STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255341	A. BUILDING _____ B. WING _____	12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GULFPORT CARE CENTER	11240 CANAL ROAD GULFPORT, MS 39503

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey from 12/16/19 to 12/19/19. The SA determined the facility was not in substantial compliance with the requirements of participation in Medicare and Medicaid. The SA cited the regulatory deficiencies at F550, F655, F656, F690, F842, and F880. At the time of the survey, the census was 81, and the facility held a license for 90 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		1/31/20

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

Electronically Signed | 01/14/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure a resident's right to dignity, as evidenced by (AEB), leaving the urinary catheter drainage bag uncovered, for one (1) of four (4) residents observed with a catheter, Resident #12. Findings include: Review of the facility's "Resident Rights" policy, dated 11/17, revealed: All residents in a long term care facility have rights guaranteed to them under Federal and State law. Residents residing at this facility will be guaranteed a dignified existence, self determination and services inside and outside the facility. On 12/16/19 at 10:54 AM, an observation was made of Resident #12's catheter drainage bag, hanging on the left side of the resident's bed. The urinary catheter drainage bag was visibly exposed to the hallway.	F 550	By submitting the enclosed material, Gulfport Care Center is not admitting the truth or accuracy of any specific findings or allegations. Gulfport Care Center reserves the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to regulatory obligations. Gulfport Care Center is continually evaluating its policies and procedures as part of an on-going quality assurance and performance improvement program. Any change in policy or procedure is not and should not be considered an admission or indication of truth of any specific findings or allegations. 1. Resident #12 was immediately provided with a dignity bag for the catheter drainage bag.	

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F 550	Continued From page 2 On 12/16/19 at 3:05 PM, Resident #12's catheter drainage bag was observed, hanging on the left side of the bed, facing the hallway door. The "Dignity" bag was hanging beside the drainage bag, but was not in use. During an interview, on 12/16/19 at 2:59 PM, Certified Nursing Assistant (CNA) #4 stated the urine drainage bag should be placed inside the catheter dignity bag, when its not being emptied. CNA #4 stated, not having the catheter drainage bag covered, would be considered a dignity problem. During an interview, on 12/16/19 at 3:07 PM, CNA #5 confirmed Resident #12's catheter drainage bag was not in the dignity bag, hanging on the resident's bedside. CNA #5 stated the catheter drainage bag is suppose to stay in the privacy/dignity bag, unless its being emptied. During an interview, on 12/17/19 at 12:02 PM, the Assistant Director of Nursing (ADON), revealed, at no time should a catheter drainage bag be seen without a cover, unless it is being emptied. The ADON stated it was a dignity problem.	F 550	2.Six residents in the facility had indwelling catheters. Any of these six residents with an indwelling catheter could have been affected by not having a dignity bag covering the catheter drainage bag. 3. An audit was completed on December 17, 2019, by the Registered Nurse Director of Nursing of all residents with indwelling catheters. No other resident with an indwelling catheter was without a dignity bag. On December 31, 2019, all staff (to include registered nurses, licenses practical nurses, certified nursing assistants, social services, activities, administrative staff, dietary, housekeeping, laundry and maintenance) were in-serviced by the Registered Nurse Director of Nursing and Nursing Home Administrator regarding facility's policy on "Dignity and Respect," ensuring all residents with indwelling catheters have a dignity bag covering the catheter drainage bag, unless the resident has a documented preference to not have a dignity bag. The Registered Nurse Director of Nursing and the Registered Nurse Assistant Director of Nursing will monitor compliance by completing audits of all residents with indwelling catheters ensuring the presence of dignity bag; audits will be completed weekly for four weeks, monthly for three months, and periodically as indicated thereafter. These audits began on December 23, 2019. 4.If any issues arise in regards to residents with indwelling catheters not having a dignity bag (unless the resident	

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F 550	Continued From page 3	F 550	has a documented preference to be without a dignity bag), the issues will be brought to the Quality Assurance and Performance Improvement Committee by either the Registered Nurse Director of Nursing or Registered Nurse Assistant Director of Nursing. The Quality Assurance and Performance Improvement Committee meets at least quarterly (though may meet more often should the need arise), and will at that time initiate a Corrective Action Plan along with root cause analysis and review on completion for any further action that may be required.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		1/31/20

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F 655	Continued From page 4 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to develop a baseline care plan for an indwelling foley catheter upon Resident 124's readmission to the facility, for one (1) out of 19 Baseline care plans reviewed for new admits. Findings include: Review of the facility's "Care Plan Process" policy, revised 08/17, revealed: The facility shall develop and implement a Baseline Care Plan within 48 hours of admission, that includes the instructions needed to provide effective and person-centered care that meets professional	F 655	1. Resident #124 had been assessed routinely by nursing staff regarding her indwelling catheter, and experienced no adverse effects per reviewed documentation in relation to the facility not having a baseline care plan for the indwelling catheter upon her return from a hospital. The indwelling catheter was added to resident #124's baseline care plan on December 18, 2019. 2. Any resident with an indwelling catheter could have been affected by not having a baseline care plan for an indwelling catheter.	

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F 655	Continued From page 5 standard for quality care. During an observation and interview, on 12/18/19 at 4:10 PM, Resident #124 was noted to have a catheter. Resident #124 stated she had returned to the facility on 12/09/19, after being in the hospital. Resident #124 stated she had a catheter, because she was having trouble urinating. Review of Resident #124's "Baseline Care Plan and Summary", dated 12/10/19, revealed the presence and care of an indwelling catheter was not addressed, as part of the resident's care needs. During an interview, on 12/18/19 at 12:11 PM, the Director of Nursing (DON) revealed, Resident #124 had returned from the hospital, on 12/9/2019, with an indwelling catheter. The DON stated although the care and documentation had been provided, the order had not been entered into the computer. During an interview, on 12/18/2019 at 12:30 PM, Registered Nurse (RN) #1/Minimum Data Set (MDS) Coordinator, confirmed after reviewing the Baseline care plan for Resident #124, the presence of a indwelling foley catheter had not been indicated.	F 655	3. An audit was completed on December 18, 2019, by the Registered Nurse Director of Nursing of all residents currently in the facility with an indwelling catheter to ensure a care plan was in place. No other resident with an indwelling catheter was without a care plan for the indwelling catheter. On January 8, 2020, the Registered Nurse Director of Nursing and the Nursing Home Administrator in-serviced the registered nurse case manager, licensed practical nurse case manager, licensed practical nurse assessment nurses, medical records licensed practical nurse, medical records clerk, registered nurse assistant director of nursing regarding facility's policy Care Plan Process, with emphasis on the baseline care plan. The Nursing Home Administrator and Registered Nurse Director of Nursing will monitor compliance by completing audits of baseline care plans weekly for four weeks, monthly for three months, and periodically as indicated thereafter. These audits began on December 30, 2019. 4. If any issues arise in regards to baseline care plans, the issues will be brought to the Quality Assurance and Performance Improvement Committee by either the Nursing Home Administrator or the Registered Nurse Director of Nursing. The Quality Assurance and Performance Improvement Committee meets at least quarterly (though may meet more often should the need arise), and will at that time initiate a Corrective Action Plan along	

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F 655	Continued From page 6	F 655	with root cause analysis and review on completion for any further action that may be required.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		1/31/20

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F 656	Continued From page 7 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to follow the comprehensive care plan, while providing incontinent care, for one (1) of 21 care plans reviewed, Resident #71. Findings include: Review of the facility's "Care Plan Process" policy, revised 8/17, revealed: the Care Plan must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being. The facility staff shall follow the care plan. During an observation, on 12/17/19 at 2:39 PM, Certified Nursing Assistant (CNA) #1 was observed performing incontinent care on Resident #71. CNA #1 cleaned Resident #71's perineal area and buttocks, using the same wash cloth (folded multiple times) and without changing gloves. During an interview, on 12/17/19 at 2:53 PM, CNA #1 revealed she should have changed towels prior to cleaning Resident #71's buttocks. CNA #1 confirmed she folded and wiped multiple times	F 656	1. Resident #71 was observed by a licensed practical nurse on December 19, 2019, for any negative effects and none were noted. Treatment Registered Nurse observed incontinent care on resident #71 on January 16, 2020, by a certified nursing assistant, and care was provided in accordance with facility policies regarding incontinent care and infection control. 2. Any resident requiring incontinent care could have been affected. 3. The Registered Nurse Director of Nursing on December 31, 2019, in-serviced direct care staff (to include registered nurses, licenses practical nurses, and certified nursing assistants) regarding facility policies on infection control, incontinent care, catheter care, and following the care plan. The Registered Nurse Director of Nursing, Registered Nurse Assistant Director of Nursing, and/or Licensed Practical Nurse Staff Development Coordinator will randomly audit by direct observation certified nursing assistants completing incontinent care, weekly for four weeks,	

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F 656	Continued From page 8 with the same towel. CNA #1 stated she had been trained on providing pericare. CNA #1 stated she was nervous because the State Agency (SA) was watching her. During an interview, on 12/18/19 at 3:47 PM, Registered Nurse (RN) #1 revealed, CNA #1 failed to follow the care plan, by not changing towels while providing care, and wiping multiple times with the same area of the towel. RN #1 stated she expected the staff to follow the care plan when providing incontinent care. RN #1 stated not providing care correctly, could cause the resident to get an infection.	F 656	monthly for three months, and then periodically as needed thereafter. These audits began on December 23, 2019. 4. If any issues arise, they will be brought to the Quality Assurance and Performance Improvement Committee by the Registered Nurse Director of Nursing. The Quality Assurance and Performance Improvement Committee meets at least quarterly (though may meet more often should the need arise), and will at that time initiate a Corrective Action Plan along with root cause analysis and review on completion for any further action that may be required.	
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 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	F 690		1/31/20

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F 690	Continued From page 9 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, interview, record review, and facility policy review, the facility failed to provide incontinent care for Resident #71, in a manner to prevent infection for one (1) of six (6) residents reviewed. Findings include: The facility's, "Perineal Care" policy, revised 10/18, revealed: the staff should use a clean portion of the washcloth or pre-moistened wash wipe after each stroke. Review of Resident 71's care plan, revealed a problem to address risk for skin breakdown, with an intervention to provide pericare after each incontinent episode. During an observation of Resident #71's incontinent care, on 12/17/19 at 2:39 PM, Certified Nursing Assistant (CNA) #1 used the same wash cloth (folded multiple times) to clean	F 690	1. Resident #71 was observed by a licensed practical nurse on December 19, 2019, for any negative effects and none were noted. Treatment Registered Nurse observed incontinent care on resident #71 on January 16, 2020, by a certified nursing assistant, and care was provided in accordance with facility policies regarding incontinent care and infection control. 2. Any resident requiring incontinent care could have been affected. 3. The Registered Nurse Director of Nursing on December 31, 2019, in-serviced direct care staff (to include registered nurses, licensed practical nurses, and certified nursing assistants) regarding facility policies on infection control, incontinent care, catheter care, and following the care plan. The	

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F 690	Continued From page 10 the perineal area and buttocks, and did not change her gloves. During an interview, on 12/17/19 at 2:53 PM, Certified Nursing Assistant (CNA) #1 revealed she should have changed towels prior to cleaning Resident #71's buttocks, and not continue to wipe with one (1) towel multiple times. CNA #1 stated she was trained to fold the towel only three (3) times. CNA #1 stated she was nervous because of the State Agency (SA) watching her. CNA #1 did not indicate a problem with not changing her gloves. During an interview, on 12/17/19 at 2:54 PM, the Director of Nursing (DON) confirmed CNA #1 should have changed gloves after cleaning the perineal area, and changed towels after folding it three (3) times. During an interview, on 12/18/19 at 3:47 PM, Registered Nurse (RN) #1/Care Plan Nurse confirmed, CNA #1 should have changed the towels and gloves while providing incontinent care to Resident #71.	F 690	Registered Nurse Director of Nursing, Registered Nurse Assistant Director of Nursing, and/or Licensed Practical Nurse Staff Development Coordinator will randomly audit by direct observation certified nursing assistants completing incontinent care, weekly for four weeks, monthly for three months, and then periodically as needed thereafter. These audits began on December 23, 2019. 4. If any issues arise, they will be brought to the Quality Assurance and Performance Improvement Committee by the Registered Nurse Director of Nursing. The Quality Assurance and Performance Improvement Committee meets at least quarterly (though may meet more often should the need arise), and will at that time initiate a Corrective Action Plan along with root cause analysis and review on completion for any further action that may be required.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		1/31/20

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F 842	Continued From page 11 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or	F 842		

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	255341	A. BUILDING _____ B. WING _____	12/19/2019

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F 842	Continued From page 12 (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to accurately complete a medical record for one (1) of 21 medical records reviewed, Resident #124. Findings include: Review of the facility policy, "Medical Records", revised 04/17, revealed: The facility maintains a resident record in accordance with regulations and accepted standards of practice that are complete and accurate. The resident's medical recored must contain sufficient information to identify the resident, resident's assessments, the comprehensive plan of care and services provided. The purpose of the clinical record is to document the course of the resident's plan of care. Review of Resident #124's cumulative Physician Orders for December 2019, revealed there was	F 842	1. A physician's order was obtained for resident #124's indwelling catheter on December 18, 2019. Resident #124 had been routinely observed by a licensed practical nurse and experienced no adverse effects related to the facility not having a physician's order for her indwelling catheter following her readmission from a hospital. 2. Any resident with an indwelling catheter could have been affected. 3. An audit was completed on December 18, 2019, by the Registered Nurse Director of Nursing of all residents currently in the facility with an indwelling catheter to ensure a physician's order for an indwelling catheter was in place. No other resident with an indwelling catheter was without a physician's order. On December 31, 2019, the Registered	

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F 842	Continued From page 13 not an order for an indwelling catheter. During an observation and interview, on 12/18/19 at 4:10 PM, revealed Resident #124 had an indwelling catheter. Resident #124, the resident stated she returned from the hospital, on 12/9/2019, with the catheter. During an interview, on 12/18/19 at 12:11 PM, the Director of Nursing (DON) revealed Resident #124 had returned from the hospital on 12/9/2019, with an indwelling catheter. The DON stated although the care and documentation had been provided, the order had not been entered into the computer. The DON stated the Medical Records designee was responsible for maintaining an accurate medical record for each resident.	F 842	Nurse Director of Nursing and the Nursing Home Administrator in-serviced all registered nurses and licensed practical nurses regarding facility's policies on Indwelling Catheterization and Physician's Orders. The Nursing Home Administrator and Registered Nurse Director of Nursing will monitor compliance by completing audits of physician's orders weekly for four weeks, monthly for three months, and periodically as indicated thereafter. These audits began on December 23, 2019. 4. If any issues arise, the issues will be brought to the Quality Assurance and Performance Improvement Committee by either the Nursing Home Administrator or the Registered Nurse Director of Nursing. The Quality Assurance and Performance Improvement Committee meets at least quarterly (though may meet more often should the need arise), and will at that time initiate a Corrective Action Plan along with root cause analysis and review on completion for any further action that may be required.	
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	F 880		1/31/20

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F 880	Continued From page 14 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 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	F 880		

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F 880	Continued From page 15 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, the facility failed to follow infection control standards, for two (2) of seven (7) incontinent care observations, Resident #71 and Resident #52. Findings include: Review of the facility's, "Infection Prevention and Control Program" policy, dated 06/14, revealed: The facility has developed and maintains an infection prevention and control program that provides a safe, sanitary and comfortable environment to help prevent the development and transmission of infection. Review of the facility's "General Infection Prevention and Control Nursing Policies", dated 06/14, revealed: "It is the policy of this facility that all nursing activities will be performed in a manner to minimize the potential for infection in	F 880	1. Resident #52's room was immediately cleaned, as was the wheelchair. Resident #52 was observed by a licensed practical nurse on December 18, 2019; no adverse effects were noted. Resident #71 was observed by a licensed practical nurse on December 19, 2019, for any negative effects and none were noted. 2. This had the potential to affect any resident in the facility requiring incontinent care. 3. The Registered Nurse Director of Nursing on December 31, 2019, in-serviced all staff (to include registered nurses, licensed practical nurses, certified nursing assistants, social services, activities, administrative staff, dietary, housekeeping, laundry and maintenance) regarding facility policies on infection	

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F 880	Continued From page 16 residents, staff, and visitors." Resident #52 During an observation, on 12/16/19 at approximately 9:00 AM, while performing incontinent care, Certified Nursing Assistant (CNA) #4 placed the linen, soiled with feces, on the floor, at the foot of Resident #52's bed. CNA #4 removed his gloves, and tossed them on top of the soiled linen, on the floor. CNA #4 assisted Resident #52 with getting dressed, placed the resident in the wheelchair, and rolled the wheelchair across the top of the soiled linen. During an interview, on 12/16/19 at 10:16 AM, CNA #4 confirmed he had placed the soiled linen on the Resident #52's floor, during incontinent care. CNA #4 stated he should have put the linen in a plastic garbage bag, and taken it out of the room to the laundry barrel. CNA #4 stated he was aware of putting the soiled linen on the floor, could spread germs and cause infection. CNA #4 stated he should have been more careful about rolling the wheelchair across the dirty linen. A review of CNA #4's "CNA Performance and Skills Evaluation, dated and signed on 10/9/19, revealed he had received training and checked off on skills for Infection Control related to the use/understanding of universal precautions, and for handling clean/dirty linen correctly. During an interview, on 12/16/19 at 10:20 AM, CNA #5 stated putting dirty linen on the floor was something the staff was not suppose to do. CNA #5 stated placing dirty linen on the floor was a way to spread bacteria and germs. CNA #5 stated the Director of Nursing (DON) had given in-services on how to handle linen, and where to	F 880	control, incontinent care, catheter care, and following the plan of care. The Registered Nurse Director of Nursing, Registered Nurse Assistant Director of Nursing, and/or Licensed Practical Nurse Staff Development Coordinator will randomly audit by direct observation certified nursing assistants completing incontinent care, weekly for four weeks, monthly for three months, and then periodically as needed thereafter. These audits began on December 23, 2019. 4. If any issues arise, they will be brought to the Quality Assurance and Performance Improvement Committee by the Registered Nurse Director of Nursing. The Quality Assurance and Performance Improvement Committee meets at least quarterly (though may meet more often should the need arise), and will at that time initiate a Corrective Action Plan along with root cause analysis and review on completion for any further action that may be required.	

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F 880	Continued From page 17 put the dirty linen, during and after giving care. During an interview, on 12/16/19 at 10:25 AM, CNA #6 confirmed the CNAs are trained on how to handle dirty linen. CNA #6 stated it was never correct to throw soiled gloves on the floor, or on top of dirty linen that's on the floor. During an interview, on 12/17/19 at 12:02 PM, the Assistant Director of Nursing, (ADON) revealed, clean or dirty linen should never be placed on the floor. The ADON stated placing dirty, soiled linen on the floor, and then rolling over the dirty linen with a resident's wheelchair, was a serious infection control problem. Resident #71 During an observation of Resident #71's perineal care, on 12/17/19 at 2:39 PM, CNA #1 opened the resident bedside drawer, removed a tube of cream, applied the cream to the resident's perineal and buttocks, using the same gloves worn during the entire incontinent care. CNA #1 then placed a brief on Resident #71, and pulled up the resident's blanket, with the same soiled gloves. CNA #1 did not change gloves during the complete procedure. Upon completion of the care, CNA #1 placed the Perineal Wash bottle, used in Resident #71's room, on the clean linen cart in the hallway. During an interview on 12/17/19 at 2:53 PM, CNA #1 confirmed she placed the dirty Perineal Wash bottle onto the clean linen cart. CNA #1 stated she was nervous because of the State Agency (SA) watching her. CNA #1 did not indicate there was a problem with her not changing gloves. During an interview, on 12/17/19 at 2:54 PM, the Director of Nursing (DON) stated CNA #1 should	F 880		

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F 880	Continued From page 18 have changed gloves after cleaning the perineal area. The DON confirmed CNA #1 should have left the Perineal Wash in the resident's room. The DON stated CNA #1 violated infection control, by placing the Perineal Wash on the clean linen cart.	F 880		

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 01/08/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 000	Initial Comments ********** Survey conducted on 12/16/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

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