STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. BUILDING _____ B. WING _____	01/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD NURSING CENTER	1500 BROAD AVENUE GULFPORT, MS 39501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification from 1/13/19 through 1/16/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited the regulatory deficiencies F 637, F 657, F 690, F812, and F880. At the time of the survey, the census was 131 and the facility held a license for 151 beds.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to complete the comprehensive Minimum Data Set (MDS) for a resident with a significant change, and admission to Hospice in a timely manner, for one (1) of 29 MDS assessments reviewed. Resident #8. Findings include:	F 637	1. The Comprehensive Minimum Data Set (MDS) that was submitted for Resident #8 has passed the timeframe to be corrected. 2. All residents with a significant change and/or admission to Hospice have the potential to be affected. All residents requiring a significant change and/or admission to Hospice Minimum Data Set	3/6/19

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

Electronically Signed | 02/07/2019

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 637	Continued From page 1 A review of the facility's policy titled "(Facility Name) MDS Policy", dated 2/1/17, revealed federal regulations require that the assessment reflects the resident's status. Timing, scheduling, and completion of MDS assessments will be carried out per the guidelines set forth in the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual for Version 3.0. Review of the RAI User's Manual for Version 3.0, revealed a significant change MDS must be completed by the 14th calendar day after the significant change has been determined. On 1/14/19 at 3:25 PM, an interview with the Director of Nursing (DON) revealed the Social Service Director (SSD) is designated as the Hospice Coordinator. The DON also stated when there was a change in Resident #8's condition, the facility notified Hospice. A review of the physician orders, dated 10/2/17, revealed Resident #8 was admitted to Hospice on 10/2/17, with a diagnosis of Hypertensive Heart Disease with Heart Failure. Review of a Significant Change in Status Assessment (SCSA) MDS (for Hospice), revealed an Assessment Reference Date (ARD) of 10/17/17, which was 16 days from the change of status, which included admission to Hospice. The comprehensive care plan with an onset date of 10/2/17, included interventions for Hospice. On 1/16/19 at 10:14 AM, an interview with Registered Nurse (RN) #2, revealed she completed a SCSA and revised the comprehensive care plan when a resident is	F 637	(MDS) within the last 90 days have the potential to be affected. The Registered Nursing (MDS Coordinator) completed an audit of those assessments and timely submissions on 1/16/19 with no adverse findings. 3. The MDS Registered Nurse Coordinator and the Nursing Home Administrator will complete audits of the significant change and/or admission to Hospice assessments monthly to ensure the timeliness of these assessments. An audit flow sheet was initiated 2/1/19 by the MDS nurses. The MDS nurses were inserviced on the Comprehensive Assessment After Significant Changes regulatory compliance by an MSN, RN, RAC-CT Instructor by 2/1/19. 4. The findings of the audits will be submitted to the Quality Assurance Committee by the Nursing Home Administrator monthly for review and recommendations.	

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F 637	Continued From page 2 admitted to Hospice. RN #2 stated the SCSA should have been completed within 14 days after Resident #8 had gone on Hospice, however, RN #2 confirmed the SCSA was not done within 14 days, and was missed by two (2) days. RN #2 also stated she used the Resident Assessment Instrument (RAI) Manual for a guideline to code the MDS assessment. On 1/16/19 at 11:32 AM, an interview with the DON revealed she would expect the MDS to be completed on time. A review of the facility's Face Sheet revealed, the facility admitted Resident #8 on 3/1/13, with a diagnosis of Heart Disease.	F 637		
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	F 657		3/6/19

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F 657	Continued From page 3 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 comprehensive care plan related to catheter care, to include a securing device for the catheter, for one (1) of three (3) catheter care observations. Resident #4. Findings Include: A review of the facility's Care Plan Policy, dated 2/1/17, revealed, the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS) assessment. The comprehensive care plan will include measurable objectives and timeframes to meet the resident needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. Review of the Society of Urological Nurses and Associates Clinical Practice Guidelines, "Care of the Patient with an Indwelling Catheter", 2015, revealed: Secure the catheter to either the patient's thigh or the abdomen. This helps to decrease the risk of bleeding, trauma, meatal necrosis, an bladder spasms from pressure and	F 657	1. The Care Plan Registered Nurse updated the Comprehensive Care Plan to indicate use of the leg strap and/or device to secure the catheter tubing for Resident #4 on 1/16/19. 2. All residents with an indwelling catheter have the potential to be affected. 3. The Care Plan Nurse will implement the care plan approach to ensure placement of the leg strap when there is an indwelling catheter in use. The unit nurse will be responsible for monitoring per shift the leg strap and/or device securing the catheter tubing via a nursing measure in the resident's Electronic Health Record (EHR) stating to check placement for catheter leg strap every shift. The Quality Assurance Nurse will monitor the completion of the EHR and Care Plan for compliance weekly. 4. The Quality Assurance Nurse will bring the monitoring findings to the monthly Quality Assurance/Care Plan meeting for review and recommendations.	

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F 657	Continued From page 4 traction. Review of the facility's Incontinent Care/Foley Catheter Care Checklist, not dated, revealed the Foley catheter care procedures included checking for the leg strap. A review of the Comprehensive Care Plan for Resident #4 revealed the Care plan was updated on 3/19/2018, to insert a 16 French indwelling catheter and to provide catheter care per facility policy. The care plan failed to include the use of a catheter strap and/or securing device to secure the catheter tubing. Observation of catheter care on 01/15/19 at 10:00 AM, with Certified Nursing Assistant (CNA) #1, revealed Resident #4 had a Foley catheter, but did not have a catheter strap or securing device in place. In an interview on 01/15/19 at 10:05 AM, CNA #1 confirmed Resident #4 did not have a catheter strap. CNA #1 also confirmed the strap was not in the bed or room. CNA #1 also stated that the night shift must have removed the catheter strap after care was provided. CNA #1 said the resident needed the strap to prevent trauma and to keep the catheter from coming out. During an interview on 01/16/19 at 9:35 AM, Registered Nurse (RN) #2 said she thought the catheter strap was documented as an intervention on the care plan. RN #2 said the catheter strap should have been documented on the care plan. During an interview on 01/16/19 10:35 AM, the Director of Nursing (DON) stated she thought the	F 657		

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F 657	Continued From page 5 catheter strap was an intervention on the care plan. A review of the facility's face sheet revealed the facility admitted Resident #4 on 9/19/2017, with diagnoses of Benign Prostatic Hyperplasia, Overactive Bladder, and Urine Retention. A review of Resident #4's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/07/2018, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had cognitive impairment.	F 657		
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	F 690		3/6/19

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F 690	Continued From page 6 (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, resident interview, staff interview, record review, and facility policy review, the facility failed to ensure the resident had a securing device for the catheter tubing for one (1) of three (3) residents for catheter care observations, Resident #4. Findings include: A review of the facility's policy for "(Facility Name) Catheter Care Policy" dated 3/1/17, revealed, it is the policy of this facility to provide catheter care to all residents that have an indwelling catheter in an effort to reduce bladder and kidney infection. Review of the Society of Urological Nurses and Associates Clinical Practice Guidelines, "Care of the Patient with an Indwelling Catheter", 2015, revealed: Secure the catheter to either the patient's thigh or the abdomen. This helps to decrease the risk of bleeding, trauma, meatal necrosis, an bladder spasms from pressure and traction. Review of the facility's Incontinent Care/Foley Catheter Care Checklist, not dated, revealed the	F 690	1. The Director of Nurses assessed Resident #4 for adverse findings due to not having a leg strap on 1/16/19. The Director of Nurses did not find any negative outcomes and applied a catheter leg strap to Resident #4 on 1/16/19. Certified Nurse Aide #1 was inserviced on Resident #4 having a leg strap on 1/16/19 by the Director of Nurses. 2. All residents with an indwelling catheter have the potential to be affected. 3. All Certified Nurse Assistants will be inserviced on residents with indwelling catheters needing a leg strap was initiated on 1/16/19 and completed by 2/22/19 by the Director of Nursing. The unit nurse will be responsible for monitoring per shift the leg strap and/or device securing the catheter tubing via a nursing measure in the resident's Electronic Health Record (EHR) for any resident with an indwelling catheter. The Quality Assurance Nurse will monitor the leg strap compliance and completion of the EHR for compliance weekly.	

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F 690	Continued From page 7 Foley catheter care procedures included checking for the leg strap. A review of the facility Physician Orders dated January 2019, revealed Resident #4 had orders for a 16 French Indwelling Foley catheter related to Urinary Retention, initiated 5/22/2018, and to provide catheter care per facility policy. An observation of catheter care with Certified Nursing Assistant (CNA) #1, on 01/15/19 at 10:00 AM, revealed Resident #4 did not have a catheter strap and/or securing device to anchor the catheter tubing. In an interview, on 01/15/19 at 10:05 AM, CNA #1 confirmed Resident #4 did not have a catheter strap/securing device in place or in the room. CNA #1 stated she had not provided catheter care for the resident today and that the night shift must have removed the catheter strap after care was provided. CNA #1 said the resident needed the strap to prevent trauma and to keep the catheter from coming out. In an interview on 01/16/19 at 9:24 AM, Registered Nurse (RN) #1 confirmed the facility policy was not followed if Resident #4 did not have a catheter strap in place. An interview on 01/16/19 at 10:35 AM, with the Director of Nursing (DON), confirmed the staff did not follow the facility policy by making sure Resident #4 had a catheter strap on all times to keep the catheter from coming out and/or causing trauma to the meatus. A review of the facility's face sheet revealed the facility admitted Resident #4 on 9/19/2017, with	F 690	4. The Quality Assurance Nurse will bring the monitoring findings to the monthly Quality Assurance/Care Plan meeting for review and recommendations.	

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F 690	Continued From page 8 diagnoses of Benign Prostatic Hyperplasia, Overactive Bladder, and Urine Retention. A review of Resident #4's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/07/2018, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had mild cognitive impairment.	F 690		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and facility policy review, the facility failed to follow proper safe/sanitation practices to reheat food to the proper serving temperature of at least 165 degrees, prior to serving; and to prevent contamination of food by not cleaning the	F 812	1. No specific resident was involved in this deficiency, as the food was discarded immediately by the Certified Dietary Manager (CDM) and not served. The cook was inserviced on 1/14/19 by the CDM.	3/6/19

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F 812	Continued From page 9 thermometer in between checking each food item on the steamtable for one (1) of three (3) kitchen observations, which had the potential to affect all residents in the facility who received a food tray. Findings Include: A Review of the facility policy, titled "Resource: Taking Accurate Temperatures", dated 2013, revealed the digital thermometer is usually battery powered, takes only a few seconds to register the temperature, and the sensor is near the tip of the probe. To take temperatures, clean, rinsed, sanitized and air-dried thermometer that is the metal stem type is needed. Should the thermometer have a tube type cover, it must be sanitized as indicated for the thermometer. To take hot food temperatures, insert the thermometer at a 45 degree angle to the middle of the food item, taking care not to touch the container or bone if applicable. Wait for the thermometer to rise to the maximum temperature from the food item, and immediately clean and sanitize. A review of the facility policy, titled, "Food Temperatures", dated 2013, revealed all hot foods must be cooked to appropriate temperatures, held, and served at a temperature of at least 135 degrees. Take temperatures often to monitor for safe food holding temperature ranges at or above 135 degrees for hot foods. Cooking temperatures must be reached and maintained according to regulations, laws, and standardized recipes while cooking. Hot food items may not fall below 135 degrees after cooking, unless it is an item which is to be rapidly cooled to below 41 degrees and reheated to at least 165 degrees prior to serving.	F 812	2. All residents of the facility that eat the prepared food have the potential to be affected. 3. An inservice was conducted by the Certified Dietary Manager with all dietary personnel by 1/18/19 on the policies Critical Temperatures for Safe Food Handling and the Taking Accurate Food Temperatures. An audit of taking temperatures correctly (by staff demonstration) was initiated and monitored for compliance for daily on 1/28/19 by the Dietary Manager. An audit of reheating food correctly (by staff demonstration) was initiated and monitored for compliance for daily on 1/28/19 by the Dietary Manager. An audit of taking temperatures correctly and reheating food correctly with monitoring for compliance for weekly will be initiated on 3/1/19 by the Dietary Manager. 4. The audit results will be submitted by the Dietary Manager to the weekly Quality Assurance Committee for review and recommendations. The dietary staff will be inserviced by the Dietary Manager quarterly on Taking Accurate Food Temperatures and Safe Food Handling policies.	

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F 812	Continued From page 10 A review of the facility policy titled, "Resources, Critical Temperatures for safe Food Handling", dated 2013, revealed to reheat left-over foods one (1) time. During an observation or steam table temperatures, on 1/14/19 at 11:31 AM, taken by Dietary Staff Member (DSM) #2/Cook, with the Dietary Manager (DM) and DSM #3 present, revealed DSM #2 allowed the plastic handle on the thermometer to touch the food while checking the temperature for all of the food items. The ham temperature was 130.8 degrees. Four (4) minutes after reheating the ham in the steam oven, DSM #3 stated the temperature was 149 degrees. DSM #3 put several pieces of ham in a pot on the stove for about three (3) minutes and placed the ham on a regular plate. The temperature of the ham at that time was 160 degrees. During an interview on 01/16/19 at 9:57 AM, with the DM confirmed DSM #2 failed to prevent the possible spread of food bourne illness by placing the thermometer plastic handle in the food. The DM stated that DSM #2 has been trained to put the thermometer one (1) to two (2) inches in the food; the staff member should not allow the handle to go into the food. DM #1 confirmed DSM #3 failed to follow the facility policy by rewarming the food twice and serving the ham at less than 165 degrees or greater. An interview on 01/16/19 at 10:11 AM, with DSM #3/Assistant Manager, confirmed the ham was reheated twice and that the temperature did not reach 165 degrees or greater. DSM #3 stated that he should have left the ham in the oven until the temperature reached 165 degrees or above.	F 812		

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F 812	Continued From page 11 During an interview on 01/16/19 at 10:14 AM, the Administrator confirmed since DSM #2 placed the thermometer handle in the food, policy was not followed. The Administrator stated that DSM #3 failed to follow the facility policy by reheating the food twice and not allowing the ham to reach a temperature of 165 degrees or greater. A review of the facility "Record of In-service Training and Attendance Form", dated 1/13/19, revealed DSM #2 was trained to wipe the Thermometer between testing each item of food and trained in safe food preparation, which included cooking internal temperatures: Poultry 165, ground meats 155, fish and other meats 145 and eggs 145 degrees.	F 812		
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: §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	F 880		3/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. BUILDING _____ B. WING _____	01/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD NURSING CENTER	1500 BROAD AVENUE GULFPORT, MS 39501

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F 880	Continued From page 12 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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	255290	A. BUILDING _____ B. WING _____	01/16/2019

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F 880	Continued From page 13 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, record review and policy review, the facility failed to prevent cross contamination when providing catheter care, for one (1) of three (3) resident catheter care observations, Resident #74. Findings include: A review of the facility's policy titled "(Facility Name) Care Policy", dated 3/1/17, revealed it is the policy of this facility to provide catheter care to all residents that have an indwelling catheter in an effort to reduce bladder and kidney infection. On 1/15/19 at 9:13 AM, an observation of catheter care for Resident #74, provided by Certified Nursing Assistant (CNA) #3, revealed he washed his hands, applied clean gloves, filled a basin with soapy water and filled another basin with clear water and turned the water off with these same gloved hands. CNA #3 then emptied the catheter drainage bag with the same gloved hands. CNA #3 washed his hands and applied clean gloves, then pulled Resident #74's covers back and with the same gloved hands, CNA #3 provided perineal care to Resident #74, washing the penial area, while holding the catheter near the penis area. On 1/16/19 at 8:00 AM, an interview with CNA #3	F 880	1. The Director of Nurses assessed Resident #74 for adverse findings 1/16/19. The Director of Nurses did not find any negative outcomes and assigned a Certified Nursing Assistant to provide catheter care according to policy. Certified Nurse Aide #3 was inserviced by the Director of Nurses on proper catheter care and following facility policy on 1/16/19. 2. All residents with an indwelling catheter have the potential to be affected. 3. The Director of Nurses developed a Quality Assurance Performance Improvement(QAPI) to include return demonstration monitoring employees providing catheter care on a monthly basis on 2/1/19 ongoing. All employees providing catheter care will be inserviced on a quarterly basis for catheter care and infection control by the Quality Assurance Nurse. 4. The Director of Nurses will bring the QAPI findings to the monthly Quality Assurance meeting for review and recommendations.	

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	255290	A. BUILDING _____ B. WING _____	01/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD NURSING CENTER	1500 BROAD AVENUE GULFPORT, MS 39501

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F 880	Continued From page 14 revealed, "Yes, there is a problem with using the same gloved hands to pull Resident #74's covers back and begin catheter care." CNA #3 confirmed that was a cross contamination issue. On 1/16/19 at 8:15 AM, an interview with the Director of Nursing (DON), revealed there was a problem with using the same gloved hands to pull Resident #74's covers back and then immediately begin catheter care using those same gloved hands; that is cross contamination. On 1/16/19 at 11:25 AM, an interview with RN #3 revealed there is a problem with using the same gloved hands to pull covers back and begin catheter care. RN #3 stated CNA #3 should have changed his gloves, because he went from dirty to clean when he provided the catheter care for Resident #74. A review of the facility's Face Sheet revealed, the facility admitted Resident #74 on 4/19/16, with diagnoses of Malignant Neoplasm of Prostate and Retention of Urine.	F 880		

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	255290	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD NURSING CENTER	**1500 BROAD AVENUE** **GULFPORT, MS 39501**

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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 | 02/06/2019

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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DRIFTWOOD NURSING CENTER	1500 BROAD AVENUE GULFPORT, MS 39501

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 1/22/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

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