STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255306	A. BUILDING _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRACE EXTENDED CARE & REHABILITATION	**1004 EAST MADISON STREET HOUSTON, MS 38851**

(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 re-certification survey at the facility from 12/12/22 to 12/14/22. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F 656, F677, F688 and F880. The facility had a census of 62 at the time of the survey and held a license 66 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		1/21/23

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

Electronically Signed | 01/05/2023

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F 656	Continued From page 1 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review the facility failed to develop and/or implement a comprehensive person-centered care plan for two (2) of 19 resident records reviewed. Resident #24 and Resident #52 Findings include: Record review revealed the facility does not have a "Comprehensive Care Plan" policy. Record review revealed a care plan dated 03/23/22: I require extensive assist with my Activity of Daily Living (ADLS) due to pain in my knees, Limited Range of Motion (LROM) in my shoulders shortness of breath with and without	F 656	Resident #24 was given a shower and shave per the Activities of Daily Living (ADL) care plan on 12/13/22 Assessment Coordinator added the hand roll splint to resident #52's care plan on 12/13/22 Director of Nursing (DON) reviewed care plans for residents #24 and #52 for complete accuracy on 12/15/2022 Facility has determined that all residents have the potential to be affected by this practice Assessment nurses were educated on 12/14/22 on person centered care plan updating by the Director of Nurses (DON). Nurses and Certified Nursing Assistants	

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F 656	Continued From page 2 exertion, safety and weakness with a goal of I will improve my current level of function through 03/05/23 and interventions that include: I need assist with sponge baths on non-shower days, I need a shower 3 times per week, prepare shower with needed items, I need assist with washing my back, feet. Legs and I need help shaving on shower days and as needed. Record review of the facilities "Shower/Sponge Off Schedule" revealed Resident #24 in Room 404 is scheduled for a shower on Monday, Wednesday, and Friday on the 7 AM-3 PM shift and a "sponge off" on Tuesday, Thursday and Saturday on the 7 AM-3 PM shift. Record review of Resident #24's "Completed Care Details" for the last two weeks revealed the resident had one bath on 12/5/22 with documentation for 12/06/22, 12/10/22 and 12/11/22 that indicated the activity did not occur. On 12/12/22 at 10:24 AM, an observation revealed Resident #24 lying in bed with eyes closed, wearing a brief and a t-shirt with a strong smell of urine in the room. At 4:40 PM on 12/12/22 an observation revealed Resident #24 sitting in his recliner with a smell of urine and facial hair stubble noted on his face. On 12/13/22 at 10:55 AM, an observation revealed Resident #24 had facial hair covering his cheeks, chin and above his lip that was approximately 1/8th of an inch long. During an interview on 12/13/22 at 2:20 PM, with the Director of Nurses (DON) confirmed that according to Resident #24's bath documentation,	F 656	(CNA) were educated on bathing assistance per the care plan on 12/14/2022 by the DON. All interdisciplinary care team members responsible for writing care plans were educated on facilities updated care plan policy on 12/19/22 by the Administrator. Assessment nurses will review new physicians orders daily for changes beginning 12/14/22. The DON will complete weekly audits on three residents per week for four weeks, two residents per week for four weeks and one resident for two weeks to ensure that comprehensive care plans are developed and updated on resident beginning 12/15/22. Audit records will be reviewed by the Administrator and DON and corrections made as needed. Audit findings will be brought to the Quality Assurance (QA)/Risk Management Committee for six months for determination of further interventions to assure consistent substantial compliance is achieved. First monthly QA meeting held on 12/29/2022	

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F 656	Continued From page 3	F 656		

the resident has only had one bath in the past two weeks. She revealed the (Certified Nursing Assistant) CNAs were supposed to notify their charge nurse when a resident refused a bath and then the nurse should make a documentation. She confirmed that Resident #24 had documentation for 12/6/22, 12/10/22 and 12/11/22 that "Activity Did Not Occur" under the bathing documentation. She confirmed that there was no corresponding progress note from the nurse that would confirm that the resident had refused a bath for those days. She revealed if something is not documented then it did not occur.

In interview on 12/13/22 at 2:30 PM, with the Administrator revealed the CNAs should be documenting the resident's baths and should not have trouble doing so, because we provide tablets for them to document on. She revealed that she understands if something is not documented then you cannot prove that it was done. She revealed that Resident #24 is getting a shower and a shave right now but confirmed it should have already occurred.

On 12/14/22 at 9:38 AM, during an interview with Resident #24 revealed it is hard to get a shower in this place. He revealed the staff will come ask him if he is ready for a shower, he will lay out his clothes and then they will never come back. He revealed he does like getting a shower regularly and thinks he usually gets one or two a week.

CNA #1 confirmed during an interview on 12/14/22 at 9:45 AM she shaved Resident #24 and gave him a shower yesterday. She confirmed that the resident did need to be shaved because his hair grows fast, and she had shaved

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F 656	Continued From page 4	F 656		

him last Thursday. She revealed she is not aware that the resident is supposed to get a shower three times per week and a shave with every shower, but confirmed she is able to see his care plans.

Record review of the Face Sheet revealed Resident #24 was admitted to the facility on 04/01/19 with medical diagnoses that included Chronic Ischemic Heart Disease/unspecified, weakness and other abnormalities of gait and mobility.

Record review of Resident #24's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/5/22 revealed in Section G that the resident needed physical help in part of bathing activity and in Section C a Brief Interview for Mental Status (BIMS) of 11 which indicates the resident is moderately cognitively impaired.

Resident # 52

A record review of the facility's policy titled "Resident Mobility and Range of Motion", revised July 2017, "Policy Statement...2 Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. .3 Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. This review revealed under "Policy Interpretation and Implementation...4) The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. .5) The care plan will include specific interventions, exercises, and

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F 656	Continued From page 5	F 656		

therapies based on the comprehensive assessment and will be revised as needed".

Record review of Resident #52's comprehensive care plans found no care plan addressing the resident's left-hand contracture.

Record review of Resident #52's Physician's Order dated 11/7/22 revealed "Hand roll to left hand during waking hours to prevent further contracture."

During an interview and observation with Resident # 52's sister on 12/12/22 at 11:05 AM, revealed her brother is supposed to have a hand roll in his left hand to prevent his contracture from getting worse. An observation revealed there was no hand roll in the residents left hand.

An observation on 12/12/22 at 3:45 PM, revealed Resident #52 with no hand roll to the left hand.

An observation on 12/13/22 at 9:39 AM, revealed no left-hand roll to Resident # 52's hand.

An observation and interview at 12/13/22 at 10:47 AM, with Registered Nurse (RN)#1 revealed Resident # 52 was not wearing a hand roll.

An interview with the Director of Nursing (DON) at 12/13/22 10:58 AM, confirmed the use of the hand roll was not on the comprehensive care plan for Resident #52.

An interview with the Minimum Data Set (MDS) nurse RN #2 on 12/14/22 at 9:00 AM, revealed the MDS department is responsible for reviewing orders Monday thru Friday and updating the care plans with any changes needed and confirmed

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F 656	Continued From page 6 she failed to update resident #52's care plan to include the resident's left-hand contracture and order for a hand roll. Record review of Resident #52's Face Sheet revealed the resident was admitted to the facility on 04/08/22 with diagnoses of Hemiplegia following cerebral infarction affecting left nondominant side. Record review of the MDS section C with an Assessment Reference Date (ARD) date of 10/10/22 revealed that Resident #52 had a Brief Interview of Mental Status (BIMS) score of 13 which indicated that he was cognitively intact.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, record review and facility policy review the facility failed to provide showers and shaving to a resident that was dependent on staff for one (1) of 19 residents reviewed. Resident #24 Findings include: Record review of the facility policy titled "Shower/Tub Bath" with a revision date of October 2010 revealed under "Purpose...The purpose of this procedure is to promote cleanliness, provide comfort to the resident and to	F 677	Resident #24 was given a shower and shave per Activities of Daily Living (ADL) care plan on 12/13/22. Certified Nursing Assistant (CNA) #1 was educated immediately on 12/13/2022 per the Director of Nursing (DON). Facility has determined that all residents have the potential to be affected by this practice. Nurses and CNA's were educated on bathing schedule and grooming, documentation of or refusal of	1/21/23

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F 677	Continued From page 7 observe the condition of the residents' skin". This review revealed under "Documentation #5...If the resident refused the shower/tub bath, the reason(s) why and the intervention taken". An observation on 12/12/22 at 10:24 AM, revealed Resident #24 lying in bed with eyes closed, wearing a brief and a t-shirt with a strong smell of urine in the room. An observation on 12/12/22 at 4:40 PM, revealed Resident #24 sitting in his recliner with a smell of urine and facial hair stubble noted on his face. An observation on 12/13/22 at 10:55 AM, revealed Resident #24 had facial hair covering his cheeks, chin and above his lip that was approximately 1/8th of an inch long. An interview on 12/13/22 at 1:55 PM, with Certified Nurse Assistant (CNA) #1 revealed that Resident #24 occasionally refuses a bath but does want to be shaved. She revealed that when a resident refuses, then the CNA is supposed to let her supervising nurse know. She revealed that when a resident refuses a bath then the CNA should document the bath was refused. An interview on 12/13/22 at 2:10 PM with Registered Nurse (RN) #3 revealed it is the responsibility of the CNAs to notify the nurse when a resident refuses a bath. She revealed it has been an issue with the CNA's not notifying the nurse when the resident refuses a bath. She revealed that Resident #24 sometimes refuses, but we hate to document it as an actual refusal because sometimes he is just confused and then gets agitated with us.	F 677	bathing/ADL care on 12/14/22 per the DON. DON implemented an ADL checklist sheet on 12/14/2022. DON, Nurse Supervisor and Admission nurse will conduct resident interviews on scheduled shower days three residents per week for four weeks, two residents per week for four weeks and one resident per week for two weeks beginning 12/19/2022 with corrective actions with staff given as needed. Audit records will be reviewed by administrator and DON with immediate corrective actions with staff as needed. Findings will be brought to the QA/ Risk management committee for six months for determination for further interventions to assure consistent substantial compliance. First QA meeting was held on 12/29/2022	

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F 677	Continued From page 8	F 677		

An interview on 12/13/22 at 2:20 PM, with the Director of Nurses (DON) confirmed that according to Resident #24's bath documentation, the resident has only had one bath in the past two weeks. She revealed that one of Resident #24's CNAs revealed she was having trouble documenting but did not make anyone aware. She revealed the CNAs were supposed to notify their charge nurse when a resident refused a bath and then the nurse should make a documentation. She confirmed that Resident #24 had documentation for 12/6/22, 12/10/22 and 12/11/22 that "Activity Did Not Occur" under the bathing documentation. She confirmed that there was no corresponding progress note from the nurse that would confirm that the resident had refused a bath for those days. She revealed if something is not documented then it did not occur.

An interview on 12/13/22 at 2:30 PM, with the Administrator revealed the CNAs should be documenting the resident's baths and should not have trouble doing so, because we provide tablets for them to document on. She revealed that she understands if something is not documented then you cannot prove that it was done. She revealed that Resident #24 is getting a shower and a shave right now but confirmed it should have already occurred.

An interview on 12/14/22 at 9:38 AM, with Resident #24 revealed it is hard to get a shower in this place. He revealed the staff will come ask him if he is ready for a shower, he will lay out his clothes and then they will never come back. He revealed he does not like getting a shower regularly and thinks he usually gets one or two a week.

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F 677	Continued From page 9 An interview on 12/14/22 at 9:45 AM, with CNA #1 confirmed she shaved Resident #24 and gave him a shower yesterday. She confirmed that the resident did need to be shaved because his hair grows fast, and she had shaved him last Thursday. She revealed she is not aware that the resident is supposed to get a shower three times per week and a shave with every shower, but confirmed she is able to see his care plans. Record review revealed Resident #24 was admitted to the facility on 04/01/19 with medical diagnoses that included Chronic Ischemic Heart Disease/unspecified, weakness and other abnormalities of gait and mobility. Record review of the facilities "Shower/Sponge Off Schedule" revealed Resident #24 is scheduled for a shower on Monday, Wednesday, and Friday on the 7 AM-3 PM shift and a "sponge off" on Tuesday, Thursday and Saturday on the 7 AM-3 PM shift. Record review of Resident #24's "Completed Care Details" for the last two weeks revealed the resident had one bath on 12/5/22 with documentation for 12/06/22, 12/10/22 and 12/11/22 that indicated the activity did not occur. Record review of Resident #24's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/5/22 revealed in Section G that the resident needed physical help in part of bathing activity and in Section C a Brief Interview for Mental Status (BIMS) score of 11 which indicates the resident has moderate cognitive impairment.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility	F 688		1/21/23

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F 688	Continued From page 10 CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident representative interview, record review and facility policy review the facility failed to provide services to prevent a further decline in range of motion for one (1) of four (4) residents reviewed for limited range of motion. Resident #52 Findings include: A record review of the facility's policy titled "Resident Mobility and Range of Motion', revised July 2017 revealed under the "Policy Statement... .2) Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. .3) Residents with limited mobility will receive appropriate services, equipment and assistance to maintain	F 688	Resident # 52 had hand roll splint applied to resident left hand per the treatment nurse on 12/13/2022. Director of Nursing (DON) observed resident for further contracture beginning 12/13/22 with no adverse outcomes noted. Facility audit determined that there were four residents with device orders that have the potential to be affected by this practice. Nursing staff were educated on administering treatments/device placement as per the physicians orders and documentation of placement or refusal per resident by the DON on	

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F 688	Continued From page 11 or improve mobility unless reduction in mobility is unavoidable". A record review revealed the facility has no policy titled "Physician's Orders". An observation and interview with Resident # 52's sister on 12/12/22 at 11:05 AM, revealed her brother is supposed to have a hand roll in his left hand to prevent his contracture from getting worse. An observation revealed there was no hand roll in the residents left hand. An observation on 12/12/22 at 3:45 PM, revealed Resident # 52 with no hand roll to his left hand. An observation on 12/13/22 at 9:39 AM, revealed there was no left-hand roll to Resident # 52's hand. Record review of Resident #52's Physician's Order dated 11/7/22 revealed "Hand roll to left hand during waking hours to prevent further contracture." Record review of the Electronic Treatment Administration Record (E-TAR) for December 2022 revealed staff documented hand roll to left hand at 6 AM and 2 PM on 12/12/22 and 12/13/22. An observation and interview on 12/13/22 at 10:47 AM, with Registered Nurse (RN) #1 revealed that Resident #52 should be wearing a left-hand roll and confirmed it was not on. An observation revealed RN #1 removed the hand roll from the resident's drawer and placed it in Resident #52's left hand and confirmed that worsening of the contracture is a possible	F 688	12/13/22. Treatment/Cart Nurse will check devices daily to ensure proper placement of ordered devices beginning 12/13/22. DON will audit treatment administration record (TAR) for completeness daily with device checks of three residents per week for four weeks, two residents per week for four weeks and one resident per week for two weeks. Audit records will be reviewed by the Administrator and DON with corrective actions as needed with staff. Findings will be brought to the monthly QA/Risk Management Committee for six months for determination of further interventions to assure consistent substantial compliance. First monthly QA date of 12/29/2022	

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F 688	Continued From page 12 complication from not wearing the hand roll. An interview with the Director of Nursing (DON) on 12/13/22 at 10:58 AM, confirmed Resident #52 had an order for a left-hand roll and is being signed off on the Treatment Administration Record as wearing the hand roll and confirmed that worsening contractures are a possible problem if the device is not applied. An interview with the Administrator on 12/13/22 at 11:00 AM, revealed that worsening of the contracture and pressure injury was a possible problem from not wearing hand roll. Record review of Resident #52's Face Sheet revealed that the resident was admitted to the facility on 04/08/22 with diagnoses of Hemiplegia following cerebral infarction affecting left nondominant side. Record review of Resident #52's admission Minimum Data Set (MDS) with an Assessment Reference Date of 4/19/22, Section G, revealed Impairment on one side to upper and lower extremity. The MDS section C with an ARD of 10/10/22 revealed that Resident #52 had a Brief Interview of Mental Status (BIMS) score of 13 which indicated that he was cognitively intact.	F 688		
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	F 880		1/21/23

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F 880	Continued From page 13	F 880		

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
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 880	Continued From page 14 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, staff interview and facility policy review the facility failed to prevent the likelihood of the spread of infection as evidenced by not wearing a mask or performing hand hygiene during meal tray pass and feeding assistance for one (1) of three (3) survey days. Findings include: Record review of the facility policy titled, "Hand Hygiene" with a revision date of 12/01/22 revealed under "Policy...All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitor. This applies to all staff working in all locations within the facility."	F 880	#1 The certified nursing assistant's (CNA) #1 and #2 were educated on proper hand hygiene procedures and wearing mask as required on 12/14/22 per the Infection Preventionist and Director of Nursing (DON). DON observed residents, for adverse outcomes beginning 12/14/22 with none noted. #2 The facility has determined that all residents have the potential to be affected by this practice. #3	

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F 880	Continued From page 15 An observation on 12/12/22 at 11:45 AM, revealed approximately 24 residents in the dining room with four (4) staff present. This observation revealed Certified Nurse Assistant (CNA) #1, and CNA #2 did not perform hand hygiene prior to setting up multiple resident lunch trays. This observation revealed CNA #1 and #2 did not perform hand hygiene prior to leaving the dining room, delivering, and setting up a lunch tray in two resident rooms. This observation revealed CNA #2 returned to the dining room did not perform hand hygiene, pulled her mask down below her chin and assisted in feeding a resident. An interview on 12/12/22 at 12:20 PM, with CNA #2 confirmed she did not perform hand hygiene before she set up lunch trays, delivered a lunch tray to a resident's room or before assisting in feeding a resident. She confirmed that she did pull her mask down below her chin while she was assisting in feeding a resident. She revealed that it is the policy of the facility that she is supposed to always wear a mask and needs to perform hand hygiene before feeding a resident. She revealed that she knows that wearing a mask and performing hand hygiene helps to decrease the spread of infections and keeps the staff from catching infections. An interview on 12/12/22 at 12:40 PM, with CNA #1 confirmed she did not perform hand hygiene prior to or at any time during passing lunch trays. She revealed she is aware she should perform hand hygiene especially after entering a resident's room and setting up a meal tray. An interview on 12/13/22 at 4:15 PM, with the Director of Nurses (DON) revealed that it is the	F 880	All staff were educated on the facility's policy on hand hygiene and wearing of source control by the Infection Preventionist and Director of Nursing beginning 12/14/2022. All staff were shown training videos Clean Hands:https://www.youtube.com/watch?v=xmYMUly7qiE and Keep Covid Out: https://www.youtube.com/watch?v=7srwrF9MGdw per Directed Plan of Correction (DPOC) beginning 12/27/22. Validation check offs are being performed on all staff with observation of all staff performing hand hygiene and proper use of source control beginning 12/14/22 by Infection Preventionist (IP) and Director of Nursing (DON) with corrective action provided as needed. Documentation of on-going staff competencies will be maintained in infection control office and updated with all staff quarterly beginning 12/14/2022. Root Cause Analysis was completed per Quality Assurance Performance Improvement (QAPI) Committee, IP, DON and Administrator with documentation remaining in QAPI minutes. Hand hygiene and Mask Compliance were added to Quality Improvement Initiative Plan (QIIP) with the Quality Improvement Organization (QIO) 12/27/2022. #4 The Infection Preventionist (IP), DON, and Registered Nurse (RN) Supervisor will complete validation checklist of staff performing hand hygiene technique in	

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F 880	Continued From page 16 policy of the facility that all staff wear a mask while working in the facility and perform hand hygiene before setting up meal trays, before and after entering a resident's room and before feeding a resident. She confirmed the purpose of the mask and performing hand hygiene is to prevent the spread of germs which can lead to infections. An interview on 12/14/22 at 9:00 AM, with the Administrator revealed the facility is requiring everyone to wear a mask, had an in-service on 10/21/22 with all staff that informed them that mask was required, and revealed they have signs on the entrance doors that a mask is required. She revealed she expects all employees to wear a mask while at work. She revealed that all staff should be performing hand hygiene before they start passing meal trays and if they touch anything else such as a resident room door then they should perform hand hygiene after touching those things and before assisting a resident to eat to help decrease the spread of infection. Record review of the facility policy titled "Coronavirus Prevention and Response with a revision date of 09/26/22 revealed under "Policy Explanation and Compliance Guidelines #5 a. Ensuring that everyone is aware of the recommended Infection Prevention and Control practices in the facility by posting visual alerts (e.g., signs, posters) at the entrance and in strategic places to include instructions about current IPC recommendations Record review of the facility in-services revealed the facility had an in-service on 06/23/22 and 12/1/22 for nurses and CNA's titled "Handwashing", an in-service on 06/28/22 topic	F 880	accordance with practice guidelines on five staff three times per week for three weeks, two times per week for three weeks and one time per week for two weeks beginning 12/14/2022. The Infection Preventionist (IP), DON, and Registered Nurse (RN) Supervisor will complete monitoring of proper use of source control per Centers for Disease Control (CDC) guidelines for healthcare settings of five staff three times per week for three weeks, two times per week for three weeks and one time per week for two weeks beginning 12/14/2022. Will discuss with QIO representative monthly beginning 12/27/2022, Audit records with be reviewed by the Administrator and DON with corrective actions with staff as needed, findings will be presented to the QA/Risk Management Committee for six months for any recommendations for further interventions to assure consistent substantial compliance. First monthly QA meeting was 12/29/2022	

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F 880	Continued From page 17 "Mandatory In-service infection control" and an in-service on 10/21/22 that included infection control.	F 880		