STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255312	A. BUILDING _____ B. WING _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNION CO HEALTH AND REHAB CENTER, INC	1111 BRATTON ROAD NEW ALBANY, MS 38652

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 05/01/23 through 05/04/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F583, F656, and F880. Census at the time of survey was 49 and the facility held a license for 60 beds.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583		5/26/23

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

Electronically Signed | 05/19/2023

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F 583	Continued From page 1 of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and facility policy review, the facility failed to provide privacy to a resident during incontinent care as evidenced by failure to close the window blinds for one (1) of three (3) residents observed for incontinent care. Resident #31 Findings include: Record review of the facility "Procedural Guideline for Performing Perineal Care for a Female Patient," revealed, "...#4 Provide privacy..." An observation on 05/02/23 at 1:13 PM, revealed Certified Nursing Assistant (CNA) #1 provided incontinent care to Resident #31 and failed to close the window blinds on the large window in the resident's room to provide privacy to the resident. The observation revealed a large open area outside of the resident's window with a walkway and a busy parking lot present outside of the window. An interview on 05/02/23 at 1:25 PM. with CNA #1 revealed that she pulled the privacy curtain to provide privacy from the door but forgot to close the window blinds for privacy at the window and	F 583	F-583 * On 5/02/2023, upon completion of incontinent care evaluation on resident #31 provided by Certified Nursing Assistant #1, Certified Nursing Assistant #1 was given a one-on-one Teachable Moment in-service by Charge Nurse on the requirement to provide privacy during incontinent care for the resident. (Attachment #F583-1) Certified Nursing Assistant #1 verbally acknowledged understanding of this requirement. The Social Services Director then talked with resident #31 to see if the failure to provide privacy resulted in any negative outcomes for the resident. (Attachment #F583-2) Resident #31 stated she did not realize that the blinds were not drawn and did not feel scared or offended in any way. * The Director of Nurses conducted a chart audit of residents to determine those receiving incontinent care, which could be affected by this deficient practice. (Attachment #F-583-3a) * On 5/3/2023, the facilities' policy and procedures on providing resident privacy	

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F 583	Continued From page 2 stated, "I was in a hurry and just didn't do it." An interview on 5/3/23 at 8:35 AM, with Resident #31 revealed that she did not know the window blind was open when they did her care, but it should have been closed where nobody would see her that might be walking by outside. An interview on 5/3/23 at 11:20 AM, with the Director of Nursing (DON) revealed the blinds should have been closed to provide privacy in case anyone was outside. Record review of the in-service forms revealed CNA #1 attended an in-service/check off on perineal care and catheter care on 4/26/23, which included providing privacy. Review of the facility Face Sheet for Resident #31 revealed an admission date of 5/27/22 with diagnoses that included Epilepsy, Heart Failure, and Anemia. Review of Section C of the significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/27/23 revealed a Brief Interview for Mental Status (BIMS) score of seven (7) which indicated Resident #31 had severely impaired cognition.	F 583	and dignity during incontinent care was reviewed by the facilities' Quality Assurance Committee. (Attachment #F583-4) No changes were recommended at this time. An in-service on privacy and dignity for residents was initiated on 5/3/2023 to direct care staff by the staff development nurse and/or charge nurse, to be completed by direct care staff by 5/18/23. (Attachment #F583-5) Any direct care staff not receiving this in-service will not be allowed to work until they receive this in-service. All shifts including weekend staff must be in-serviced. * The staff development nurse and charge nurse will conduct unannounced observations of staff providing resident privacy during incontinent care starting 05/03/2023, one observation of incontinent care per day on each shift for two weeks for a total of 24 direct care staff being observed/evaluated during this time frame, then staff development nurse and or charge nurse will observe incontinent care and compliance with privacy policies and procedures two times a week for two weeks, eight personnel observed during this time frame, for a total of eight personnel, then one time a week for two weeks, for a total of four direct care staff being observed for that two week period, with a total of 40 personnel being observed thru the intensified observation period. After completion of this intensified observation period monthly observations will be conducted as part of ongoing Quality Assurance measures for the	

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F 583	Continued From page 3	F 583	facility commencing in July 2023. (Attachment #F583-6) Results will be recorded on a Quality Assurance worksheet and copies provided to the Administrator and Director of Nursing within forty eight hours of the observation. The facilities' Quality Assurance Committee will meet once a week on Thursday at 1400 hours and lasting approximately one hour, instead of once a month beginning 5/3/2023, to review the results of the privacy and dignity observations thru the intensified observation period. Should there be negative results identified thru the observations, the Quality Assurance Committee will recommend any changes necessary to correct the problem at this meeting. The Quality Assurance Committee will resume monthly meeting in July 2023 and review finding of observations of incontinent care privacy concerns provided thru monthly incontinent care observations. The Director of Nursing will provide the Quality Assurance Committee with copies of the compliance observations at the Quality Assurance Meeting each week, at which time The Director of Nursing will verbally review findings of weekly and or monthly observations. Weekly Quality Assurance meeting will end 6/15/2023 at which time monthly Quality Assurance Meeting will return to once a month scheduled to accommodate our Medical Directors Schedule.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		5/26/23

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F 656	Continued From page 4	F 656		

§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 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

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F 656	Continued From page 5 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 observation, staff interview, record review and facility policy review the facility failed to implement the care plan related to the proper handling of a catheter bag for one (1) of thirteen (13) care plans reviewed. Resident #15 Findings include: Review of the facility policy titled, "Using the Care Plan," revealed the care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Record review of the Care Plan with a problem onset date of 2/2/23 revealed, "Problem/Need: Potential for urinary tract infection related to presence of indwelling catheter ... Approaches: ... Position catheter tubing and urine collection bag below level of bladder ..." On 05/02/23 at 3:20 PM, an observation of catheter and incontinent care for Resident #15 revealed the resident up in her wheelchair and was transferred to the bed by Certified Nursing Assistants (CNA) #2 and CNA #3 with a sit to stand lift. The observation revealed that CNA #3 removed the resident's catheter bag from the privacy	F 656	F-656 * On 5/2/2023 Certified Nursing Assistants #2 and #3 received a teachable moment in-service given by the charge nurse on following the resident #15's plan of care as it related to providing catheter care and ensuring that the catheter bag is kept below the level of the residents bladder. (Attachment #F656-1) Certified Nursing Assistants #2 and #3 voiced understanding of these instructions. Charge Nurse then assessed resident #15 for sign and symptoms of urinary tract infection and results were negative. (Attachment #F656-2) On 5/3/2023 the Quality Assurance Committee met to review facilities Policy and Procedures related to care plans as they relate to providing incontinent care, catheter collection bags, and their positioning related to residents' bladder and no recommendations were made. (Attachment #F656-3) * All residents having a catheter and utilizing a catheter bag could be affected by this deficient practice. * An in-service to direct care staff on	

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F 656	Continued From page 6	F 656		

cover and handed it to CNA #2 who held the urinary catheter bag at chest level to the resident during the transfer, then moved the urinary catheter bag to the arm/hand support area of the lift before finally placing the catheter bag on the lower bed rail after the resident was in bed.

An interview on 05/02/23 at 3:40 PM, with CNA #2 revealed they should always hang the catheter bag on the bed and keep it below the bladder and stated that holding the bag too high can cause a urinary tract infection. CNA #2 confirmed that she had attended an in-service on incontinent care within the past year.

An interview on 05/03/2023 at 11:15 AM. with the DON revealed the CNAs know they are supposed to keep the catheter bag below the bladder to prevent backflow and stated that this could cause a urinary tract infection. She confirmed that it is the only catheter they have in the building and these two CNAs don't normally take care of this resident, but all CNA's should know to keep the catheter bag below the bladder.

An interview on 5/04/23 at 10:00 AM, with the Director of Nurses (DON) confirmed the care plan had not been followed if the resident's catheter bag had been held above the level of the bladder.

Review of the facility Face Sheet for Resident #15 revealed a readmission date of 2/02/23 with diagnoses that included Obstructive Uropathy, and Hypertensive Heart Disease without Heart Failure.

Review of Section C of the Minimum Data Set (MDS) with an Assessment Reference Date

ensuring compliance with the plan of care as it relates to providing catheter care ensuring catheter/collection bag is kept below the level of the residents' bladder was started on 5/3/2023 by staff development nurse and/or charge nurse. (Attachment #F656-4) Direct care staff that have not received this in-service by 5/18/2023 will not be allowed to work until they have completed it. Medication nurse will monitor resident #15 for signs and symptoms of infection each shift for 72 hours starting 5/2/2023. (Attachment #F656-5) Results will be reported to Director of Nurses as soon as possible after being identified. Staff development nurse or the charge nurse will conduct observations of catheter care once a shift for two weeks beginning 5/3/2023, then twice a week for each shift for two weeks, and then once a week for each shift for two weeks. Results will be documented on Quality Assurance Monitoring sheet with a copy being provided to the Director of Nursing. (Attachment #F656-6)

* Staff development nurse or the charge nurse will conduct observations of catheter care once a shift for two weeks beginning 5/3/2023, then twice a week for each shift for two weeks, and then once a week for each shift for two weeks. Results will be documented on Quality Assurance Monitoring sheet with a copy being provided to the Director of Nursing. (Attachment #F656-6) Director of Nursing will report negative findings of monitoring to the Quality Assurance Committee at weekly Quality Assurance meeting for

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F 656	Continued From page 7 (ARD) of 2/9/23 revealed a Brief Interview for Mental Status score of 15 which indicated Resident #15 was cognitively intact.	F 656	possible changes to residents plan of care. Quality Assurance Committee will also review results of observation of staff following care plans during catheter care at weekly meetings held on Thursday at 1400 hours and lasting approximately one hour. The Quality Assurance Committee will meet once a week during the intensified observation period to assess effectiveness of corrective actions and make changes if necessary.	
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	F 880		5/26/23

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F 880	Continued From page 8	F 880		

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

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

§483.80(e) Linens.
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

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F 880	Continued From page 9 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 possibility of the spread of infection by failure to perform hand hygiene during incontinent care for one (1) of three (3) residents observed for incontinent care. Resident #15 Findings include: Review of the in-service education titled, "Procedural Guidelines for Providing Catheter Care", revealed under #1. Perform hand hygiene and under #19. Dispose of all contaminated supplies in the appropriate receptacles. remove your gloves and perform hand hygiene. On 05/02/23 at 3:20 PM, an observation of catheter care and incontinent care for Resident #15 revealed Certified Nursing Assistant (CNA) #3 proceeded to perform catheter care and incontinent care and did not change her gloves during the procedure. After placing a clean brief on the resident, CNA #3 removed her gloves, adjusted the resident's shirt, and bed linens, placed a wedge under the resident's legs, adjusted her own glasses, and then handled the bed control and call light before washing her hands. An interview on 05/02/23 at 3:45 PM with CNA #3 confirmed she should have washed her hands when she took her gloves off because it could spread germs. Record review revealed CNA #3 had attended a check off/ in-service on perineal care and	F 880	F-880 * On 5/3/23, Facilities policy and procedure on Hand Hygiene was reviewed by the Quality Assurance Committee with no recommendations for changes. (Attachment #F880-1) Certified Nursing Assistant #3 received a teachable moment in-service one on one by the charge nurse on 5/3/2023. (Attachment #F880-2) Certified Nursing Assistant #3 voiced understanding of hand hygiene requirements during incontinent care. * All residents in this facility receiving incontinent care could be affected by this deficient practice. * An in-service on hand hygiene provided during incontinent care was initiated on 5/3/2023 by the Infection Control Preventionist to direct care staff. (Attachment #F880-3) Direct care staff that have not received this in-service will not be allowed to return to work until they have completed it after 5/18/2023. Exam Gloves will be placed in dispensers by the entrance door of residents' rooms to make exam gloves more convenient to the personnel engaged in providing incontinent care. (Attachment #F880-4) * Infection Control Preventionist and/or charge nurse will make observations of direct care staff providing incontinent care starting on 5/3/23, to ensure compliance	

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F 880	Continued From page 10 catheter care on 4/25/23. Review of the facility Face Sheet for Resident #15 revealed a readmission date of 2/02/23 with diagnoses that include Displaced bimalleolar fracture left lower leg, Obstructive Uropathy, and Hypertensive Heart Disease without Heart Failure.	F 880	of infection control hand sanitation/washing policies and procedures, one incontinent care session(one direct care staff), each shift a day for two weeks, twenty eight personnel, twice a week for two weeks, sixteen direct care personnel, then once a week for two weeks, four direct care personnel, all shifts. (Attachment #F880-5) Results of these observations will be recorded on a Quality Assurance Worksheet which will be submitted to the Director of Nursing within forty eight hours of the observation. The Director of Nursing will provide the Quality Assurance Committee results of Hand hygiene observations weekly at Quality Assurance Committee meetings held on Thursday at 1400 hours thru the 6/15/2023, for review and possible changes to our plan. The Quality Assurance Committee will be meeting once a week starting 5/3/23 and continuing thru the intensified observation period to review progress and make recommendations for change if necessary, 6/15/23. Quality Assurance Committee will return to regular meeting schedule of once a month beginning in July of 2023 to review results of ongoing Quality Assurance observations related direct care staff following infection control policies and procedures during incontinent care. The date of facilities monthly Quality Assurance meeting determined by our Medical Directors schedule and events in the Facility.	