facility shall use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care. The facility shall follow the care plan. Record review of the comprehensive care plan with a problem onset dated 10/20/21 revealed Resident #42 is at risk for urinary incontinence. The goal is for Resident # 42 is to remain continent through the next review 1/20/22. The facility's approaches included to evaluate Resident #42's bladder control and pattern PRN (as needed). Observation on 01/04/22 at 03:29 PM, of incontinent care with Certified Nursing Assistant (CNA) #1 revealed the CNA failed to change wipes with each stroke. CNA #1 also cleansed the penis with the same wipe wiping multiple	F 657	reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. on 1/6/2022 Resident #42's incontinent care plan was modified by The Facility Director of Nursing to reflect incontinent status of resident 82 out of 82 residents have the potential to be affected by this deficient practice On 1/6/2022 The Facility Administrator in serviced the Director of Nursing, Registered Nurse Case Manager, and Licensed Practical Assessment Nurse on the Care Planning Process Policy. On 1/6/2022 The facility held a QA meeting with no changes related to current policies relating to care plan process. Beginning 1/10/2022 The facility Director of Nursing and/or the Registered Nurse Case Manager will review at least 10 incontinent care plans weekly for 4 weeks and 5 incontinent care plans monthly for 3 months to ensure accuracy. Any incontinent care plan that does not reflect residents current incontinence status will be modified by the Director of Nursing and or Nurse Case Manager. On 1/24/2022 The Quality Assurance Committee began evaluating audits/documentation completed monthly for 3 months and make recommendations and changes to ensure compliance.	

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F 657	Continued From page 5 times in the same area. CNA #1 also failed to cleanse Resident #42 with the wipes from front to back. During an interview on 01/06/22 at 03:58 PM, with the Director of Nursing (DON) confirmed the facility failed to revise the care plan to reflect the resident's incontinent episodes. During an interview on 01/06/22 at 04:22 PM, with Registered Nurse (RN) #1 confirmed she failed to revise the residents care plan to reflect the resident having incontinent episodes. RN #1 said she thought the resident was still continent of bowel and bladder. RN #1 also confirmed the resident's care plan did not reflect the resident's current bladder status at this time. During an interview on 01/06/22 at 05:12 PM with CNA #1 confirmed Resident #42 has incontinent episodes all the time. Record review of Resident #42's five (5) day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/12/21 revealed in Section H that Resident #42 is always continent of bladder. Record review of the Face Sheet revealed Resident #42 was admitted to the facility on 10/07/21 with the diagnoses that included Urinary Tract Infection (UTI), Chronic Obstructive Pulmonary Disease (COPD) and Heart Failure.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		2/7/22

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F 689	Continued From page 6 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews and facility policy review, the facility failed to ensure the residents' environment is free from possible accidents by not providing adequate supervision while smoking for one (1) of five (5) observations of residents smoking. Resident #14, Resident #58, and Resident #67. Findings include: Record review of the facility's policy, "Smoking Policies and Regulations", with a review date of 8/2021, revealed the facility will provide matches and will light cigarettes upon request in designated areas set aside for smoking. These areas will be monitored by designated staff. On 1/3/22 at 3:44 PM, the State Agency (SA) observed residents smoking in the designated area without supervision. Resident #58 stated, "she went to get her coat, she was cold". The SA observed Laundry Aide #1 return to the designated smoking area at 3:52 PM. On 1/3/22 at 3:53 PM, in an interview with Laundry Aide #1, she stated she was cold, and she went to use the restroom and get her coat. She acknowledged she should have stayed with the residents because something could have happened when the residents are left alone, and they could get burned.	F 689	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. On 1/6/2022 Resident #14, Resident #58, and Resident #67 were assessed by the Director of Nursing for any adverse affects relating to Residents being left unsupervised while smoking with no adverse effects noted. 21 out of 21 Residents that smoke have the potential to be affected by this deficient practice On 1/6/2022 Administrator in serviced Laundry Aide #1 regarding the facility's policy on Smoking and Regulations. On 1/6/2022 all staff were in serviced by the Administrator on the facility's policy on Smoking and Regulations. On 1/6/2022 the facility held a Quality Assurance Meeting with no changes noted to current policies related to smoking policies and regulations. On 1/7/2022 Administrator and/or the	

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F 689	Continued From page 7 On 1/5/22 at 1:58 PM, in an interview with the Administrator, she stated that staff are supposed to be with residents when they are smoking and by staff not supervising the residents, it could cause a resident to fall or to get burned. She stated the facility policy is that staff are supposed to be with residents at all times when residents are smoking. Resident #14 On 1/5/22 at 4:50 PM, in an interview with Resident #14, she stated the residents have often been left alone while smoking. She stated the staff takes them out to light their cigarettes and leaves and she could get hurt being left outside alone. Record review of Resident #14's Face Sheet revealed the facility admitted her on 9/24/21. Record review of Resident #14's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/4/21 revealed a Brief Interview for Mental Status score of 13, which indicated the resident is cognitively intact. Resident #58 On 1/4/22 at 10:30 AM, during Resident Council meeting, Resident #58 stated that residents are left unattended during smoke breaks and that it has happened all the time. Record review of the Resident #58's Face Sheet revealed the facility admitted the resident on 10/10/19.	F 689	Director of Nursing began monitoring smoke breaks to ensure that designated staff is present during resident breaks twice a day for 5 days for 2 weeks, and then once a day for 5 days for 3months. On 1/24/2022 The Quality Assurance Committee began evaluating audits/documentation completed monthly for 3 months and make recommendations and changes to ensure compliance.	

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F 689	Continued From page 8 Record review of the Quarterly MDS with an ARD of 11/23/21 revealed Resident #58 had a BIMS score of 12, which indicated the resident has moderate cognitive impairment. Resident #67 On 1/6/22 at 4:40 PM, in an interview with Resident #67, she stated staff will leave them and step inside the building when it is cold outside. She stated the staff goes inside to sit at the tables while the residents are smoking and that the staff cannot see what is going on outside when they are sitting inside. She stated it has happened a couple of times. Record review of Resident #67's Face Sheet revealed the facility admitted her on 9/7/21. Record review of the admission MDS with an ARD of 9/14/21 revealed a BIMS score of 15, which indicated the resident is cognitively intact.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		2/7/22

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F 690	Continued From page 9 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review the facility failed to provide incontinent care utilizing correct technique for one (1) of five (5) incontinent care observations. Resident #42. Findings include: The facility policy, "Perineal Care", revised 10/2018 revealed the purpose is to cleanse the perineum, to eliminate odor, to prevent irritation or infection and to enhance the Resident's dignity and self-esteem. Under male- without catheter the policy revealed while providing perineal care the staff should hold the shaft of the penis with one hand. Using the other hand gently cleanse	F 690	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. On 1/6/2022 The Director of Nursing assessed Resident # 42 and found no adverse reactions noted relating to deficient practice 79 out of 82 Residents have the potential to be affected by this deficient practice	

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F 690	Continued From page 10 from the tip to the base of the penis. Use a clean portion of the washcloth or pre-moistened wash wipe after each stroke. Observation on 01/04/22 at 03:29 PM, of incontinent care with CNA #1 revealed the CNA, cleansed the resident's perineal area with one wipe. CNA #1 wiped the same area multiple times without changing the wipes. CNA #1 also cleansed Resident #42's penis with the same wipe, wiping multiple times in the same area. CNA #1 turned Resident #42 over and wiped the resident with a wet wipe from back to front. CNA #1 failed to change wipes with each stroke and failed to wipe from front to back while providing incontinent care. During an interview on 01/06/22 at 03:58 PM, with the Director of Nursing (DON) confirmed CNA #1 could have caused an infection. The DON also said Resident #42 could become septic from an infection. The DON stated CNA #1 was trained on the appropriate steps to providing incontinent care. During an interview on 01/06/22 at 05:07 PM, with License Practical Nurse (LPN)#1 confirmed CNA #1 failed to follow the facility policy by cleansing the resident's perineal area with the same wipe and wiping the residents' buttocks from back to front. LPN #1 said CNA #1 has been trained how to provide incontinent care properly, and this could cause urinary tract infections (UTIs). During an interview on 01/06/22 at 05:12 PM, CNA #1 confirmed she failed to change wipes with each stroke while providing perineal care. CNA #1 said she was nervous and was thrown off her regular routine. CNA #1 also said the resident	F 690	On 1/7/2022 The Director of Nursing in serviced CNA #1 regarding Perineal Policy. On 1/7/2022 the Facility Infection Control Nurse initiated and in service on the Perineal Policy for 7 Registered Nurses, 21 License Practical Nurses, and 35 Certified Nursing Assistants. On 1/6/2022 the Facility held a Quality Assurance Meeting with no changes noted to Perineal Care Policy. on 1/10/2022 The Director of Nursing and/or Infection Control Nurse began observations of at least 6 Certified Nursing Assistants performing perineal care for 4 weeks and then observations of at least 4 Certified Nursing Assistants performing perineal care monthly for 3 months. On 1/24/2022 The Quality Assurance Committee began evaluating audits/documentation completed monthly for 3 months and make recommendations and changes to ensure compliance	

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F 690	Continued From page 11 has incontinent episodes all the time. CNA #1 confirmed that by not cleaning the resident appropriately, this could cause the resident to get UTIs. Record review of the Face Sheet revealed Resident #42 was admitted to the facility on 10/07/21 with diagnoses that included Urinary Tract Infection (UTI), Chronic Obstructive Pulmonary Disease (COPD) and Heart Failure. Record review of the five (5) day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/12/21 revealed Resident#42 had a Brief Interview for Mental Status (BIMS) of 15 that indicted Resident #42 is cognitively intact. Record review of Certified Nursing Assistant (CNA) #1 Perineal care in-service dated 11/07/21 revealed CNA #1 was in-serviced on providing perineal care appropriately.	F 690		
F 880 SS=D	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:	F 880		2/7/22

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§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 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

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F 880	Continued From page 13 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 reviews, and facility policy review the facility failed to prevent the possible spread of infection during incontinent care for two (2) of five (5) residents reviewed. Resident #49 and Resident #21. Finding include: Record review of facility's policy for "Infection Prevention and Control Surveillance" revealed "It is the policy of this facility to prevent infections whenever possible ..." Record review of the facility's policy for "Hand Hygiene" revealed the purpose of the policy is "to cleanse hands to prevent transmission of infection or other conditions... Indications for hand washing ... 3. Before and after procedures. 4. Before and after applying gloves. 5. When hands are visibly soiled...Selecting hand washing method...2. When to wash with soap and water a. when hands are visibly soiled/dirty...d. when hands are visibly contaminated with blood or body fluids..." Resident #49	F 880	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. On 1/6/2022 the Director of Nursing assessed Resident # 49 and Resident #21 with no adverse reactions noted 79 out of 82 Residents have the potential to be affected by this deficient practice On 1/7/2022 The Director of Nursing in serviced Registered Nurse # 2, Certified Nursing Assistant #4, and Certified Nursing Assistant # 5 on the Infection Control Policy. On 1/7/2022 The Director of Nursing in serviced Certified Nursing Assistant #2 on the Hand Hygiene Policy. On 1/7/2022 the Facility Infection Control Nurse initiated an in-service on Infection Control and Hand Hygiene Policies for all staff. No staff will be allowed to work a	

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F 880	Continued From page 14 On 1/5/22 at 11:40 AM, the SA observed catheter and perineal care provided by Certified Nursing Assistant (CNA) #4 and assisted by CNA #5 and Registered Nurse (RN) #2. During the procedure, as RN #2 and both CNA's were positioning and turning Resident #49, a bag containing soiled items that had been used during care fell onto the floor and the contents of the bag spilled. RN #2 picked up the spilled contents and placed them back into the bag. She then placed the contaminated bag onto the resident's bed. On 1/6/21 at 4:46 PM, in an interview with RN #2, she confirmed she picked the bag up off the floor after it fell from the resident's bed. The bag landed upside down and the soiled contents fell onto the floor. She acknowledged that she then picked the bag up and placed it back onto the resident's bed. She stated she should have left the bag on the floor and not put the contaminated bag onto the resident's bed because her actions could have caused the resident to have multiple health issues related to infection control. RN #2 was unable to recall the last in-service she had received on infection control. On 1/6/21 at 6:15 PM, in an interview with the Director of Nursing (DON), she stated RN #2 should not have put the contaminated bag back onto Resident #2's bed. She confirmed RN #2 should have left the room and disposed of the bag and the actions of RN #2 could have caused the resident to acquire and spread a bacterial infection. On 1/6/22 at 6:25 PM, in an interview with Licensed Practical Nurse #1 (LPN)/Infection Control Nurse, she confirmed RN #2 should have	F 880	shift until participation in directed in-service for infection control has been completed. On 1/6/2022 the facility held a Quality Assurance Meeting with no changes to current policies related to the Infection Control Policy On 1/10/2022 The Director of Nursing and/or Infection Control Nurse began observations of Registered Nurse performing wound care with emphasis on infection control practices on at least 2 Residents daily for 5 days for 2 weeks and then once daily for 5 days for 3 months. On 1/10/2022 the Director of Nursing and/or Infection Control Nurse began observations of Certified Nursing Assistants performing perineal care with emphasis on hand hygiene on 2 Residents daily for 5 days and then once daily for 5 days for 3 months. On 1/24/2022 The Quality Assurance Committee began evaluating audits/documentation completed monthly for 3 months and make recommendations an changes to ensure compliance	

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left the bag on the floor and that by picking up the bag of soiled items and placing it back on the bed, she contaminated the bed and could have caused the resident to acquire an infection.

Record review of Resident #49's Face Sheet revealed the facility admitted the resident on 10/5/19, with diagnoses that included Alzheimer's and Dementia with behavioral disturbance.

Record review of the In-service training sheet revealed an in-service was conducted on 12/8/21 with the topic of infection control. RN #2's signature was on the sign in sheet indicating she has been trained on infection control.

Resident #21

During an observation of incontinent care, on 01/03/21 at 12:45 PM, CNA #2 did not change her visibly soiled gloves, wash or sanitizer her hands, or don clean gloves after cleaning feces from Resident #21 and before applying a clean brief.

On 01/03/21 at 1:00 PM, during an interview with CNA #2, she acknowledged she did not remove her soiled gloves and wash her hands. CNA #2 explained she should have changed her gloves after cleaning resident, washed or sanitized her hands, and applied clean gloves before applying the clean brief.

On 01/06/21 at 4:00 PM, during interview with the Director of Nursing (DON), she explained CNA #2 came to her right after she completed incontinent care and advised that she didn't change her gloves before placing the clean brief on the resident. The DON confirmed CNA #2 should have changed gloves when they were visibly

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soiled with feces and these actions could have caused the resident to have a urinary tract infection. The DON reported that CNA #2 had completed a check off list related to Infection Control when hired.

On 01/06/22 at 5:30 PM, during an interview with LPN #1/Infection Preventionist, she confirmed CNA #2 should have changed her gloves and washed her hands after cleaning the resident and before applying a clean brief. The CNA's actions caused an infection control breach, and this could have caused a urinary tract infection and the spread of bacteria.

Record review of the Face Sheet for Resident #21 revealed the facility admitted Resident #21 on 10/14/21, with diagnoses that included Urinary tract infection, Pressure ulcer, High Blood pressure, and Cardiomegaly.

Record review of the admission Five Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/21/21, revealed a Brief Interview for Mental Status (BIMS) score of 07 which indicated Resident #21 had severe cognitive impairment. Section G revealed Resident #21 required extensive assistance with personal hygiene and was frequently incontinent of bowel and bladder.