STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255283	A. BUILDING _____ B. WING _____	06/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 6/13/23 through 6/15/23. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation related to F584, F656, F692 and F880. The census at the time of the survey was 58 and the facility is licensed for 60.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		7/21/23

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

Electronically Signed | 06/27/2023

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F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and facility policy review the facility failed to clean a visibly soiled overbed light and window blind and replace a broken window blind for two (2) of 58 residents reviewed. Resident #1 and Resident 21. Findings include: Record review of the facility policy titled, "Maintenance Service" with a revision date of June 2000 revealed, "Policy Statement: It is the policy of this facility that maintenance service be provided to all areas of the building, grounds, and equipment ... Procedure ...2. The following functions are performed by maintenance, but are not limited to ... k. Others that may become necessary as appropriate. Ex.(example) Replace broken blinds". Record review of the facility policy titled, "Cleaning and Disinfection of Environmental	F 584	1. Resident #1's broken window blind was replaced 06/14/2023. Resident #21's soiled window blind was cleaned, and the brown substance removed on 06/14/2023. Resident #21's overbed light was taken down and cleaned and the brown substance removed 06/14/2023. 2. All residents have the potential to be affected by the deficient practice. 3. The Maintenance Supervisor was in-serviced on 06/15/2023 by the Administrator on making room rounds to ensure broken blinds or other furniture that is broken will be repaired or replaced. The Housekeeping Supervisor was in serviced on 06/15/2023 by the Administrator on making room rounds to ensure soiled or dirty blinds and light	

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F 584	Continued From page 2 Surfaces" with a revision date of August 2009 revealed ...Policy Interpretation and Implementation ...9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled... 11. Walls, blinds, and window curtains in resident areas will be cleaned when the surfaces are visibly contaminated or soiled ..." Resident #1 An interview and observation on 06/13/23 at 2:20 PM, with Resident #1 in her room revealed that her window blinds were not working properly. She stated that the blinds will not close unless she takes her hand and closes each blind slate individually. She stated that she told Maintenance about it a while back and the Administrator a week or so ago, but it's still not fixed. An interview and observation on 6/14/23 at 8:05 AM with Resident #1 in her room revealed that the lower part of her window blinds was closed, and the upper part was open. This observation revealed there was no wand or string attached to the blinds to close or open them. Resident #1 stated that the blinds had been that way since she moved in this room in March of 2023 and that she closes them by hand. An interview on 6/14/23 at 8:10 AM, with Registered Nurse (RN) #1 revealed that if staff notices something that is broken then they let maintenance know and put it in his logbook that is kept at the nurse's station. She revealed the staff usually text or call him. She stated that if she notices something that needs to be cleaned then she will let housekeeping know or just clean it	F 584	covers are clean and free of any stained marks. It was discovered six (6) resident rooms need new blinds. Six (6) window blinds have been ordered on 06/26/2023 to replace the six (6) that are deficient. One (1) light cover had to be taken down to be cleaned. It was cleaned on 06/15/2023. Staff was in serviced on 06/15/2023 by the Administrator to write a work order form of any items such as resident blinds, light covers, or furniture that needs repairing and or replaced and place it in the maintenance work order notebook that is located at the nurse's station. 4. The Maintenance Supervisor will make environmental rounds weekly times four (4) weeks beginning on 06/15/2023 and then monthly to ensure any broken or soiled blinds are repaired/replaced. The Housekeeping Supervisor will make environmental rounds weekly times four(4) weeks beginning on 06/15/2023 and then monthly to ensure blinds and light covers are clean. The Maintenance Supervisor will report findings to the Quality Assurance Performance Improvement Committee (QAPI) beginning 07/13/2023 and then monthly for three (3) months then as needed for review, revision and/or resolution to the plan.	

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F 584	Continued From page 3	F 584		

herself. She revealed the rooms get deep cleaned per housekeeping schedule and when they do that everything is taken out of the room and the walls are cleaned in addition to everything else.

An interview and observation on 6/14/23 at 8:40 AM, with the Administrator confirmed that resident rooms do get deep cleaned as the Housekeeping Supervisor had revealed. She confirmed that Resident #1 had told her about her blinds being messed up about a week and a half ago and she notified maintenance but has not followed up on the issue. She revealed she did not put it in the maintenance logbook but should have so that would have been followed up on and fixed.

Record review of the maintenance logbook at the nurse's station revealed there was no request for the broken blinds in Resident #1's room.

Record review of Resident #1's Admission Record revealed the resident was admitted to the facility on 3/21/23 with medical diagnoses that included Unspecified Fracture of Shaft of Humerus, Left Arm, Initial Encounter for Closed Fracture.

Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/28/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.

Resident #21

On 06/13/23 at 2:45 PM, an observation and interview with Resident #21 in his room revealed

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F 584	Continued From page 4	F 584		

numerous raised spots of a brown substance along with a white substance that was the size of a tennis ball stuck to the light cover that was directly over his bed.

An interview and observation on 6/14/23 at 8:20 AM, with the Housekeeping Supervisor revealed that a different room each day gets deep cleaned. She revealed that when a room gets deep cleaned then the residents are moved out, the floors get stripped and waxed and the walls and everything gets wiped down and dusted. An observation of Resident #21's room with the Housekeeping Supervisor confirmed that there was a brown substance splattered all over half of the residents overbed light and on half of his window blinds. She revealed that this resident's room had been deep cleaned a couple of weeks ago. She stated that they had tried to get the brown substance off the blinds, but they could not, so maintenance had ordered more blinds.

An interview on 6/14/23 at 9:00 AM, with the Maintenance Director and the Administrator revealed that no one had mentioned the substance on the light cover in Resident #21's room to the Maintenance Director. The Administrator stated that she thinks the staff get tunnel vision and don't look up so that is why they never noticed Resident #21's light.

Record review of Resident #21's Admission Record revealed the resident was admitted to the facility on 3/27/23 with medical diagnoses that included Obstructive and Reflux Uropathy, Unspecified.

Record review of Resident #21's Minimum Data Set (MDS) with an Assessment Reference Date

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F 584	Continued From page 5 (ARD) of 4/7/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 11, which indicated that the resident had moderate cognitive impairment.	F 584		
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 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	F 656		7/21/23

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F 656	Continued From page 6 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 observation, resident and staff interview, record review, and facility policy review the facility failed to implement a fluid restriction care plan for one (1) of 17 care plans reviewed. Resident #9 Findings include: A review of the facility policy titled, "Care plans, Comprehensive Person Centered," revealed, "Policy Statement": A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial needs is developed and implemented for each resident...Policy Interpretation and Implementation ...7. The comprehensive, person-centered care plan ...: b.) describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ..." An observation and interview with Resident #9 on 6/13/23 at 11:00 AM, revealed she was on	F 656	1. Resident #9's water pitcher was removed on 06/14/2023. 2. Three (3) of 58 residents have the potential to be affected by the deficient practice. 3. The Residents care plans and task list who are on fluid restriction have been updated on to reflect do not provide any fluids to residents on fluid restrictions other than fluids on meal trays and by the Medication Nurse during medication pass due to fluid restrictions per order on 06/26/2023. Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs) were in serviced by the Director of Nursing (DON) on 06/15/2023 educating do not provide any fluids to residents on fluid restriction other than fluids provided on meal trays and by the Medication Nurse during	

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F 656	Continued From page 7 dialysis, and is doing well, and is on fluid restrictions. The State Agent (SA) also observed a plastic measured water pitcher on the bedside table with 600 ml (milliliters) of water in the pitcher. A review of the care plan revealed "Focus: I need dialysis (hemo) hemodialysis related to (r/t) renal failure. I receive hemodialysis Monday, Wednesday, Friday (Mon, Wed, Fri) at (Proper name) of kidney care clinic in (proper name), revision on 3/31/21 ...Interventions/Tasks: "1000 ml fluid restriction as ordered. FLUID RESTRICTION: 1000 ml (milliliters)/24 HR (hour). Nursing to provide 280 ML/day: 7a-7p (AM-PM) 140 ML, 7p-7a (PM-AM) 140 ML. Dietary to provide 720 ml/day: B-(Breakfast)240 ml, L-(Lunch) 240 ml, D- (Dinner) 240 ml..." A record review of the medical record for Resident #9 and interview with the Director of Nursing (DON) on 6/13/23 at 3:20 PM, revealed Resident #9 was on a 1000 ml fluid restriction. She revealed the fluid restriction was care planned and on the "Care Guide" for the Certified Nurse's Assistant's (CNA's) but confirmed the care guide does not reflect the fact that the CNAs are not to give resident any fluids. She also confirmed staff are not following the fluid restriction care plan. Record review of the Care Guide for the CNAs revealed, "FLUID RESTRICTION: 1000 ML/24 HR. Nursing to provide 280 ML/day: 7a-7p 140 ML, 7p-7a 140 ML. Dietary to provide 720 ml/day: B-240 ml, L-240ml, D-240 ml." An interview with the Minimum Data Set (MDS) Nurse on 6/14/23 at 10:04 AM, revealed the	F 656	medication pass due to fluid restrictions per order. 4. Resident Room Checks will be made three (3) times weekly for four (4) weeks beginning on 06/16/2023 by the Registered Nurse (RN) Supervisor or Director of Nursing (DON) and then one (1) time weekly for three (3) months to ensure the deficient practice is corrected and there being no water pitchers in the room. The Director of Nursing (DON) will report findings to the Quality Assurance Performance Committee (QAPI) beginning 07/13/2023 and then monthly times three (3) months for review, revision and/or resolution to the plan. The Medical Records Licensed Practical Nurse (LPN) will monitor the fluid intake documentation weekly times four (4) weeks beginning 06/29/2023 and then monthly times three (3) months and report findings to the Quality Assurance Performance Improvement (QAPI) Committee beginning 07/13/2023 for review, revision and/or resolution to the plan.	

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F 656	Continued From page 8 purpose of the comprehensive care plan was to map out the individualized care needed by each resident and confirmed that staff were not following Resident #9's fluid restriction plan of care. Record review of the Admission Record revealed that the facility admitted Resident #9 to the facility on 9/09/19 with diagnoses of Chronic Kidney Disease and Right sided heart failure, unspecified. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 4/14/23, revealed that Resident # 9 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated that she was cognitively intact.	F 656		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		7/21/23

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F 692	Continued From page 9 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy the facility failed to follow a resident's physician prescribed fluid restriction for one (1) of three (3) residents on fluid restriction. Resident #9 Findings include: Record review of the facility policy titled, "Fluids, Encouraging, and Restricting," with a revised date of August 25, 2014, revealed, "Purpose: The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging and restricting fluids... General guidelines: 1. Follow specific instructions concerning fluid restrictions ... 7. When a resident has been placed on restricted fluids, remove the water pitcher and cup from the room. If the resident refuses, notify the supervisor and in turn, the physician ... Documentation ...The following information should be recorded in the resident's medical record... 8. If the resident refuses treatment, the reason why and the intervention taken ..." An observation and interview with Resident #9 on 6/13/23 at 11:00 AM, revealed she was on dialysis, and she was to be following fluid restrictions. The staff provided the number of fluids she needs each day. The State Agent (SA) observed a plastic measured water pitcher on the bedside table with 600 ml (milliliters) of water in the pitcher. Resident #9 revealed one of the	F 692	1. Resident #9's water pitcher was removed on 06/14/2023. 2. Three (3) of 58 residents have the potential to be affected by the deficient practice. 3. The Residents care plans and task list who are on fluid restriction have been updated to reflect do not provide any fluids to residents on fluid restrictions other than fluids on meal trays and by the Medication Nurse during medication pass due to fluid restrictions per order on 06/26/2023. Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs) were in serviced on 06/15/2023 by the Director of Nursing (DON) educating do not provide any fluids to residents on fluid restriction other than fluids provided on meal trays and by the Medication Nurse during medication pass due to fluid restrictions per order. 4. Resident Room Checks will be made three (3) times weekly for four (4) weeks beginning on 06/16/2023 by the Registered Nurse (RN) Supervisor or Director of Nursing (DON) and then one (1) time weekly for three (3) months to ensure the deficient practice is corrected	

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F 692	Continued From page 10 Certified Nurse Assistant's (CNA's) came in earlier and filled it up with water and ice. Resident #9 confirmed staff are good about making sure she has fresh water. An observation and interview with Licensed Practical Nurse (LPN) #1 on 6/13/23 at 3:15 PM, confirmed there was a pitcher with water in Resident #9's room and there should not be, because the resident was on a 1000 ml fluid restriction daily. LPN #1 stated that staff should never leave water or any fluids in Resident #9's room and should notify the nurse if the resident is drinking something she should not. LPN #1 confirmed staff were not following Resident #9's fluid restriction orders and that could lead to fluid overload and distress. A record review of the Order Summary Report dated June 13, 2023 revealed a physician order with an order date of 12/08/22 for Resident #9 "Fluid Restriction: 1000 ml/24 hr (hours).Nursing to provide 280 ml/day: 7a-7p 140 ml, 7p-7a 140 ml. Dietary to provide 720 ml/day, B-(Breakfast) 240 ml, L- (lunch) 240 ml, D-(Dinner) 240 ml ...". An interview with the Director of Nursing (DON) on 6/13/23 at 3:20 PM, revealed that Resident #9 had a physician's order for 1000 ml fluid restriction daily and confirmed Resident #9 should not have a water pitcher in her room. The DON stated that a resident on dialysis receiving more than the prescribed fluids ordered is "fluid overload" and confirmed staff are not following physician prescribed fluid restriction orders. An interview with CNA #1 on 6/13/23 at 3:30 PM, she revealed that she provides care for Resident #9 often and she fills the water pitcher for	F 692	by there being no water pitchers in the room. The Director of Nursing (DON) will report findings to the Quality Assurance Performance Committee (QAPI) beginning 07/13/2023 and then monthly times three (3) months for review, revision and/or resolution to the plan. The Medical Records Licensed Practical Nurse (LPN) will monitor the fluid intake documentation weekly times four (4) weeks beginning 06/29/2023 and then monthly times three (3) months and report findings to the Quality Assurance Performance Improvement (QAPI) Committee beginning 07/13/2023 for review, revision and/or resolution to the plan.	

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F 692	Continued From page 11 Resident #9 "twice a shift." CNA #1 confirmed she was unaware Resident #9 was on a fluid restriction and that she was not supposed to provide her with water. An interview with CNA #2 on 6/14/23 at 9:39 AM revealed she provides care for Resident #9 at least two days a week and is aware that the resident is on fluid restriction. She stated that she does not give the resident any fluids other than those that come with her meals. She stated she fills up Resident #9's water pitcher twice per shift and that she never asks for any extra fluids. If she did, she would remind her of her fluid restriction and inform the nurse. Record review of the Admission Record for Resident #9 revealed the resident was admitted to the facility on 9/09/19 with diagnoses of Chronic kidney disease and Right sided heart failure, unspecified. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 4/14/23, revealed that Resident # 9 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated that she was cognitively intact. Review of Section O revealed that the resident was receiving dialysis.	F 692		
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	F 880		7/21/23

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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 circumstances.
(v) The circumstances under which the facility

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F 880	Continued From page 13 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, record review, and facility policy review the facility failed to maintain strict aseptic technique to prevent the spread of infection during an observation of medication administration via percutaneous endoscopic gastrostomy (PEG) tube for one (1) of four (4) medication administration observations. Resident #20 Findings Include: A review of the facility's policy titled, "Cleaning/Disinfection of Resident Care Items and Equipment," dated June 15, 2010, revealed, "Policy Statement: Resident care equipment, including reusable items ...will be cleaned and disinfected according to the CDC (Centers for Disease Control) for disinfection and OSHA	F 880	1. The used enteral feeding tube declogger wand used on Resident #20 was discarded on 06/14/2023. The old enteral feeding tubing for Resident #20 was replaced with new tubing for Resident #20 on 06/14/2023. The old syringe used for Resident #20 was discarded and replaced with a new syringe on 06/14/2023. Employee Coaching was performed with Licensed Practical Nurse (LPN) #2 by the Director of Nursing (DON) on 06/14/2023 on failure to use a clean barrier and	

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F 880	Continued From page 14 (Occupational Safety and Health Administration) Bloodborne Pathogen Standard...Reusable Items ... 1. Single resident use items are to be cleaned/disinfected between uses by a single resident and disposed of afterward...Single use items will be discarded after a single use ..." A review of the facility's policy titled, "Enteral Tube Medication Administration," dated May 10, 2013, revealed ..."Procedures ...U. Clean feeding syringe and store ..." A review of the facility's policy titled, "Enteral Feedings-Safety Precautions." dated May 10, 2013, revealed, "Purpose: To ensure the safe administration of enteral nutrition .... Preventing contamination: 1. Maintain strict aseptic technique at all times when working with enteral nutrition systems and formulas..." A review of the manufacturer guidelines for the Enteral Feeding Tube clog remover revealed "Once the clog is clear dispose of the wand...Single use only ..." An observation of medication administration via PEG tube for Resident #20 with Licensed Practical Nurse (LPN) #2 on 6/14/23 at 7:50 AM revealed, LPN #2 placed the continuous feeding pump on hold, disconnected the tubing from Resident #20's PEG tube and placed it on the resident's bed. After placement check, LPN #2 revealed she could not get the diluted medication to go in the PEG tube confirming "it must be clogged." LPN #2 removed the PEG tube adapter and syringe and placed it on the over bed table with no barrier. She then removed an Enteral feeding Tube Clog Remover wand from Resident #20's bedside table drawer that was not bagged	F 880	failure to obtain an unopened enteral feeding declogger. Licensed Practical Nurse (LPN) #2 was in serviced by the Director of Nursing (DON) on 06/14/20223 on proper rinsing, drying and storing of an enteral feeding tube syringe. 2. Five (5) of fifty-eight (58) residents have the potential to be affected by the deficient practice. 3. Registered Nurses (RNs) and Licensed Practical Nurses (LPN's) were in serviced on 06/15/2023 on Infection Control procedures related to Enteral Feedings to include enteral feeding tube declogger as a one (1) time use only and discard, proper rinsing, drying and storage of the feeding tube syringe after each feeding and proper use of clean barrier during the handing of enteral feedings by the Director of Nursing (DON). Enteral Feeding Checkoffs will be completed on Nurses by 07/03/2023 by the Director of Nursing (DON) or the Infection Preventionist (IP) Nurse Licensed Practical Nurse (LPN). 4. Enteral feeding checks will be monitored weekly times four (4) weeks beginning 06/16/2023 and then monthly by the Director of Nursing (DON) or the Infection Preventionist (IP) Licensed Practical Nurse (LPN). Findings will be reported by the Infection Preventionist (IP) Licensed Practical Nurse (LPN) monthly	

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F 880	Continued From page 15 and lying open on top of the resident's personal items and inserted the clog remover wand into the PEG tube. She then removed the wand and placed it on the bedside table with no barrier. LPN #2 then picked up the PEG tube adapter that was lying on the bedside table with no barrier and inserted it in the resident's PEG tube. The State Agent (SA) observed LPN #2 repeat this process three times, each time placing the items on the bedside table with no barrier. LPN #2 stated, "I cannot get the PEG tube unclogged. I am calling the charge nurse." While waiting for the charge nurse the SA observed the formula tubing that was placed on Resident #20's bed by LPN #2 earlier hanging off the side of the bed and touching the floor. When Registered Nurse (RN) #1 entered Resident #20's room, LPN #2 handed RN #1 the peg tube syringe and clog remover wand from the bedside table with no barrier and RN #1 inserted them into Resident #20's PEG tube to unclog the tube. LPN #2 then picked up the PEG tube adapter from the bedside table and reinserted it into Resident #20's PEG tube and administered all the medications. After completion of administering the medications, LPN #2 flushed the tube placed the PEG syringe in the storage bag on the bedside table without rinsing and drying the syringe, picked up the formula feeding tube that was hanging off the bed and touching the floor and connected it to Resident #20. LPN #2 then rinsed the clog remover wand and placed it back in Resident #20's bedside table drawer with no storage bag. An interview with LPN #2 on 6/14/23 at 8:15 AM, confirmed she placed the PEG tube syringe, adapter, and tube clog remover on the bedside table with no barrier and confirmed she should have put the supplies on a clean barrier. LPN #2	F 880	to the Quality Assurance Performance Improvement (QAPI) Committee beginning 07/13/2023 for three (3) months and then as needed for review, revision and/or resolution to the plan.	

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then revealed both the PEG tube syringe and clog remover should have been rinsed, dried .and stored in a clean storage bag but confirmed that she did not do that. LPN #2 went on to confirm she had placed the formula feeding tube on Resident #20's bed and saw it hanging off but did not realize it was on the floor. She then confirmed the formula tubing should have been placed in a clean area and not on the bed. LPN #2 stated the tubing would be considered dirty after touching the floor and should not have been reconnected to Resident #20's PEG tube. When the SA asked LPN #2 of possible concerns with using equipment considered "dirty", LPN #2 replied "possible transfer of bacteria, causing a bacterial or gastrointestinal infection" could have occurred.

An interview with the Director of Nurses (DON) on 6/14/23 at 8:30 AM, reviewed the findings of the infection control concerns that were observed during medication administration for Resident #20. The DON confirmed the PEG syringe, clog remover, and the formula tubing was considered dirty after not being placed on a clean barrier by LPN #2.

An interview with the RN #1 on 6/14/23 at 1:00 PM, she revealed she believed the equipment that LPN #2 handed her to unclog Resident #20's PEG tube to be clean, and confirmed that the PEG syringe would have been considered dirty if it was placed on the bedside table with no barrier and also confirmed the clog remover wand is single use item only and should have been disposed of.

An interview with the Infection Control nurse on 6/14/23 at 1:20 PM, she revealed any item placed on a dirty surface must be cleaned after use. If

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items are not cleaned or discarded, then the resident is at risk for transfer of numerous types of infections.

A record review of LPN# 2's "Continuing Education Earned" form revealed, "Infection Prevention in Long-Term Care Setting" with a completion date of 5/17/23 and "Basics of Enteral Nutrition" with a completion date of 5/18/23.

Record review of the Admission Record revealed the facility admitted Resident #20 to the facility on 8/15/19.Diagnosis Information included diagnoses that included Encounter for attention to gastrostomy and Dysphagia.

Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) on 4/12/23, revealed Resident #20 had a Brief Interview of Mental Status (BIMS) score of 99 which indicated the resident was unable to complete the interview. Section K indicated Resident #20 had a feeding tube while a resident.