STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255269	A. BUILDING _____ B. WING _____	01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD OXFORD, MS 38655

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey from 01/20/2020 to 01/23/2020. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid regulations of participation. The SA cited deficiencies at F561, F641, F656, F657, F677, F690, and F880. The facility was licensed for 180 beds, and had a census of 151, at the time of the survey.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to	F 561		3/9/20

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

Electronically Signed | 02/25/2020

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 561	Continued From page 1 participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, record review, and facility policy review, the facility failed to honor the resident's choice for receiving baths and showers, for two (2) of 30 residents reviewed, Resident #54 and #88. Findings include: Review of the facility's "Rights and Responsibilities of the Individual" policy, dated 11/28/2017, revealed: The facility policy shall adopt the Statement of Resident Rights, in accordance with all Federal and State Regulatory requirements, and shall protect and promote the rights of each resident. Review of the facility's "Our Resident's Rights" policy, dated 09/26/2019, revealed: Right to Self-Determination - choice of activities, schedules, health care, and providers, including physician. Resident #88 A review of Resident #88's care plan, with an onset date of 07/17/2018, revealed she required extensive to total assistance with Activities of Daily Living (ADL) related to diagnoses which included Multiple Sclerosis (MS) and Morbid Obesity. Interventions included "Shower QOD (every other day)extensive assist." During an interview, on 01/20/2020 at 10:59 AM, Resident #88 revealed she wanted a shower	F 561	1. Resident #54 &#58 Were interviewed by the Director of Nursing (DON)and social worker on 2/18/20 on the choice of their bath and shower days. The Smart Chart was updated on 2/24/20 and the care-plan was updated on 2/25/20to reflect each resident choice. 2. On 1/28/20 a 100% audit was completed for all residents on the choice for bath and shower days. The Smart charting was updated on 2/24/20according to each resident□s preference. The Family members were interviewed on 2/20/20 for those residents who were unable to express their choice. 3. The facility has determined that all resident have the potential to be affected by this deficient practice. 4. On 2/18/20 an inservice was conducted by the Staff Educator, Registered Nurse(RN) with the Certified Nurse Assistants (CNA□s) on following the smart charting plan of care that indicates residents preference of shower and bath days. 5. On 2/18/20 an in service was conducted by the Staff educator, RN with the Social worker to interview residents on admission regarding choice and	

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F 561	Continued From page 2 three times a week. Resident #88 stated she got one (1) shower last week. During an interview, on 01/22/2020 at 3:30 PM, Resident #88 stated she gets her shower on Tuesday and Thursday, but not on Saturday. Resident #88 stated the staff always tell her they are going to give her a bed bath. Resident #88 revealed there was not a problem with the showers being given like they were supposed to be, until the facility changed the shower aides. On 01/23/2020 at 10:57 AM, during an interview, with the Director of Nursing (DON), she revealed the Certified Nursing Assistants (CNA) have hand written sheets for each day and the care to be provided is flagged in Smart charting, on the computer for them. The DON stated bath days flag for Resident #88 on Tuesday, Thursday, and Saturday, and the resident should get a shower on those days. The DON confirmed, after viewing the Resident #88's Bath Day Roster, she did not receive showers on the days indicated. Review of Resident #88's "Bath Day Roster", dated 01/01/2020 through 01/23/2020, documented the resident received only two (2) showers during this time-frame. Resident #54 During an interview on 01/20/2020 at 10:30 AM, Resident #54 stated facility staff does not let her choose her schedule for bathing. Resident #54 stated there are times she does not want to take a bath at the time staff offers, and she is not offered another time for bath. Resident #54 stated staff has told her she could get her bath now or wait until the next bath day. On 01/20/2020 at 4:00 PM, Resident #54 stated she had mentioned to staff about getting her bath, but	F 561	preference on Bath and Shower days. This information will be inputed in the smart charting 6. Quality Assurance (QA) Nurse will interview five residents weekly regarding choice of bath and showers for four consecutive weeks and five monthly for two months or until substantial compliance is achieved. This plan will be monitored by QA monthly until such time Consistent substantial compliance has been met.	

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F 561	Continued From page 3 had not received it. During an interview, on 01/23/2020 at 9:18 AM, Certified Nursing Assistant (CNA) #1 stated bath days for residents are on Monday, Wednesday and Friday, or Tuesday, Thursday and Saturday. CNA #1 stated the shower team works from 6:00 AM to 2:00 PM, Monday through Friday. CNA #1 revealed the shower team starts taking the residents to the shower at 6:00 AM, and after breakfast, the bed baths are done by the shower/bath team. CNA #1 stated if a resident refuses a bath when it is offered, the staff will ask if the resident would like it later that day or the next day, and will try to reschedule the resident's bath. CNA #1 stated it depended on available staff if a bath could be rescheduled. On 01/23/2020 at 1:41 PM, during an interview, the Director of Nursing (DON) stated the resident should have the choice on their bath times. The DON stated if the resident does not feel well or just wants another bath time, the facility staff should accommodate their choice. The DON further stated it was important for the resident to have control over their care in this area, as well as other areas. Review of Resident #54's Admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 11/29/2019, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated cognitively intact.	F 561		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		3/9/20

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F 641	Continued From page 4 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to accurately code the discharge status for one (1) of eight (8) Minimum Data Set (MDS) assessments reviewed for discharge, Resident #146. Findings include: Review of the Centers for Medicare and Medicaid Services Long Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, dated October 2018, revealed: Chapter 1.3 (Completion of the RAI) - The RAI process requires the assessment to accurately reflect the resident's status. An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. A review of Resident # 146's Discharge Return Not Anticipated MDS assessment, with an Assessment Reference Date (ARD) of 12/20/2019, revealed Section A2100 (Discharge Status) was coded as discharged to an acute hospital. Record review of Resident #146's Physician Orders, dated 12/19/2019, revealed an order to discharge home on 12/20/19 with Home Health services. A review of the Departmental Notes for Resident #146, dated 12/20/2019, documented the resident was discharged home with wife.	F 641	1. Resident #146 Minimum Data Set(MDS) was completed by the MDS Nurse on 1/23/20 2. All Discharged residents have the potential to be affected. 3. An Inservice was held 1/28/20 by the Director of Nursing (DON) and Staff Educator on the importance of coding the discharge status correctly under Section A2100 of the MDS. 4. The Risk Manager will audit section A2100 on all Discharge resident on Friday during the weekly Transmission meeting beginning 2/28/20 for six weeks and Monthly for three Months. 5. This Plan of Correction will be monitored by Quality Assurance Nurse(QA) monthly until such time consistent substantial compliance has been met.	

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F 641	Continued From page 5 During an interview, on 01/23/2020 at 9:15 AM, Registered Nurse (RN) #2/MDS Coordinator confirmed she completed Resident #146's Discharge Assessment, dated 12/20/2019, and had coded Section A to indicate the resident was discharged to the hospital. RN #2 revealed the incorrect coding of Resident #146's discharge status was in error and that she would do a correction.	F 641		
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.	F 656		3/9/20

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F 656	Continued From page 6 (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 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 staff interview,record review, and facility policy review, the facility failed to implement a care plan related to Activities of Daily Living for Resident #88, for one (1) of 30 resident care plans reviewed. Findings include: Review of the facility's "Comprehensive Plan of Care" policy, dated 11/28/2017, revealed: Plans of Care are developed by the interdisciplinary team, to coordinate and communicate care approaches and goals for the resident related to clinical diagnosis and identified concerns. The facility develops a comprehensive care plan for each resident that includes measurable objective and timetable to meet a resident's medical, nursing and mental/psychosocial needs. The facility staff will use the objectives to monitor resident progress. Record review of Resident #88's care plan revealed a problem to address extensive	F 656	1. On 2/19/20 Resident #88 was found to be clean by the Director of Nursing with no issues with showers for the week. There were no skin issues noted 2. All Resident receiving a Shower/ Bath have the potential to be affected. 3. On 2/18/20 all Nursing assistants were in serviced by Staff Educator on the importance of Following the plan of care on receiving bath/ Shower. The Bath Roster for each Unit will be updated 2/20/20 and reviewed weekly on Monday by the Unit Managers. 4. The Quality Assurance Nurse (QA) will review the bath Roster Report Monday through□ Friday for one weeks on all residents due for Bath/ Showers then weekly for four weeks on 10 residents, then Monthly until substanial compliance have been achieved.	

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F 656	Continued From page 7 assistance with Activities of Daily Living, with an onset date of 07/17/2013. The approaches included a shower every other day (QOD) with extensive staff assist. During an interview, on 01/20/20 at 10:59 AM, Resident #88 revealed she wanted a shower three (3) times a week. Resident #88 stated she got one (1) shower last week. Review of Resident #88's "Bath Day Roster", dated 01/01/2020 to 01/23/2020, revealed she only received two (2) showers, which were on 01/07/2020 and 01/21/2020. During an interview, on 01/23/2020 at 11:10 AM, the Director of Nursing (DON) confirmed Resident #88's care plan was not followed for her showers. The DON stated the care plan does not match their schedule for shower days. The DON confirmed Resident #88 should be getting a shower every other day.	F 656	5. QA will bring all discrepancies to the Administrator and Director on Nursing and will be discussed in the Monthly QA Meeting.	
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.	F 657		3/9/20

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F 657	Continued From page 8 (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 revise the care plan to related Activities of Daily Living (ADL), for two (2) of 30 resident care plans reviewed, Resident #78 and #129. Findings include: Review of the facility's "Comprehensive Plan of Care" policy, dated 11/28/2017, revealed: The plan of care will be reviewed and revised quarterly, annually, with significant change of status and as needed to enhance the resident's ability to meet his/her objectives. Resident #78 A review of Resident #78's care plan related to Activities of Daily Living (ADL), with a problem onset date of 04/18/2019, and target date of 03/02/2020, revealed the resident required two (2) staff to assist with transfers and incontinent care/assist with toileting every 2 hours and as needed (PRN).	F 657	1. Resident #78 was discharged back to the community on 2/8/20- no further action is required. 2. Resident #129 care plan was updated on 2/18/20 to reflect nail care to be provided weekly 3. On 2/26/20 a 100% audit on all nail care- plans were updated 4. On 2/26/20 a 100% audit on Activity of Daily Living (ADL) care-plans were updated to reflect bowel and bladder Status and assistance to provide 5. All Residents have the potential to be affected by the deficient practice. 6. Minimum Data Set (MDS) nurses were in serviced by the Staff Educator 2/18/20 on when to update the plan of care and instruct for staff assistance to be provided	

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F 657	Continued From page 9 Record review of Resident #78's Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) date of 11/28/2019, revealed Section G (Functional Status) was coded to indicate the resident could transfer with supervision and oversight and one (1) person physical assist to support during transfer. Toileting was coded to indicate the resident was independent and staff provided setup help only. Resident #78 had a Brief Interview of Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. During an interview, on 01/20/2020 at 11:03 AM, Resident #78 stated she goes to the restroom by herself. On 01/22/2020 at 11:30 AM, during an interview with Registered Nurse (RN) #3 and Licensed Practical Nurse (LPN) #1, both confirmed Resident #78 toilets herself. During an interview, with Certified Nursing Assistant (CNA) #2, on 01/22/2020 at 3:15 PM, she stated Resident #78 toilets herself. CNA #2 revealed staff only helped Resident #78 if she was sick or asked for help. An interview with RN #2/MDS Coordinator, on 01/23/2020 at 9:15 AM, revealed the care plan is updated after the completion of the MDS assessment, and the care plan should match the MDS. Resident #129 Record review revealed a care plan with a problem titled, " Activities of Daily Living (ADL) Function Impaired" as evidenced by (AEB)	F 657	with ADL□s according to the resident daily needs or the assistance requested for resident. 7. MDS nurses were in serviced by the Staff Educator 2/18/20 on updated the Bowel and Bladder status with every MDS according to the status coded 8. MDS nurses were in serviced by the Staff Educator 2/18/20 to include nail care provided on ADL Care- Plans. 9. Quality Assurance Nurse (QA) will audit ten ADL□s Care-Plans for nail care provided and that the care-plan instruct for staff to assist with ADL□s according to the residents daily need or assistance requested per resident, daily for one week, weekly for three weeks then monthly for two months thereafter until substantial compliance is achieved. 10. Risk Manager will audit All discharges on Friday in the weekly transmission meeting weekly for one month then monthly for two months thereafter until substantial compliance is achieved. 11. Risk manager will Audit Bowel and Bladder status and the updated care-plans for bowel and bladder status weekly beginning 2/28/20 in the transmission meeting prior to the submission of the MDS for one month then monthly for two months until substantial compliance has been met.	

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F 657	Continued From page 10 requires set up to extensive assistance due to Cerebrovascular Accident (CVA) with hemiplegia with left sided weakness, debility. The problem onset date was 08/24/2014. The goal revealed that Resident #129's needs will be met per staff that the resident is unable to meet. The care plan revealed no approach for care of Resident #129's finger nails. An observation, on 01/20/20 at 10:48 AM, revealed Resident #129's left hand and wrist contracted with long fingernails and pressing into her hand. The nails on her right hand where slightly longer than the end of her fingers. She stated that was the length she liked, but her left hand fingernails were way too long. On 01/22/20 at 10:45 AM, an observation and interview with the Director of Nursing (DON) confirmed Resident #129's fingernails on her left hand looked bad and could get her hands messed up. The DON stated the resident's long fingernails were not good at all. She confirmed the nurses should do the nail care and it should be on the care plan.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility policy review, the facility failed to provide oral care and fingernail care for one (1) of 30 residents reviewed for Activities of	F 677	1. Nail care was provided to resident #129 on 1/23/20 by the A Unit Manager, Registered Nurse	3/9/20

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F 677	Continued From page 11 Daily Living (ADL) care, Resident #129. Findings include: Review of the facility's "Finger Nail and Toe Nail Care", revised 11/28/2017, revealed, the nurse must trim the finger nails on the following residents: Diabetics, residents taking anticoagulant medication, and others, as appropriate or necessary. Nail care includes daily cleaning and regular trimming. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his/her skin. During an observation and interview, on 01/20/2020 at 10:48 AM, Resident #129 was observed sitting up in her wheelchair. Resident #129's left hand and wrist were contracted, with very long fingernails pressing into her hand. The nails on Resident #129's right hand extended slightly over the tips of her fingers. Resident #129 stated the nails on her right hand were the length she liked, but her left hand fingernails were way too long. An interview on 01/22/2020 at 10:30 AM, with Registered Nurse (RN) #1, revealed the nurses are responsible for trimming the residents' fingernails. RN #1 stated residents should get a skin audit every week. During an interview, on 01/22/2020 at 10:30 AM, in the presence of RN #1, Resident #129 stated her fingernails on her left hand were horrible. Resident #129 revealed she had asked several people to trim her nails and was told they would be back, but didn't come back. On 01/22/2020 at 10:35 AM, during an	F 677	2. A 100% audit was completed on each resident(s) nail care on 1/28/20 3. The facility has determined that all residents have the potential to be affected. 4. An Inservice was held 2/6/20 by the Staff Educator with all nurses and nursing assistants on Providing nail Care. 5. Quality Assurance (QA will monitor five residents weekly for four weeks and monthly for three months. Any discrepancy will be brought to QA committee monthly for further discussion and action.	

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	255269	A. BUILDING _____ B. WING _____	01/23/2020

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F 677	Continued From page 12 observation and interview with RN #1, she confirmed Resident #129's fingernails on her left hand needed to be clipped. RN #1 confirmed Resident #129's were too long and could cause skin breakdown due to her contracture. During an observation and interview, on 01/22/2020 at 10:45 AM, the Director of Nursing (DON) confirmed Resident #129's fingernails, on her left hand, looked bad and could mess her hands up. The DON stated Resident #129's long fingernails were not good at all.	F 677		
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 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		3/9/20

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F 690	Continued From page 13 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, and facility policy review, the facility failed to anchor the catheter during care to prevent trauma, for one (1) of six (6) catheter care observations, Resident #38. Findings include: Review of the facility's "Bladder and Bowel Habits, Urinary Incontinence and Catheter Care" policy, dated 05/29/2018, revealed catheter care shall be performed by nursing staff utilizing soap and water, and performed every shift or as needed. The policy did not address securing the catheter tube. During an observation of Resident #38's catheter care, on 01/22/2020 at 10:35 AM, Licensed Practical Nurse (LPN) secured the catheter tubing approximately 10 inches away from the point of entrance into the penis. LPN #4 cleaned the tubing from the entrance of tubing into the penis, down to the point of where the catheter was secured. On 01/22/2020 at 10:50 AM, during an interview,	F 690	1. On 1/28/20 The Registered Nurse (RN) assessed resident #38 the catheter was patent and intact and the resident did not have any signs and symptoms of Infection 2. On 1/28/20 Licensed Practical Nurse (LPN) #4 Passed her skill check off on Catheter care. 3. All residents with an indwelling Foley Catheter have the potential to be affected. 4. Between 1/23/20 and 2/18/20 All Nurses Passed their Skill check off on Catheter Care with the Staff Educator to include demonstration properly securing the Foley Catheter with a leg Strap 5. The staff educator will perform skill check off beginning 2/27/20 on five nurses weekly for four Weeks then five Nurses monthly for two months then Quarterly thereafter. Any discrepancies will be brought to Quality Assurance committee monthly or until substantial compliance	

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F 690	Continued From page 14 LPN #4 confirmed she secured the catheter approximately 10 inches from the base of the catheter entering the penis, and cleaned the tubing from the entrance into the penis, out to the point of where she was secured the catheter. LPN #4 revealed by not securing the catheter tubing at the base, she could have possibly caused the tube to pull and hurt the resident. LPN #4 revealed she wasn't sure if she had an in-service on catheter care because they have had so many and she couldn't remember. During an interview, on 01/22/2020 at 2:45 PM, the Director of Nursing confirmed the catheter tube should be secured at the meatus to prevent possible harm. Review of the facility's procedure on providing catheter care, undated, revealed, to hold the catheter near the meatus to avoid tugging the catheter. Review of the facility's "Skills Fair" check off list, dated October 17-18, 2019, revealed LPN #4 signed and was checked off on 10/17/2019, for meeting the requirement skills for catheter care.	F 690	has been met.	
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		3/9/20

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F 880	Continued From page 15 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 16 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, staff interview, and facility policy review, the facility failed to prevent the potential spread of infection as evidenced by touching Resident #38's furniture with contaminated gloves following care, for one (1) of 14 care observations. Findings include: Review of the facility's "Infection Control" policy, dated 11/28/2017, revealed, it is the facility's policy to operate in compliance with Environmental Protection Agency guidelines for the management of health care associated infections. During an observation, on 01/22/2020 at 10:35 AM, Licensed Practical Nurse (LPN) #4 performed catheter care for Resident #38. After cleaning Resident #38's catheter, LPN #4 opened the dresser drawer, using contaminated gloves,	F 880	1. On 1/23/20 The Registered Nurse (RN) assessed resident #38. The catheter was patent and intact and the resident did not have any signs and symptoms of Infection 2. Licensed Practical Nurse (LPN) #4 was in serviced on 2/18/20 by the staff educator on infection control during Catheter care. 3. All residents with an indwelling Foley Catheter have the potential to be affected. 4. By 2/18/20 all nurse were in-service by the Staff Educator on infection Control , proper hand washing and changing of gloves. during Catheter care. All Nurses will perform a skill check off on Catheter care and Infection Control with the Staff Educator beginning 2/27/20.	

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F 880	Continued From page 17 removed a plastic bag filled with wash cloths and towels and placed the plastic bag on the over-the-bed table. LPN #4 then removed her contaminated gloves. On 01/22/2020 at 10:50 AM, during an interview with LPN # 4, she confirmed after she cleaned Resident #38's catheter, used contaminated gloves to open a dresser drawer, removed a plastic bag of wash cloths and towels, and placed the bag on the over-the-bed table. LPN #4 stated she should have changed her gloves after cleaning Resident #38's catheter because her gloves were contaminated and could spread infection. During an interview, on 01/22/2020 at 2:45 PM, the Director of Nursing (DON) confirmed LPN #4 should have removed the contaminated gloves, after she completed Resident # 38's catheter care. Review of the facility's "Skills Fair" check off list, dated October 17-18, 2019, revealed LPN #4 signed and was checked off on 10/17/2019, for meeting the requirement skills for Infections.	F 880	5. The staff educator will perform skill check off beginning 2/27/20, on five nurses weekly for four Weeks then five Nurses monthly for two months then Quarterly thereafter. Any discrepancies will be brought to Quality Assurance committee monthly or until substantial compliance has been met.	

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	255269	A. BUILDING **01 - MAIN BUILDING 01 & 02** B. WING _____	**01/23/2020**

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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 | 02/25/2020

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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	255269	A. BUILDING **02 - BUILDING 02** B. WING _____	**01/23/2020**

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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		

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E 000	Initial Comments ********** Survey conducted on 01/23/20 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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