STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255250	A. BUILDING _____ B. WING _____	10/10/2019

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MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST/P. O. BOX 459 MORTON, MS 39117

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey from 10/7/2019 to 10/10/2019, along with Complaint Investigation (CI) MS #15844 and MS #16029. CI MS #15844 was not substantiated for abuse/neglect with no cited deficiencies related to the complaint. CI MS #16029 was substantiated for elopement with no cited deficiencies, as the resident had shown no exit-seeking behaviors and was not assessed to be an elopement risk. The SA determined, during the survey, the facility was not in compliance with Medicare and Medicaid requirements of participation and cited the regulatory deficiencies at F656, F690, F693, and F880. The facility had a census of 113, with 120 licensed beds.	F 000		
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	F 656		11/15/19

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

Electronically Signed | 10/28/2019

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 656	Continued From page 1 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 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, record review, facility policy review, and staff interview, the facility failed to implement the care plan for three (3) of 26 care plans reviewed, for Resident #15, Resident #49, and Resident #64. Findings include: Review of the undated facility policy, "Comprehensive Resident Centered Care Plans", under the subtitle, "Develop/Implement Comprehensive Care Plan", revealed the facility will develop and implement a comprehensive person-centered care plan for each resident,	F 656	1 a. Resident #15 refused for a dry dressing to be placed on his indwelling catheter site by the Charge Nurse on 10/9/19. The dry dressing was discontinued on 10/10/19 and updated on the care plan to reflect Resident #15's wishes. Resident #64's care plan was updated to reflect the clarification order. b. Resident #49 had a leg strap applied by the Charge Nurse on 10/9/19. The Charge Nurse reassessed the catheter tubing and found it to be on top of the lowered rail and below the level of the bladder.	

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F 656	Continued From page 2 consistent with the resident's rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment. Resident #49 Review of Resident #49's current Care Plan, revealed that the problem of a frequent Urinary Tract Infection (UTI), with an onset date of 10/12/2017. The Care Plan revealed the resident had an indwelling Foley catheter. Resident #49's Care Plan noted an intervention for the catheter tubing to be secured with a leg band. During an observation of catheter care, on 10/9/19 at 10:45 AM, Resident #49 had no catheter tubing securing device or leg band in place. Resident #49's catheter tubing was caught underneath the side rail of the bed. Resident #49 complained that sometimes the tubing would get caught under the side rail of the bed and pull. Certified Nursing Assistant (CNA) #1 completed the catheter care without putting a leg band in place to secure the catheter tubing. During an interview, on 10/9/2019 at 11:12 AM, Registered Nurse (RN) #1/Assistant Director of Nursing (ADON) confirmed Resident #49 should have a catheter tube securing device on. The ADON stated there is a possibility that he could have removed the strap, but he was not absolutely sure why Resident #49 did not have a securing device for the catheter tubing. During an interview, on 10/9/2019 at 10:50 AM, CNA #1 confirmed that the resident was not wearing a device or leg band to secure the catheter tube, when the catheter care was	F 656	c. Resident #64's gastrostomy tube site was covered with a 4X4 abdominal dressing per orders on 10/9/19 by the Charge Nurse. 2 All residents with gastrostomy tubes and catheters have the potential to be affected. All resident's care plans with gastrostomy tubes, and catheters have been reviewed by the Director of Nursing on 10/28/19 and found to be accurate. 3 a. A clarification order for Resident #64 was written by the Director of Nursing on 10/28/19 to specify the correct type of dressing to be applied to the gastrostomy tube site which was a split 4X4. b. The Nursing staff will be in-serviced on 10/29/19 by the Staff Development Nurse regarding following the care plan to direct the Resident's care. c. The Care Plan Policies and Procedures were reviewed by the Director of Nursing on 10/28/19 with no changes made. d. Starting 11/4/19, The Care Plan Audit will be performed weekly by the Director of Nursing for four weeks, monthly for three months, then quarterly. This audit will ensure that care plans are updated to reflect Resident's care as ordered by the Physician. 4 a. The Director of Nursing will report Care Plan audit findings to the Quality Assurance Committee to ensure continued compliance. The Quality Assurance Committee will make recommendations and changes as needed.	

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F 656	Continued From page 3 completed on Resident #49. CNA #1 stated she wasn't sure why there was no device, but maybe the resident took it off before she went in to do care. During an interview, on 10/9/2019 at 2:27 PM, Resident #49, stated that he hasn't had a strap on his leg to hold the catheter tubing in place for quite a while. Resident #49 stated that someone had put something like a butterfly dressing on his leg to hold the tubing in place, just after his care was finished today and stated, "But it didn't last long, as a matter of fact, it's loose right now". Resident #15 A review of the care plan, initiated 10/14/14, revealed Resident #15 had a suprapubic catheter/activity of daily living (ADL) care plan, with interventions to clean the suprapubic catheter site with soap and water daily and as needed. Another intervention included to clean around suprapubic catheter site with soap and water and apply dry dressing. An observation on 10/09/19 at 9:48 AM, revealed CNA #1 entered Resident #15's room to provide catheter care. CNA #1 had no pattern at any time during the care process of where the clean from dirty was on the wash cloth during care, because of the tossing of the cloth in her hand. CNA #1 did not perform hand hygiene before catheter care or after cleaning the tubing and before drying the tube with a clean cloth. CNA #1 did not follow the care plan for placing a dressing on the site. During an interview on 10/10/19 at 8:35 AM, CNA #1 stated she felt like she did follow the care plan because she did the care right. CNA #1 stated she should have been more specific with the	F 656		

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F 656	Continued From page 4 areas on the wash cloth in cleaning the catheter tubing. During an interview on 10/10/19 at 09:15 AM, RN #2 stated that her expectation was for all staff to follow the care plan. RN #2 stated that she felt that CNA #1 did not follow the care plan for Resident #15. Resident #64 A review of the Comprehensive Care Plan, initiated 11/9/16, titled "Food and Nutrition", revealed Resident #64 had a Gastrostomy (G)-tube with an intervention: "I need the nurse to clean my G-tube site as ordered and as needed". A review of the physician's orders revealed Resident #64 had current orders, dated 7/5/19, to clean the G-tube site with normal saline, pat dry, apply Bactroban to area every shift and as needed. Cover with a 4 x 4 ADM (Abdominal) dressing and secure with tape. An observation on 10/09/19 at 9:35 AM, revealed Licensed Practical Nurse (LPN) #1 provided Gastrostomy (G)-tube care. LPN #1 removed the soiled dressing from the G-tube stoma and discarded it into a clear bag; and without hand hygiene or changing gloves, LPN #1 obtained a 4 x 4 gauze, placed normal saline on the gauze, and patted the stoma in several places and then turned the gauze over and wiped an area of the stoma again. LPN #1 obtained a dry 4 x 4 and patted the stoma dry touching some areas on the stoma twice. LPN #1 changed gloves without performing hand hygiene, obtained a long Q-tip applicator, applied Bactroban ointment to the stoma site, and covered the stoma site with a	F 656		

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F 656	Continued From page 5 drain gauze (not the ADM). During an interview on 10/09/19 at 04:56 PM, LPN #1 stated when asked if she felt as if she had followed the care plan for Resident #64 during stoma care, LPN #1 shook her head "no". During an interview on 10/10/19 at 09:15 AM, Registered Nurse (RN) #3/Care Plan Nurse stated her expectation was for all staff to follow the care plan. RN #3 stated that she didn't feel like LPN #1 followed the care plan. During an interview, on 10/10/2019 at 9:29 AM, Registered Nurse (RN) #2/Minimum Data Set (MDS) and Care Plan Nurse, revealed the expectation is to follow the interventions listed on the care plan for each and all disciplines. During an interview, on 10/10/19 at 09:35 AM, the Director of Nursing (DON) stated that it is her expectation for staff to follow the care plan. On further interview, on 10/10/19 at 9:54 AM, the DON confirmed that any intervention or area of care listed on the resident's person-centered care plan should be followed. The DON stated that each discipline is in-serviced about a resident's care plan and participates in the decision-making process.	F 656		
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	F 690		11/15/19

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F 690	Continued From page 6 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 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, record review, facility policy review, and resident/staff interview, the facility failed to provide appropriate care and services to prevent possible urinary tract infections for two (2) of three (3) catheter care observations, for Resident #15 and Resident #49. Findings include:	F 690	1 a. Resident #15 refused for a dry dressing to be placed on his indwelling catheter site by the Charge Nurse on 10/9/19. The dry dressing was discontinued on 10/10/19 and updated on the care plan to reflect Resident #15's wishes. b. Resident #49 had a leg strap applied by the Charge Nurse on 10/9/19.	

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F 690	Continued From page 7 Review of the undated facility's, "Catheterization", policy revealed a device will be used to maintain proper placement and positioning. The facility policy also noted that catheter care should be done with soap and water every shift and as needed (PRN), unless otherwise indicated by the physician. Resident #49 Review of Resident #49's October 2019 Physician's Orders, revealed an order to monitor the leg band (catheter tube securing device) every (Q) shift for proper placement, with a start date of 4/23/2018. Resident #49's care plan, initiated 10/12/17, also revealed the resident should have a leg band in place to secure the catheter. During an observation on 10/9/19 at 10:45 AM, Certified Nursing Assistant (CNA) #1 performed catheter care for Resident #49. There was no catheter tubing securing device in place and the catheter tubing was caught underneath the side rail of the bed. Resident #49 complained that sometimes the tubing would get caught under the bed side rail. CNA #1 performed the catheter care for the resident and failed to place a leg band or securing device in place after care. During an interview, on 10/9/2019 at 11:12 AM, Registered Nurse (RN) #1/Assistant Director of Nursing (ADON) revealed the resident should have a securing device (leg band) to secure the catheter tubing. The ADON stated there was a possibility that Resident #49 could have removed the strap, but he was not sure why the resident did not have a securing device for the catheter tubing.	F 690	The Charge Nurse reassessed the catheter tubing and found it to be on top of the lowered rail and below the level of the bladder. Facility has a total of three indwelling catheters. 2 a. All residents with indwelling catheters have the potential to be affected. 3 a. An in-service will be done on 10/29/19 by the Staff Development Nurse for all nursing staff on catheter care for proper infection control technique during catheter care. b. Beginning 11/4/19, The Catheter Care Audit will be done by the Director of Nursing every week for four weeks, monthly for three months, then quarterly. The audit will ensure that catheter care is being provided according to the Physician's order and that proper infection control procedures are followed. c. The Catheter Care Policy was reviewed by the Director of Nursing on 10/28/19 with no changes necessary. 4 The Catheter Care Audit findings will be reported to the Quality Assurance Committee by the Director of Nursing to ensure continued compliance. The Quality Assurance Committee will make recommendations and changes as needed.	

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F 690	Continued From page 8 During an interview, on 10/9/2019 at 10:50 AM, CNA #1 confirmed Resident #49 was not wearing a leg band to secure the catheter tubing. CNA #1 stated she wasn't sure why there was no device, but maybe Resident #49 removed the device before she went in to do care. During an interview, on 10/9/2019 at 2:27 PM, Resident #49 stated there had not been a strap on his leg to hold the catheter tubing in place for quite a while. Resident #49 stated that someone had put something like a butterfly dressing on his leg to hold the tubing in place, just after his care was finished, and the State Agency (SA) had left the room that morning. Resident #49 stated, "But it didn't last long, as a matter of fact, it's loose right now." During an interview, on 10/10/2019 at 9:29 AM, Registered Nurse (RN) #2/Minimum Data Set (MDS) and Care Plan Nurse confirmed the care was expected to be provided per orders/care plan. During an interview, on 10/10/2019 at 9:54 AM, the Director of Nursing (DON) confirmed that any intervention or area of care listed on the resident's person-centered care plan should be followed. Resident #15 A review of current physician's orders, intimated 12/01/14, revealed to provide Resident #15's catheter care every shift with soap and water and as needed. Orders, intimated 2/2/16, revealed to clean around the catheter with soap and water and apply a dressing. An observation 10/09/19 at 9:48 AM, revealed	F 690		

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F 690	Continued From page 9 CNA #1 entered Resident #15's room to provide catheter care. The CNA did not make it know if she had performed hand hygiene prior to the process. CNA #1 tossed the wash cloth multiple times in the air, letting it fall into her hand, making it difficult to determine if the same area of the cloth was used. CNA #1 had no pattern at any time during the care process of where the clean from dirty was on the wash cloth, because of the tossing of the cloth in her hand. CNA #1 did not perform hand hygiene before catheter care or after cleaning the tubing and before drying the tube with a clean cloth. CNA #1 did not place a dressing on the site. A review of a facility document titled "Clinical Skills Competency check off", dated 10/25/18, revealed CNA #1 received a check- off in performing catheter care. During an interview on 10/10/19 at 8:35 AM, CNA #1 stated that she should have made it known that she washed her hands before starting care. CNA #1 stated that she should have been more specific with the areas on the wash cloth in cleaning the catheter tubing; not being able to identify the area on the cloth could have spread germs. During an interview on 10/10/19 at 8:42 AM, Registered Nurse (RN) #3 stated that CNA #1 wiping more than once with the same cloth, and tossing the cloth, not knowing the exact location on the cloth that she had just used, could have caused cross contamination. RN #3 stated it certainly could have increased the risk of infection. During an interview on 10/10/19 at 9:00 AM, the	F 690		

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F 690	Continued From page 10 Director of Nursing (DON) stated that CNA #1's technique was wrong in providing catheter care for Resident #15. She stated that CNA #1 tossing the cloth in her hand and wiping several times could have caused cross contamination; it could have caused an infection.	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to provide care to a Gastromy (G) tube site in a manner to prevent infection, and failed to follow the physician's order to apply the correct G-tube	F 693	1 Resident #64's order for a gastrostomy dressing change was clarified on 10/28/19 by the Director of Nursing. Licensed Practical Nurse #1 will be in-serviced on 10/29/19 on proper	11/15/19

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F 693	Continued From page 11 dressing for one (1) of two (2) observations of G-tube care, Resident #64 Findings Include: Review of facility's "Tube Feedings" policy, undated, revealed, "All tube feedings will be administered in accordance with verified medical necessity, established infection control policies and procedure and physician's orders. Site care will be provided per a physician's order". A review of physician's order, dated 7/5/19, revealed Resident #64 has orders to clean the G-tube site with normal saline, pat dry, apply Bactroban to the area every (Q) shift and as needed (PRN). Cover with a 4 x 4 secure Abdominal (ADM) dressing and secure with tape. An observation on 10/09/19 at 9:35 AM, revealed Licensed Practical Nurse (LPN) #1 entered Resident #64's room, used hand sanitizer, gloved, and removed Resident #64's abdominal binder. LPN #1 removed the soiled dressing from the G-tube stoma and discarded it in a clear bag. LPN #1 obtained a 4 x 4 gauze, placed normal saline on the gauze, and patted the stoma in several places, then turned the gauze over and wiped an area of the stoma again. LPN #1 obtained a dry 4 x 4 and patted the stoma dry, touching some areas on the stoma twice. LPN #1 removed gloves, and without performing hand hygiene, applied clean gloves, then obtained a long Q-tip applicator, applied Bactroban ointment to the stoma site and covered the stoma site with a drain gauze, not the ADM dressing as ordered. During an interview on 10/09/19 at 4:56 PM, LPN	F 693	gastrostomy dressing change technique. Facility has a total of four Residents with gastrostomy tubes at this time. 2 a. All residents with gastrostomy tubes have the potential to be affected. All resident's orders containing gastrostomy tube dressing changes have been reviewed by the Director of Nursing on 10/28/19 and found to be accurate. 3 a. The Infection Control Policy and Procedure regarding dressing changes was reviewed by the Director of Nursing on 10/28/19 with no changes necessary. b. An in-service will be done on 10/29/19 by the Staff Development Nurse on gastrostomy care for proper infection control technique. This in-service will be for all nursing staff. c. Beginning on 11/4/19, The Gastrostomy Care Audit will be done by the Director of Nursing every week for four weeks, monthly for three months, then quarterly. The audit will ensure that gastrostomy tube care is being done by our nurses according to the Physician's orders and that infection prevention procedures are being followed. 4 a. The Gastrostomy Care Audit will be reported by the Director of Nursing to the Quality Assurance Committee (QA) to ensure continued compliance. The Quality Assurance Committee will make recommendations and changes as needed.	

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	255250	A. BUILDING _____ B. WING _____	10/10/2019

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F 693	Continued From page 12 #1 revealed that she should have performed hand hygiene after removing the soiled dressing and before cleaning the stoma site, after cleaning the stoma site and before applying the clean dressing to the stoma, after she took her gloves off, and before putting on clean gloves. LPN #1 stated she should have wiped the stoma site with the gauze in one direction and then threw the gauze away during both cleaning and drying the stoma site. LPN #1 stated she remembered patting the stoma site, but didn't realize she touched the cleaned areas more than once. A review of a document, provided by the facility, titled "Annual Clinical Skills Check-off for Nurses", dated 8/26/19, revealed, LPN #1 received a check-off in providing Enteral Feeding and Care (dressing change). During an interview on 10/10/19 at 9:55 AM, Registered Nurse (RN) #3 stated LPN #1 should have wiped from the inner of the stoma wound to the outer area of wound, using one sweep, and then discarded the gauze. RN #3 stated, "We don't teach patting a stoma". RN #3 stated any time you take your gloves off and perform a different procedure you're supposed to wash your hands. During an interview on 10/10/19 at 09:05 AM, the Director of Nursing (DON) stated LPN #1's technique for cleaning the stoma was not what the facility teaches.	F 693		
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	F 880		11/15/19

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F 880	Continued From page 13 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880		

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F 880	Continued From page 14 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to prevent the possible spread of infection when providing care for two (2) of four (4) resident care observations, Resident #64 for Gastrostomy (G) tube care, and Resident #15 for catheter care. Findings Include: Review of facility's "Infection Control Program: Prevention and Control of Transmission of Infection-Standard Precautions", undated, revealed: Standard precautions are based upon the principle that all blood, body fluids, secretions,	F 880	1 a. Resident #64's gastrostomy tube care was performed correctly on 10/10/19 by the Resident's assigned nurse, after being made aware on 10/10/19 of improper technique on 10/9/19. b. Resident #15's catheter care was performed correctly on 10/10/19 by the resident's Certified Nursing Assistant (CNA) after being made aware on 10/10/19 of improper technique on 10/9/19. 2 All residents with gastrostomy tubes and catheters have the potential to be affected.	

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F 880	Continued From page 15 excretions, non-intact skin, and mucous membranes may contain transmissible infectious agents. This precaution is applied to the care of all persons in the healthcare settings, regardless of suspected or confirmed presence of an infected agent. Hand hygiene is the primary means and is critical in preventing the transmission of infections. Hand hygiene is required: when coming on duty; before and after direct contact with residents; before and after changing a dressing; after contact with a resident's mucous membranes and body fluids or excretions; after handling soiled or used linens, dressings, bedpans, catheters or urinals; after removing gloves". A review of a document provided by the facility titled, "Hand Hygiene" undated, revealed employees may use alcohol-based hand sanitizer before handling clean or soiled dressings, gauze pads, and contaminated equipment, etc. Resident #15 An observation on 10/09/19 at 9:48 AM, revealed Certified Nurse Aid (CNA) #1 entered Resident #15's room to provide catheter care. CNA #1 did not identify hand hygiene before beginning care. CNA #1 obtained a basin of water and placed it on the over-bed table on a barrier. CNA #1 gloved, took a wash cloth, secure tubing at the meatus, applied soap to the open cloth and wiped upward on the tubing away from the meatus. CNA #1 flipped the open cloth up in the air and around in her hand, wiped a second time upward on the cloth, flipped the cloth again in the air and wiped the tubing upward the third time before discarding the cloth. CNA #1 opened a clean dry wash cloth in her hand, secured the tubing at the meatus, and wiped once upward on the tubing away from	F 880	3 a. Resident #15 was assessed on 10/10/19 by the Director of Nursing and found capable of providing his own catheter care.The care plan was revised on 10/10/19 for Resident #15 to perform his own catheter care per Resident's request. b. Infection Prevention Policies and Procedures were reviewed on 10/10/19 by the Director of Nursing with no revisions needed. c. An in-service will be provided for nursing staff on gastrostomy and catheter care on 10/29/19 by the Staff Development Nurse. d. Beginning 11/4/19, The Gastrostomy Care Audit and the Catheter Care Audit will be performed weekly by the Director of Nursing for four weeks, monthly for three months, then quarterly. These audits will ensure that catheter care and gastrostomy tube care is being provided according to Physician's orders and that proper infection prevention procedures are being followed. 4 a. The Gastrostomy Care and Catheter Care Audits will be reported to the Quality Assurance Committee by the Director of Nursing to ensure continued compliance. The Quality Assurance Committee will make recommendations and changes as needed.	

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F 880	Continued From page 16 the meatus. CNA #1 flipped the cloth in her hand and wiped the tubing a second time away from the meatus. CNA #1 flipped the cloth a third time and missed catching the cloth flat in her hand allowing the cloth to fall halfway out of her hand. CNA straightened the cloth in her hand and continued wiping the tubing. CNA #1 had no pattern at any time during the care process of where the clean from dirty was on the wash cloth because of the tossing of the cloth in her hand. CNA #1 did not perform hand hygiene before catheter care or after cleaning the tubing, and before drying the tube with a clean cloth. During an interview on 10/10/19 at 8:35 AM, CNA #1 stated that she should have made it known she washed her hands before starting care. CNA #1 stated that she should have been more specific with the areas on the wash cloth in cleaning the catheter tubing. She stated, not being able to identify the area on the cloth could have spread germs. During an interview on 10/10/19 at 8:42 AM, Registered Nurse (RN) #3 stated CNA #1 wiping more than once with the same cloth and her tossing the cloth, not knowing the exact location on the cloth that she had just used, could have caused cross-contamination. RN #3 stated it certainly could have increased the risk of infection. During an interview on 10/10/19 at 9:00 AM, the Director of Nursing (DON) stated CNA #1's technique was wrong in providing catheter care for Resident #15; the CNA tossing the cloth in her hand and wiping several times could have caused cross contamination and caused an infection.	F 880		

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F 880	Continued From page 17	F 880		

Resident #64
During an observation, on 10/09/19 at 9:35 AM, LPN #1 entered Resident #64's room to provide G-tube care. LPN #1 placed supplies on a tray then placed the tray on an over-bed table. LPN #1 placed an opened clear bag on the over bed table (not a red biohazard bag). LPN #1 used hand sanitizer, gloved, and removed Resident #64's abdominal binder. LPN #1 removed the soiled dressing from the G-tube stoma and discarded in the clear bag. LPN #1 obtained a 4 x 4 gauze, placed normal saline on the gauze, and patted the stoma in several places and then turned the gauze over and wiped an area of the stoma again. LPN #1 obtained a dry 4 x 4 and patted the stoma dry touching some areas on the stoma twice. LPN #1 removed gloves and without performing hand hygiene, applied clean gloves, and obtained a long Q-tip applicator. LPN #1 applied Bactroban ointment to the stoma site and covered the stoma site with a drain gauze. LPN #1 removed gloves, and secured the dressing with tape to the skin. LPN #1 gathered unused supplies and exited the room without performing hand hygiene. LPN #1 placed the tape and the unused Q-tip applicators back into the drawer of the medication cart.

During an interview on 10/09/19 at 4:56 PM, LPN #1 stated she should have performed hand hygiene after removing the soiled dressing and before cleaning the stoma site, after cleaning the stoma site, and before applying the clean dressing to the stoma. LPN #1 stated she should have performed hand hygiene after she took her gloves off and before putting on clean gloves. LPN #1 stated she should have wiped the stoma

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F 880	Continued From page 18 site with the gauze in one direction and then threw the gauze away during both cleaning and drying the stoma site. LPN #1 stated she remembered patting the stoma site but didn't realize she touched the cleaned areas more than once. LPN #1 stated that not performing proper hand hygiene and gloving during G-tube care could have caused cross contamination and spread infection to the area. LPN #1 stated that she left Resident #64's room with unused supplies and placed the tape and unused Q-tips back on the medication cart. LPN #1 stated that she should have taken two (2)-three (3) Q-tips out of the package and took them into the room, instead of carrying the pack of 100, because once something goes into a room, it is considered contaminated. During an interview on 10/10/19 at 9:55 AM, RN #3 stated LPN #1 should have used a red biohazard bag to dispose of the soiled bandage for Resident #64. RN #3 stated LPN #1 should have wiped from the inner of the wound to the outer area of the wound using one sweep, and then discard the gauze. RN #3 stated they don't teach patting a stoma. RN #3 stated LPN #1 not changing gloves appropriately and not performing hand hygiene is a infection control issue; anytime you take your gloves off and perform a different procedure you're supposed to wash your hands. RN #3 stated LPN #1 should not have taken the whole pack of Q-tip applicators into the room, only a few on her tray, because placing the tape and the pack of Q-tips back on the cart contaminated the entire cart. During an interview on 10/10/19 at 9:05 AM, the Director of Nursing (DON) stated LPN #1 not changing her gloves appropriately and not	F 880		

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F 880	Continued From page 19 washing her hands was definitely an infection control issue, and placing the Q-tips back on the cart contaminated the whole cart. The DON stated LPN #1 should have only took what she needed into the room. The DON stated LPN #1 also should have used a red biohazard bag. The DON stated LPN #1's technique for cleaning the stoma was "not what we teach".	F 880		

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	255250	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/08/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70 (a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 364 SS=D	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly protect corridors openings as per NFPA101 section 19 3.6.5.2. This deficiency affected one (1) of seven (7) smoke compartments in the facility on day of survey. Findings include:	K 364	1 a. The transfer grille in the wall near the therapy room was sealed by the Maintenance Supervisor on 10/8/19 using sheet rock on both sides of the wall. 2 Any future air vents will be placed in the ceiling instead of the wall. 3 a. An in-service was provided for the maintenance staff on 10/8/19 by the	11/15/19

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

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K 364	Continued From page 1 On 10/8/19 at 10:15AM, observation revealed a hole in the corridor wall near the Therapy Room of the facility. Based on interview with the maintenance supervisor on 10/8/19 at 10:20 AM, the hole was created while installing an air transfer grille in corridor wall near the Therapy Room. The Maintenance Supervisor also mentioned the air transfer grille was installed to equalize air pressure between the Therapy Room and the main corridor of the facility.	K 364	Administrator regarding proper installation of vents in the ceiling instead of walls. b. The Corridor - Opening requirement was reviewed on 10/8/19 from the National Fire Protection Association (NFPA101) Manual, Section 19 3.6.5.2. 4 a. The Corridor - Opening Audit will be completed October, 2019 and Bi-Annually in the months of October and April assuring there is no penetration and reported to the Quality Assurance Committee (QA) to ensure continued compliance.	

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E 000	Initial Comments ********** Survey conducted on 10/08/19 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

Electronically Signed | 10/28/2019

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.