STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255348	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH & REHAB OF MERIDIAN LLC	517 33RD STREET MERIDIAN, MS 39305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Survey Agency (SSA) conducted an annual re-certification survey at the facility from 01/03/2023 to 01/05/2023. During the survey, it was determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SSA cited F567, F576, F679, F690, and F880. The facility had a census of 49 and was licensed for 58.	F 000		
F 567 SS=C	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must	F 567		2/1/23

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

Electronically Signed | 01/25/2023

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 567	Continued From page 1 maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on staff and resident council interviews, record review, and facility policy review, the facility failed to ensure that residents have reasonable and ready access to their funds, as funds are not available on weekends for six (6) of 6 residents present in the Resident Council meeting. This had the potential to affect 38 of 38 residents who had funds held by the facility. Resident #19, #22, #25, #35, #38, and #44. Findings include: A record review of the facility's policy "Resident Funds Weekend Availability," dated 5/18/2018 revealed, "It is the policy of this facility to maintain Petty Cash availability on weekends to our residents who are participating in the Trust fund account option ..." On 1/04/22 at 3:00 PM, during the Resident Council meeting, six residents present in the meeting stated they have never been able to get personal funds on weekends (Resident #19, #22,	F 567	1. On January 6, 2023 the administrator inquired with residents #19, #22, #35, #38, and #44 to ask if they needed any funds that were available to them. All residents responded they did not need to access funds at that time. The policy concerning resident funds was presented to them at that time by the administrator. 2. On January 6, 2023 it was determined by the administrator that any resident participating in the Resident Trust Fund Management System have the potential to be affected by the stated deficient practice. 3. On January 6, 2023 An In-service was conducted by the administrator with nursing staff to educate on resident funds availability. The charge nurse, or in the absence of the charge nurse, the nurse in charge of cart A is responsible for ensuring resident funds are available. On	

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F 567	Continued From page 2 #25, #35, #38, and #44). On 01/05/23 at 09:40 AM, during an interview with the Administrator, she revealed that she was unaware residents have not had access to their personal funds on weekends. She confirmed that the facility policy has a procedure that includes the Charge Nurse being responsible for the locked box with petty cash that is made available for the weekends. However, with staff turnover, there has not been a consistent Charge Nurse and therefore, the staff are not always aware of the money box. She stated that the facility needed to make sure all residents with Trust Fund Accounts were aware of the money box and how to get access to money on the weekend. Record review of the Trust Fund Account List provided by the facility revealed there were 38 residents who had trust fund accounts. Resident #19 Record review of the Admission Record for Resident #19 revealed, the facility admitted the resident on 12/09/21 with diagnoses including Pulmonary Hypertension and Essential (Primary) Hypertension. Record review of the Quarterly Minimum Data Set (MDS) for Resident #19, with an Assessment Reference Date (ARD) of 12/14/22 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. A record review of the list of residents with Trust Fund Accounts provided by the facility revealed,	F 567	January 6, 2023 a resident council meeting was held to inform residents about the availability of resident funds and how to access said funds. Residents that were not in attendance of the resident council meeting were informed verbally via the Activities Coordinator about access and availability to resident funds. All nurses will be in-serviced monthly for six months on the facility policy concerning resident funds. Reminders of this policy will be added to the agenda for monthly resident council meetings starting at the meeting on January 19, 2023 for six months. 4. After the policy took effect on January 7, 2023, the administrator began monitoring on January 9, 2023 and will continue weekly for 3 months. Monitoring includes reviewing the Resident Funds log from the previous weekend and following up with residents who received funds to monitor feedback. The data from the monitoring will be discussed in the Quality Assurance and Performance Improvement Plan on January 31, 2023 times 3 months.	

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F 567	Continued From page 3	F 567		

Resident #19 had a Trust Fund Account.

Resident #22

Record review of the Admission Record for Resident #22 revealed, the facility admitted the resident on 1/05/22 with diagnoses including Type 2 Diabetes Mellitus, Sleep Apnea, and Essential (Primary) Hypertension.

Record review of the Annual MDS, with an ARD of 12/15/22, for Resident #22 revealed a BIMS score of 15, which indicated the resident was cognitively intact.

A record review of the list of residents with Trust Fund Accounts provided by the facility revealed, Resident #22 had a Trust Fund Account.

Resident #25

On 1/03/23 at 11:14 AM, in an interview with Resident # 25, she revealed since her admission to the facility last February, she has never been able to get money on the weekends.

Record review of the Admission Record for Resident #25 revealed, the resident was admitted to the facility on 2/04/22, with diagnoses including Wedge Compression Fracture of Fifth Lumbar Vertebra, Spondylolysis, Paroxysmal Atrial Fibrillation, and Hypertension.

Record review of the Quarterly MDS for Resident #25, with an ARD of 11/08/22, revealed a BIMS score of 15, which indicated the resident is cognitively intact.

A record review of the list of residents with Trust

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F 567	Continued From page 4	F 567		

Fund Accounts provided by the facility revealed, Resident #25 had a Trust Fund Account.

Resident #35

Record review of the Admission Record for Resident #35 revealed, the resident was admitted to the facility on 1/30/20, with diagnoses including Type 2 Diabetes Mellitus, Essential (Primary) Hypertension, and Ataxia.

Record review of the Quarterly MDS for Resident #35, with an ARD of 8/31/22, revealed a BIMS score of 15, which indicated the resident was cognitively intact.

A record review of the list of residents with Trust Fund Accounts provided by the facility revealed, Resident #35 had a Trust Fund Account.

Resident #38

Record review of the Admission Record for Resident #38 revealed, the facility admitted the resident on 10/06/20 with diagnoses including Chronic Obstructive Pulmonary Disease.

Record review of the Quarterly MDS, with an ARD of 8/25/22, for Resident #38 revealed a BIMS score of 15, which indicated the resident was cognitively intact.

A record review of the list of residents with Trust Fund Accounts provided by the facility revealed, Resident #38 had a Trust Fund Account.

Resident #44

Record review of the Admission Record for

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F 567	Continued From page 5 Resident #44 revealed the facility admitted resident on 07/09/21 with diagnoses including Interstitial Pulmonary Disease and Essential (Primary) Hypertension. Record review of the Quarterly MDS for Resident #44, with an ARD of 8/30/22, revealed a BIMS score of 12, which indicated the resident had moderate cognitive impairment. A record review of the list of residents with Trust Fund Accounts, provided by the facility, revealed Resident #44 had a Trust Fund Account.	F 567		
	Surveyor: Howard, Wendy			
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.	F 576		2/1/23

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F 576	Continued From page 6 §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on staff and resident council interviews, record review, and facility policy review, the facility failed to provide mail delivery on Saturday to residents for six (6) of 6 residents present in Resident Council. This had the potential to affect all 49 residents residing in the facility. Resident	F 576	1. On January 6, 2023 the administrator inquired with residents #19, #22, #25, #35, #38, and #44 to ask for feedback on mail delivery for the weekend. All residents responded they did not feel weekend delivery was consistent. The	

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F 576	Continued From page 7 #19, #22, #25, #35, #38, and #44. Findings include: A record review of the facility's policy "Mail Delivery Policy," dated 2/2009 revealed, "It is the policy of this facility to deliver the resident's mail timely ... If the resident receives mail on Saturday it will be delivered to the resident by the weekend Registered Nurse (RN) Unit Manager." On 1/04/22 at 3:00 PM, during the Resident council meeting, (6) of the (6) residents present in the meeting complained of not getting their mail regularly and not getting mail on Saturdays. (Resident #19, #22, #25, #35, #38, and #44). On 01/05/23 at 8:50 AM, during an interview with Activities #1, she explained she delivers mail to the residents Monday through Friday. She revealed the facility does not have a system in place to ensure mail is delivered on Saturdays. On 01/05/23 at 09:40 AM, during an interview with the Administrator she explained the Charge Nurse should deliver mail on Saturdays. The Administrator confirmed that mail should be delivered on Saturday, but due to the turnover in staff, the facility has not had a consistent Charge Nurse, so the mail may not have been delivered. Resident #19 Record review of the Admission Record for Resident #19 revealed, the facility admitted the resident on 12/09/21, with diagnoses including Pulmonary Hypertension and Essential (Primary) Hypertension.	F 576	policy concerning resident mail delivery was presented to them at that time by the administrator. 2.On January 6, 2023 it was determined by the administrator that any resident with the availability to receive mail has the potential to be affected by this deficient practice. 3. On January 6, 2023 An In-service was conducted by the administrator with nursing staff to educate on resident mail delivery. The charge nurse, or in the absence of the charge nurse, the nurse in charge of cart B is responsible for ensuring resident mail is delivered. On January 6, 2023 a resident council meeting was held to inform residents about the weekend delivery of resident mail. Residents that were not in attendance of the resident council meeting were informed verbally via the Activities Coordinator about weekend delivery of resident mail. All nurses will be in-serviced monthly for six months on the facility policy concerning resident mail delivery. Reminders of this policy will be added to the agenda for monthly resident council meetings starting at the meeting on January 19, 2023 for six months. 4. After the policy took effect on January 7, 2023, the administrator began monitoring on January 9, 2023 and continued weekly for 3 months. Monitoring includes reviewing the Resident Mail Delivery log from the previous weekend and following up with residents who	

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F 576	Continued From page 8	F 576		

Record review of the Quarterly Minimum Data Set (MDS) for Resident #19, with an Assessment Reference Date (ARD) of 12/14/22, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.

Resident #22

Record review of the Admission Record for Resident #22 revealed, the facility admitted the resident on 1/05/22, with diagnoses including Type 2 Diabetes Mellitus, Sleep Apnea, and Essential (Primary) Hypertension.

Record review of the Annual MDS, with an ARD of 12/15/22, for Resident #22 revealed a BIMS score of 15, which indicated the resident was cognitively intact.

Resident #25

Record review of the Admission Record for Resident #25 revealed, the resident was admitted to the facility on 2/04/22, with diagnoses including Wedge Compression Fracture of Fifth Lumbar Vertebra, Spondylolysis, and Hypertension.

Record review of the Quarterly MDS for Resident #25, with an ARD of 11/08/22, revealed a BIMS score of 15, which indicated the resident was cognitively intact.

Resident #35

Record review of the Admission Record for Resident #35 revealed, the resident was admitted to the facility on 1/30/20, with diagnoses including Type 2 Diabetes Mellitus, Essential (Primary)

received mail to monitor feedback. The data from the monitoring will be discussed in the Quality Assurance and Performance Improvement Plan on January 31, 2023 times 3 months.

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F 576	Continued From page 9 Hypertension, and Ataxia. Record review of the Quarterly MDS for Resident #35, with an ARD of 8/31/22, revealed a BIMS score of 15, which indicated the resident was cognitively intact. Resident #38 Record review of the Admission Record for Resident #38 revealed, the facility admitted the resident on 10/06/20 with diagnoses including Chronic Obstructive Pulmonary Disease. Record review of the Quarterly MDS, with an ARD of 8/25/22, for Resident #38 revealed a BIMS score of 15, which indicated the resident was cognitively intact. Resident #44 Record review of the Admission Record for Resident #44 revealed the facility admitted resident on 7/09/21 with diagnoses including Interstitial Pulmonary Disease and Essential (Primary) Hypertension. Record review of the Quarterly MDS for Resident #44, with an ARD of 8/30/22, revealed a BIMS score of 12, which indicated the resident was cognitively intact.	F 576		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing	F 679		2/1/23

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F 679	Continued From page 10 program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on staff, resident and Resident Representative interviews, record reviews, and facility's policy review, the facility failed to provide an activities program on weekends for three (3) of 49 residents. Resident #14, Resident #44, and Resident #45. Findings include: Review of the facility's policy, "Activities Program" dated 12/2008 revealed, " ...An ongoing program of activities is designed to meet the needs of each resident ...2. Activities are scheduled daily ...6. Individualized and group activities are provided that ...b. Are offered at hours convenient to the residents, including evenings, holidays and weekends ..." Record review facility's Activities Calendar for December 2022 revealed there were scheduled activities on weekends that would require the assistance of the facility staff to implement for the residents. Resident #14 In an interview on 01/03/23 at 12:46 PM, with Resident #14's daughter, she said Resident #14 was a pastor of a church and enjoyed spiritual activities, such as listening to gospel music,	F 679	1. On January 6, 2023 the administrator inquired with residents #14, #44, and #45 to ask for feedback on resident activities for the weekend. All residents responded with the desire for weekend activities. The policy concerning resident weekend activities was presented to them at that time by the administrator. 2. On January 6, 2023 it was determined by the administrator that any resident with the desire to participate in resident activities has the potential to be affected by this deficient practice. 3. On January 6, 2023 An In-service was conducted by the administrator with all staff to educate on weekend resident activities. The Activities Coordinator is responsible for planning daily activities, and a designated staff member will be responsible for conducting scheduled activities on weekends. On January 6, 2023 a resident council meeting was held to inform residents about the resident activities on weekends. Residents that were not in attendance of the resident council meeting were informed verbally via the Activities Coordinator about resident activities on weekends. All staff	

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F 679	Continued From page 11 talking to people, and having the Bible read to him. She stated that she had been told by facility staff that they have church services on Sundays, but most of the time they do not have church. She commented that when she visits on Sundays, she turns on the television so he can watch church services and during most of her visits, her father will be sitting in the front entrance near the nurse's station in a Geri-chair. She said had been told that the Activities Department only works Monday through Friday. The daughter confirmed her father is unable to physically do his own activities because he is contracted and has poor vision and is dependent upon the facility to assist with activities. A record review of the "Admission Record" revealed the facility admitted Resident #14 on 11/16/2012 with diagnoses including Hemiplegia and Hemiparesis, Dementia, and Anxiety Disorder. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/21/22 revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 00 which indicated he had severe cognitive impairment. A record review of the annual MDS with an ARD of 7/5/22 revealed on Section F "Interview of Activity Preferences" it was "Very important" to Resident #14 to listen to music, do things with groups of people, do favorite activities, and participate in religious services or practices. Resident #44 During an interview on 01/03/23 at 3:47 PM, with	F 679	will be in-serviced monthly for six months on the facility policy concerning resident activities on weekends. Reminders of this policy will be added to the agenda for monthly resident council meetings starting at the meeting on January 19, 2023 for six months. 4. After the policy took effect on January 7, 2023, the administrator began monitoring on January 9, 2023 and will continue weekly for 3 months. Monitoring includes reviewing the Resident Activities participation log from the previous weekend and following up with residents who participated in weekend activities to monitor feedback. The data from the monitoring will be discussed in the Quality Assurance and Performance Improvement Plan on January 31, 2023 times 3 months.	

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F 679	Continued From page 12	F 679		

Resident #44, she stated that the facility does not offer activities on weekends, and that sometimes the facility will have a church scheduled, but they don't show up. She said the residents usually sit in the hallway at the front entrance to gossip because they don't have anything else to do and that she gets bored.

A record review of the "Admission Record" revealed the facility admitted Resident #44 on 07/09/2021 with diagnoses including Interstitial Pulmonary Disease and Hypertension.

A record review of the Quarterly MDS with an ARD of 8/30/22 revealed Resident #44 had a BIMS score of 12 which indicated her cognition was moderately impaired.

A record review of the Annual MDS with an ARD of 11/22/22 revealed on Section F "Interview of Activity Preferences" it was "Very important" to Resident #44 to listen to music, do things with groups of people, and do favorite activities.

Resident #45

In an interview on 01/03/23 at 10:45 AM, with Resident #45, she said that she sits at the front entrance in the hallway because it is considered the "gossip corner". Resident #45 stated the facility does not have activities on weekends and that although church is on the calendar, it does not happen. Resident #45 commented that she hates weekends because there is nothing to do and expressed that the facility needs to find something for them to do.

A record review of the "Admission Record" revealed the facility admitted Resident #45 on

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F 679	Continued From page 13 3/23/22 with a diagnosis of Dementia. A record review of the Quarterly MDS with an ARD of 9/8/22 revealed Resident #45 had a BIMS of 09 which indicated her cognition was moderately impaired. During an interview on 01/04/23 at 03:57 PM, with the Activity Director (AD), she confirmed the facility does not have activities on the weekends. The AD said she leaves word search puzzles and color pages for the residents that want to participate. The AD said she is the only person in the activity department and she only works Monday thru Friday. During an interview on 01/04/23 at 04:21 PM, the Administrator confirmed the AD only works Monday thru Friday. The Administrator said she has been trying to hire an activity aide. The Administrator confirmed the residents need activities seven days a week.	F 679		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		2/1/23

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F 690	Continued From page 14 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, staff interview, record review, and facility policy review, the facility failed to provide incontinent care in a manner to prevent the possibility of urinary tract infections (UTI) for one (1) of two (2) residents reviewed for incontinent care. Resident #42. Findings include: Review of the facility's, "Perineal Care Policy" revised 1/2010, revealed " ...It is the policy of the facility to provide perineal cleanliness and comfort to the resident, to prevent infections ...Procedure ...For a female resident ...b. Wash perineal area ...c. Instruct or assist the resident to turn on her side ...e. Wash the rectal area thoroughly ..."	F 690	1. On 1-3-23 at 12:00pm the Registered Nurse Supervisor assessed and performed peri care including the front and back of the perineal area on resident #42 with proper infection control practice. On 01-05-2023 resident #42 was assessed by Registered Nurse Supervisor for any signs of infection. Resident #42 denied any complaints of pain or difficulty from front of perineal area not being cleaned during pericare on 1-3-23 at 11:00am 2. Any resident receiving pericare from a nursing staff member has the potential to be affected by this deficient practice. 3. Beginning on 1-4-23 the Assistant	

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F 690	Continued From page 15 During observation of incontinent care on 01/03/23 at 11:00 AM, the State Agency (SA) observed Certified Nurse Aide (CNA) #1 providing incontinent care. CNA #1 began incontinent care by turning the resident on her side and wiping her rectal area. She then placed a clean brief on the resident and positioned her in the bed. CNA #1 did not clean the front perineal area of the resident. During an interview on 01/05/23 at 01:47 PM, the Director of Nursing (DON) confirmed CNA #1 failed to prevent the possibility of a UTI by not cleaning the resident's front perineal area and only cleaning the rectal area. The DON stated that the nursing staff have been trained to cleanse the perineal area every time care is provided, and the perineum should have been cleaned during care. During an interview on 01/05/23 at 03:15 PM, with CNA #1 she confirmed she failed to clean the front perineal area of the resident because she forgot. She stated the resident could acquire an infection by not providing incontinent care appropriately. Record review of the "Admission Record" revealed the facility admitted Resident #42 on 03/30/2021 with diagnoses including Hematuria, Retention of Urine, and Dementia. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/29/22 for Urinary and Bowel Continence revealed Resident #42 was frequently incontinent.	F 690	Director of Nursing and/or The Infection Prevention Nurse began skills validations, Handling of Soiled Linen and Infection Prevention during peri care with certified nursing assistants on 1-4-23. All staff were in serviced on Infection prevention and watched the Sparkling Surfaces and Clean hands Video demonstration on 1-23-23. 4. The Infection Preventionist and or the Assistant Director of Nursing will observe skills validation for proper perineal care, handling of soiled linen and infection control with 4 certified nursing assistants weekly times 3 months. This plan of correction was brought to the Quality Assurance meeting on 1-31-23 by the Director of Nursing. The Administrator or Director of Nursing will continue to report findings monthly to the Quality Assurance Committee times 3 months to ensure consistent substantial compliance has been met.	

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F 880	Continued From page 16	F 880		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals 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;	F 880		2/1/23

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F 880	Continued From page 17 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. 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 observations, interviews, record reviews, and facility's policy review the facility failed to prevent the possible spread of infection by placing dirty linen directly onto the floor and not washing or sanitizing hands after contact with body fluids during incontinent care for one (1) of two (2) residents reviewed for incontinent care. Resident # 42.	F 880	1. On 1-3-2023 the Registered Nurse Supervisor assessed resident #42 room. There no linens on the floor. On 1-5-23 resident #42 denied any complaints of pain or difficulty from dirty linen put on the floor during peri care on 1-3-23. 2. Any resident receiving bed linen change from a nursing staff member has the potential to be affected.	

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F 880	Continued From page 18 Findings Include: Review of the facility's policy, "Infection Prevention and Control Program", dated 9/2022, revealed, " ...This facility has established and maintained 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 as per accepted national standards and guidelines ...Policy Explanation and Compliance Guidelines: ...9. Equipment Protocol ...c. Reusable items potentially contaminated with infectious materials shall be placed in an impervious clear plastic bag ...11. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infections ...e. Soiled linen shall be collected at the bedside and placed in a linen bag ..." Review of the facility's document, "Procedure for Handwashing" revised 4/2015 revealed, " ...When to Wash Hands (at a minimum) ...After contact with any body fluids ...After handling any contaminated items (linens, soiled diapers, garbage, etc.)" During an observation on 01/03/23 at 11:00 AM, the State Agency (SA) observed CNA #1 providing incontinent care and changing Resident #42's linen. The SA observed that the dirty linen was placed directly on the floor and not in a container. CNA #1 turned the resident on her side and wiped her rectal area. CNA #1 then placed a clean brief on the resident. She did not wash or sanitize her hands or change her gloves before she positioned the resident in bed. She also placed a clean top sheet on the resident while	F 880	3. Beginning on 1-4-23 the Assistant Director of Nursing and or the Infection Prevention Nurse began skills validations, Handling of soiled linen and Infection Prevention during pericare with certified nursing assistants. All staff were inserviced on Infection prevention and watched the Sparkling Surfaces and Clean Hand Video demonstration on 1-23-2023 On January 26, 2023 the infection preventionist, Quality Assurance and Improvement Committee, and Corporate Compliance Nurses completed the Root Cause Analysis to determine the root cause. 4. The Infection Preventionist and or the Assistant Director of Nursing will observe skills validation for proper perineal care, handling of soiled linen and infection control with 4 certified nursing assistants weekly times 3 months beginning 1-4-23. The Administrator or Director of Nursing will report findings monthly to the Quality Assurance Committee times 3 months beginning 1-31-23 to ensure consistent substantial compliance has been met.	

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F 880	Continued From page 19	F 880		

wearing the same gloves that were used during incontinent care.

During an interview on 01/05/23 at 1:47 PM, the Director of Nursing (DON) confirmed CNA #1 failed to prevent the possible spread of infection by not changing her dirty gloves prior to repositioning and placing a clean sheet on the resident. The DON stated that CNA #1 should have placed the dirty linen in a bag instead of on the floor. The DON expressed that nursing staff are trained on perineal care and hand hygiene.

During an interview on 01/05/23 at 3:15 PM with CNA #1, she confirmed she would normally wash her hands and change her gloves after care, but she was nervous and forgot. CNA #1 also confirmed the dirty linen should have been placed in a plastic bag and not directly onto the floor.

Record review of the "Admission Record" revealed the facility admitted Resident #42 on 03/30/2021 with diagnoses including Hematuria, Retention of Urine, and Dementia.