STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255283	A. BUILDING _____ B. WING _____	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAIDEN COMMUNITY LIVING CENTER	868 MULBERRY STREET VAIDEN, MS 39176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 2/7/22 through 2/9/22. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid regulations for participation. The SA cited deficiencies at F623, F645, F656, F695, and F880. The facility had a census of 50 at the time of the survey and held a license for 60 beds.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		3/7/22

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

Electronically Signed | 03/07/2022

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F 623	Continued From page 1	F 623		

before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with

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F 623	Continued From page 2 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify the resident representative in writing of a transfer to the hospital for one (1) of 22 residents reviewed for transfer. Resident #46. Findings include:	F 623	1. Resident #46 responsible party was notified via written notification on 02-09-2022 by the facility's Social Services Director. On 02-16-2022 the Social Services Director was in-serviced using the facility's Employee Coaching Plan form by the Administrator regarding sending written notification to the	

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F 623	Continued From page 3 Record review of a Health Status Note dated 10/22/21 revealed Resident #46 was transferred to the local hospital by emergency services and review of a Health Status Note dated 1/28/22 revealed she was transferred to the local emergency room. An interview, on 02/08/22 at 5:20 PM, with the Social Service Director revealed that she was not aware of transfer forms needing to be sent to the families. She stated that she sends the bed holds and she calls the responsible parties. An interview, on 02/10/22 at 5:25 PM, with the Administrator revealed that she stated that she "dropped the ball". She stated that she accepts responsibility because she should have told her new social worker about the forms.	F 623	Resident's responsible party when being transferred out to a hospital. 2. Residents being sent out of the facility to the emergency room have the potential to be affected by this practice. 3. Any residents sent out of the facility will have notification of transfer sent to their responsible party by the next business day following the transfer. An inservice was done on 02-09-2022 by the Administrator with the Social Services Director on sending notification to the resident□s responsible party. The Administrator/Business Office Manager will audit weekly for four (4) weeks beginning 02/10/2022 to ensure notification has been sent to the responsible party. Findings will be corrected immediately. 4. The Administrator/Business Office Manager will report results of the audit to the Quality Assurance weekly for three (3) months beginning 02-10-2022 and to the Quality Assurance Performance Improvement Committee (QAPI) monthly starting on 02-17-2022 for four (4)months and as needed for review, revision and/or resolution to the plan.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.	F 645		3/7/22

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F 645	Continued From page 4 §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission	F 645		

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F 645	Continued From page 5 to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately complete a Preadmission Screening and Resident Review (PASRR) Level 2 change in status form for one (1) of three (3) residents reviewed for PASRR. Resident #44. Findings include: Record review of a typed statement and signed by the Administrator on 2/9/22 revealed, "Currently (Proper Name of Facility) does not have a specific policy related to doing a Level 2." An interview with the Social Worker on 2/9/22 at	F 645	F645 1. A request for a Pre Admission Screening Resident Review (PASSR) Status Change was done on 02-09-22 by the facility's Social Services Director for Resident number (#)44. The Pre Admission Screening Resident Review (PASRR) status change review outcome revealed no further Pre Admission Screening Resident Review (PASRR) is required for Resident #44 on 02-15-2022. On 02-16-22 the Social Services Director was inserviced by the Administrator on performing a Pre	

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F 645	Continued From page 6 10:30 AM, revealed that at the facility, she is responsible to complete the request for a PASRR Level 2. She stated she was unaware of the requirement that a PASRR Level 2 was needed when the resident had a change of diagnosis or condition. She confirmed she failed to submit the requests. She confirmed that requests for PASRR Level 2 were not done by the facility for the diagnoses of Anxiety Disorder on 8/6/20 and for Mood (Affective) Disorder on 7/19/2021 for Resident #44. She confirmed this was needed to ensure safe placement for the residents. An interview with the Administrator on 2/9/22 at 10:45 AM, revealed she was not aware that Resident #44 needed a request for PASRR Level 2 and the request had not been done. She confirmed the facility failed to submit the PASRR Level II Change in Status Request for this resident. She confirmed this is needed for the safe care of the resident and to ensure appropriate placement. She confirmed the facility does not have a policy for PASRR submission. Record review of the Admission Record revealed the resident was admitted to the facility on 11/17/2015. Resident #44 has diagnoses of Unspecified Psychosis not due to a substance or known physiological condition (6/7/2019), Recurrent Depressive Disorders (4/20/18), Anxiety Disorder (8/6/20), and Unspecified Mood (Affective) Disorder (7/19/2021).	F 645	Admission Screening Resident Review (PASRR) status change request any time there is a change in status or condition of a resident in the facility. 2. Residents that have a change of status or condition have the potential to be affected by the deficient practice. 3. Medical Records Nurse/Social Services Director will audit new diagnosis of mental illness or mental retardation or related condition or a significant change in the resident's physical or mental condition weekly beginning on 02-14-2022. A Pre Admission Screening Resident Review (PASRR) status change request will be made by the Social Services Director if needed. An inservice was done and completed on 02-09-22 with Social Services Director by the Administrator regarding doing a Pre Admission Screening Resident Review (PASRR) on residents that have a change of status or condition. The Administrator/Business Office Manager began weekly auditing in morning meetings beginning on 02-14-2022 and will audit weekly for a period of four (4) weeks to ensure a Pre Admission Screening Resident Review (PASSR) is done if necessary. Findings will be corrected immediately. 4. The Administrator/Business Office Manager (BOM) will report to the Quality Assurance Committee weekly beginning 02-24-2022 for four (4) weeks and to the Quality Assurance Performance Improvement Committee (QAPI) monthly	

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F 645	Continued From page 7	F 645	starting on 02-17-2022 and as needed for review, revision and or resolution to the plan.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		3/7/22

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F 656	Continued From page 8 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 facility policy review, record review, and facility staff interviews, the facility failed to develop an oxygen care plan for a resident with a physician's order for oxygen therapy for one (1) of four (4) residents reviewed for oxygen therapy. Resident #4. Findings include: Review of the facility policy, undated, titled, "Care Plan - Comprehensive Policy Statement," revealed "It is the policy of this facility to develop comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs." Record review of the Care Plan with a date initiated of 9/17/2018 revealed "Focus I have shortness(SOB) on exertion, history of cough, congestion. Goal I will have no complications related to SOB through the review date 2/3/22. There were no interventions to address the use of oxygen therapy that had been ordered by the physician. Resident #4 did not have a care plan developed for Oxygen (O2) therapy. Record review, of the Physician's Orders, with an order date of 1/30/22 revealed Resident #4 had a	F 656	F656 1. On 02-09-2022 Resident #4 was assessed by the Director of Nursing for any physical effects related to the failure of not having a care plan for oxygen and no negative findings noted. An Oxygen care plan was developed for Resident #4 by the Minimum Data Set (MDS) Nurse on 02-09-2022. 2. Thirteen (13) of fifty (50) Residents have a physician’s order for oxygen and have the potential to be affected by the deficient practice. 3. Residents that have a physician’s order for oxygen have been audited to ensure a care plan for oxygen is in place on 03-02-2022 by the Director of Nursing. The Minimum Data Set (MDS) Nurse was inserviced by the Director of Nursing on 02-16-22 that any resident that has a physician's order for oxygen must have a care plan for oxygen. The Minimum Date Set Nurse (MDS)/ Director of Nursing (DON) will audit any new physician's orders for oxygen three (3) times a week for four weeks beginning 03-02-2022 in	

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F 656	Continued From page 9 physician's order, "Administer 2 liters (L) of O2 BNC (by nasal cannula), as needed (PRN) ..." An interview, on 2/9/22 at 10:40 AM, with the Minimum Data Set (MDS) Nurse, revealed she missed seeing the physician's order for O2 therapy and did not develop an oxygen therapy care plan for Resident #4. The MDS nurse confirmed there was not an O2 care plan in the medical record for Resident #4. The MDS Nurse revealed that there was a possibility that Resident #4 would not receive all of the care needed with her O2 therapy from the nursing staff, because an O2 care plan was not developed. An interview, on 2/9/22 at 11:00 AM, with the Administrator, revealed she was not aware that Resident #4 did not have an O2 care plan. The Administrator revealed a care plan should have been developed from the physician's order for O2 therapy for Resident #4.	F 656	the facility's daily clinical meeting and oxygen care plan will be updated as needed. Findings will be corrected immediately. 4. The Director of Nursing will report findings to the weekly Quality Assurance Committee weekly for a period of four (4) weeks beginning on 02-24-2022 and to the Quality Assurance and Performance Improvement Committee (QAPI) monthly starting on 02-17-2022 and as needed for review, revision, and/or resolution to the plan.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, facility policy review and record review the facility failed to date the oxygen (O2) tubing,	F 695	F695 1. Resident #4□s oxygen tubing was	3/7/22

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F 695	Continued From page 10	F 695		

failed to provide storage bags for oxygen tubing and failed to place oxygen in use signage on the entrance door to a resident's room, for two (2) of four (4) residents reviewed for oxygen therapy. Resident #4 and #247

Findings include:

Review of the facility policy titled, "OXYGEN ADMINISTRATION," dated August 25, 2014, revealed "Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration ... Steps in the Procedure: 2. Place an "Oxygen in Use" sign on the outside of the room entrance door..." The facility policy did not include information regarding dating of the O2 tubing and the humidifier bottle or storage of oxygen tubing in a bag.

Resident #4

An observation and interview, on 02/07/22 at 11:29 AM, revealed Resident #4 did not have a date on her O2 tubing or a storage bag for the O2 tubing. There was no O2 in use signage on the outside of the entrance door. Resident #4 revealed that her O2 tubing had never been placed in a bag when she was not using it.

Record review of the Physician's Orders, revealed Resident #4 had a physician's order for O2 at 2 liters (L), by nasal cannual (BNC), as needed (PRN), dated 1/30/22.

Record review of a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/5/21 for Resident #4 revealed a Brief Interview for Mental Status (BIMS) score of 15,

replaced, and dated and a storage bag was provided, and signage was placed on the door on 02/08/22.

Resident #247□s oxygen tubing was replaced, and dated and a storge bag was provided, and signage was placed on the door on 02/08/22.

2. Thirteen (13) of fifty (50) Residents have a physician□s order for oxygen have the potential to be affected by the deficient practice.

3. The RN Supervisor/Director of Nursing will audit any physician's orders for oxygen weekly to ensure the oxygen policy is being followed starting on 02-21-2022. Residents that have a physician's order for oxygen have been audited to ensure Resident's oxygen tubing is dated on assigned date and bagged when not in use and ensured signage on the resident's door on 02-21-2022. An inservice was done on 02-16-2022 with the nursing staff by the Director of Nurses on the facility's Oxygen (O2) Policy and completed on 03-03-2022. The RN Supervisor/Director of Nursing will audit three (3) residents on oxygen weekly for eight (8) weeks to ensure the oxygen policy is followed beginning on 02-21-2022. Findings will be corrected immediately.
4. The Director of Nursing will report findings to the Quality Assurance Committee for a period of weekly for eight (8) weeks beginning on 02-24-2022 and monthly to the Quality Assurance

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(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 695	Continued From page 11 indicating Resident #4 is cognitively intact. Resident #247 An observation and interview, on 02/07/22 at 11:29 AM, revealed Resident #247 did not have a date on her oxygen (O2) tubing, no storage bag for the O2 tubing, and no O2 in use signage on the outside of the entrance door. Resident #247 revealed that her O2 tubing had never been placed in a bag when she was not using it. Record review of the Physician's Orders revealed Resident #247 had a physician's order for O2, continuously, at 2 liters (L) per minute, by nasal cannula (BNC) dated 2/9/22. Record review of a Five (5) Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/3/22, for Resident #247, revealed a Brief Interview for Mental Status (BIMS) score of 08, indicating Resident #247 has moderately impaired cognition. An interview on 2/8/22 at 3:34 PM, with Registered Nurse (RN)#1, revealed the process for set up of O2 in a resident's room included dating on the O2 tubing, on the humidifier bottle, and a storage bag had to be provided and dated for the O2 tubing and an O2 in use sign had to be place on the outside of the resident's entrance door. RN #1 confirmed there was no O2 signage outside Resident #4 and #247's entrance door. RN #1 revealed Resident #4 and Resident #247 were possibly at risk for a respiratory infection because the O2 tubing was not dated, which would have indicated the last time the O2 tubing was changed, and a storage bag was not	F 695	Performance Committee monthly starting on 02-24-2022 and as needed for review, revision, and/or resolution to the plan.	

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F 695	Continued From page 12 provided for the O2 tubing when it was not being used by Resident #4 and #247. An interview, on 2/8/22 at 3:47 PM, with the Director of Nursing (DON), revealed she was not aware Resident #4 and #247 did not have a date on their O2 tubing, a storage bag for O2 tubing, and that there was no O2 in use signage outside Resident #4 and #247's entrance door. The DON revealed Resident #4 and #247could have been placed at risk for a respiratory infection because they did not have a date on their O2 tubing and did not have a storage bag provided for the O2 tubing. The DON revealed the O2 in use signage should have been posted outside Resident #4 and #247's entrance door to alert all staff and visitors to be aware that there was O2 being used in the room and to use appropriate safety precautions.	F 695		
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	F 880		3/7/22

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F 880	Continued From page 13	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 14 §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, record review and facility policy review, the facility failed to prevent the likelihood of the spread of infection as evidenced by failure to perform hand hygiene while passing meal trays and ice, inappropriate handling of medication during medication pass and failure to screen a vaccinated contract worker for COVID-19 signs and symptoms for two (2) of three (3) days of survey. Findings include: Record review of the facility policy, "Handwashing" dated June 1,2000 revealed, "It is the policy of this facility that hand washing be regarded as the single most important means of preventing the spread of infections. Procedure:...2. Appropriate ten (10) to fifteen (15) second hand washing must be performed under the following conditions:..f. Before touching, preparing, or serving food ..." Hydration Pass An observation, on 02/07/22 at 11:29 AM revealed Certified Nurse Assistant (CNA) #1 scooped ice from a cooler in the hall, put it into a cup, dispensed some water into the cup and took	F 880	F880 1. Residents in room numbers (#□s) 305, 306B, 309B were assessed by the Director of Nursing (DON) on 2-9-2022 for any physical effects related to failure to perform hand hygiene with no negative findings noted. Certified Nurse Assistant (CNA) number (#)1 was inserviced on performing hand hygiene and following the facility□s Infection Control Policy by the Director of Nursing on 02-16-2022. Residents in room number (#□s) 106, 108, 109, 110, 112, and both residents in Room 114 was assessed by the Director of Nursing (DON) on 02-09-2022 for any physical effects related to failure to perform hand hygiene with no negative findings noted. Certified Nurse Assistant (CNA) number (#)3 was inserviced on performing hand hygiene and following the facility□s Infection Control policy by the Director of Nursing on 02-16-2022. Resident number (#)13 was assessed by the Director of Nursing on 02-08-2022 for any physical effects from failure to follow	

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F 880	Continued From page 15 it to the resident in room 305B without performing hand hygiene. Observed CNA #1 leave room 305B without performing hand hygiene and scoop ice from the cooler, dispense water into a cup and take it to the resident in room 306B. Observed CNA #1 leave room 306B without performing hand hygiene, scoop ice into a cup, dispense water into that cup and take it to the resident in room 309B without performing hand hygiene. An interview, on 2/7/22 at 11:35 AM with CNA #1 confirmed that she did not perform hand hygiene between the residents while passing ice water. CNA #1 stated, "I guess I just got nervous." CNA #1 confirmed that she should have performed hand hygiene between the residents to prevent the spread of germs. CNA #1 revealed that she had been in-serviced on hand hygiene. An interview, on 2/9/22 at 9:38 AM with the Director of Nurses (DON) confirmed that hand hygiene needs to be performed in between residents when passing out ice and water. Record review of the facility in-service dated 11/18/21 and titled, "Handwashing/Sanitizing Between Trays" revealed it was attended by CNA #1. Record review of CNA #1's "CNA (Certified Nursing Assistant) Skills Competency Check Off List" revealed that CNA #1 completed a "satisfactory" completion of "handwashing skill" on 11/20/21. Meal Tray Pass An observation on 2/7/2022 at 12:10 PM, revealed Nursing Assistant (NA) #3 was observed	F 880	infection control measure by pouring medication directly in bare hand by LPN (Licensed Practical Nurse) number (#) 1 with no negative findings noted. Director of Nursing (DON) inserviced Licensed Practical Nurse (LPN) number (#)1 on 02-16-2022 on the importance of following the facility□s Infection Control Policy. An inservice on the facility□s Covid-19 Protocols which included screening all visitors began on 02-09-22 by the Administrator with staff and completed on 03-03-2022. Signage was placed by the Administrator on the outside of the entrance door that ALL VISITORS AND VENDORS MUST BE SCREENED UPON ENTRANCE TO THE FACILITY BY A STAFF MEMBER on 02-11-2022. The Administrator placed signage at the front nurse's station on 02-11-2022 notifying all visitors must been screened for Covid-19 symptoms prior to visiting a resident. 2. 23 of 50 residents that received meal trays delivered to them from Certified Nurses Assistant (CNA) number (#)1 have the potential to be affected by the deficient practice. 19 of 22 residents that receive ice and water delivered to them from Certified Nurses Assistant (CNA) number(#)3 the ice/water pass have the potential to be affected by deficient practice. 22 of 22 residents that receive medication from Licensed Practical Nurse (LPN) number (#)1 have the potential to be	

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delivering lunch trays to the residents. NA #3 delivered trays to residents in room 106, 108, then delivered and set up trays to rooms 109 and 110. NA #3 delivered the tray to room 112, then delivered and set up trays to both residents in room 114. Between each of these tray deliveries and set ups, NA #3 did not use hand hygiene.

An interview on 2/7/22 at 2:30 PM, with Nursing Assistant #3, revealed she did not perform hand hygiene between the residents while passing lunch trays on the 100 hall. She stated she should sanitized her hands between tray deliveries to residents to prevent the spread of germs. She revealed she had been in-serviced on hand hygiene and infection control.

Record review of the in-service log revealed NA #3 attended an Infection Control in-service titled "Covid-19 Protocols, Infection Control" on 11/15/2021.

An interview with the Administrator on 2/9/22 at 11:00 AM, confirmed the facility failed to provide sufficient infection control measures by the trays being passed without proper hand hygiene. She confirmed this could spread infection from one resident to another resident.

Medication Administration

Record review of facility policy titled, "Medications, Oral", dated August 25, 2014, revealed, "The purpose of this procedure is to provide guidelines for the safe administration of oral medications". The policy also revealed, "For tablets or capsules from a bottle, pour the desired number into the bottle cap and transfer to the medication cup. Do not touch the medication with

affected by the deficient practice.

Residents that receive visitors have the potential to be affected by the deficient practice of not screening visitors for signs and symptoms of Covid-19.

3. An inservice on the facility□s infection control policy and medication pass policy with nursing staff and Covid-19 Protocols with all staff began on 02/07/2022 and completed on 03-03-2022 by the Administrator and Director of Nursing. On 02-15-2022 the Infection Control Nurse/Director of Nursing began auditing staff during hydration pass, meal tray pass and medication pass and will continue to audit five (5) staff on passing ice, meals, and medications weekly for four (4) weeks to ensure the infection control policy is followed. The Business Office Manager (BOM)/Administrator will audit three (3) visitors being screened by staff weekly beginning on 02-10-2022 for four (4) weeks to ensure the Covid-19 Protocols are being followed regarding screening vendors and visitors. Findings will be corrected immediately.

Root Cause Analysis for the DPOC (Directed Plan of Correction) began on 02-26-2022 and completed on 03-03-2022 with assistance from the Infection Preventionist Nurse, QAPI (Quality Assurance Performance Committee), and the Governing Body to include the RDO (Regional Director of Operations)and the RNC (Regional Nurse Consultant and CDC (Centers Disease Control) videos on

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F 880	Continued From page 17 your hands. Return extra capsules/tablets to the bottle." An observation on 2/8/22 at 8:40 AM, of medication administration by Licensed Practical Nurse (LPN) #1 revealed a concern with infection control. LPN #1 was preparing the oral medications for administration to Resident #13. Resident #13 received 12 different oral pill medications, six of these were in prepackaged, individualized medication cards from the pharmacy. The remaining six were from the individual bottles of stock medications on the medication cart. LPN #1 placed the individual medications from the pharmacy cards into the cup by pushing the medications directly from the card into the medication cup. Then, for each of the other six medications, LPN #1 opened the bottle and poured some of the pills into her ungloved hand, picked one up with her other ungloved hand, placed this one into resident's medication cup, then placed the remaining pills in her hand back into the medication bottle. This process was repeated for the six medications in the stock bottles. An interview with LPN #1 on 2/8/22 at 4:15 PM, revealed that by pouring the medications in her ungloved hand, placing medication from her ungloved hand into the resident's medication cup, and returning the remaining pills back into the bottle, the medications could be contaminated and spread infection. She revealed she should have placed the medications in the lid and not touch the medications with her bare hands. She stated she had been in-serviced on infection control and handwashing and she was not following infection control guidelines in administering medications.	F 880	Sparkling Sufaces, Clean Hands and Keep COVID-19 out were watched beginning 03-07-2022 and will be completed 03-17-2022. Competencies on hand hygiene with current staff and new hires began on 03-07-2022 and will be completed on 03-17-2022. 4. The Director of Nursing will report findings to the Quality Assurance Committee for a period of four (4) weeks weekly beginning 02-10-2022. The Administrator will report findings to the Quality Assurance Committee for a period of weekly for four (4) weeks beginning 02-10-2022. All findings will be reported to the Quality Assurance and Performance Improvement Committee (QAPI) beginning on 02-17-2022 and monthly as needed for review, revision, and/or resolution to the plan.	

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An interview on 2/9/22 at 11:00 AM, with the Administrator, confirmed medications should not be poured into a bare hand and placed in the resident's medicine cup and remaining pills should not be returned to the medication bottle. She confirmed the facility failed to use proper infection control measures that are needed to ensure that the risk of the spread of infection is decreased. She confirmed this practice could contaminate the medications and spread infection.

Record review of the in-service log revealed LPN #1 attended an Infection Control in-service titled "Covid-19 Protocols, Infection Control" on 11/15/2021.

Visitor Screening

Review of the facility protocol titled "COVID 19 GUIDELINES" revealed under "Guidelines for Visitation" that "Medically necessary individuals should be permitted after meeting the testing requirements and being screened (regardless of vaccination and Visitation status)".

An observation, on 2/7/22 at 3:30 PM, revealed a contract X-ray Technician entered the front entrance of the facility and was not screened for signs and symptoms of COVID or a body temperature.

An interview, on 2/7/22 at 3:40 pm with the Administrator confirmed that the contract X-ray Technician had not been screened when he entered the building. The administrator revealed that it is the policy of the facility that everyone must be screened when they enter the building to

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F 880	Continued From page 19 prevent the spread of COVID. An interview, on 2/7/22 at 4:40 PM with the contract X-ray Technician revealed that a facility staff member let him in the front entrance of the facility. The contract x-ray technician confirmed he did not have his temperature obtained or get screened for COVID signs and symptoms when he entered the facility. The contract x-ray technician revealed he had no signs or symptoms of COVID, and he is fully vaccinated. Review of the vaccination record revealed COVID vaccination dates confirmed as: Moderna 12/28/20 and Moderna 01/25/21.	F 880		