STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255262	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMMUNITY LIVING CENTER	1036 WEST DRIVE LAUREL, MS 39440

(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 a Complaint Investigation (CI) MS #22259 at the facility from 8/9/23 through 8/10/23. The SA investigated the complaint for resident left wet and soiled, grooming, inappropriate feeding assistance, and improper infection control. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F684 and F880. The facility was licensed for 60 beds and had a census of 42 at the time of survey.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to provide treatment and services in accordance with professional standards for one (1) of two (2) residents reviewed with wounds. Resident #1 Findings Include: A review of the facility's "Skin Care Process" policy, dated 1/17/2018, revealed, " ...It is the policy of this facility to provide care and services	F 684	*Resident #1 was assessed 08/10/23 by Director of Nursing (DON) with no adverse findings. The package of gauze, spray container of wound cleanser, container of betadine, package of Alginate and container of hand sanitizer that the Registered Nurse #1 put back in wound cart was removed on 08/10/23 by Director of Nursing (DON)and wound cart was disinfected .	9/1/23

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

Electronically Signed | 08/25/2023

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F 684	Continued From page 1 that meet professional standards to treat the loss of skin integrity ..." On 8/10/23 at 10:05 AM, during an observation of wound care for Resident #1 with Registered Nurse (RN) #1, revealed RN #1 gathered supplies including a package of gauze, spray container of wound cleanser, container of betadine, package of Alginate, and container of hand sanitizer. All items were gathered in her arms and held against her chest and in contact with her clothing. RN #1 removed and discarded the soiled dressing. She retrieved several of the gauze from the packet, touching the container, and applied wound cleanser to the gauze. She cleaned the lower wound to the abdomen by blotting up and down on and around the wound, used the same gauze to clean the upper wound by blotting up and down on and around the wound, then used the same gauze to make one swipe from the top of the upper wound all the way down to the bottom of the lower wound. She did not discard and use clean gauze, or reposition the gauze to use a clean area while cleaning the wound. RN #1 then discarded the soiled gloves, applied hand sanitizer, and donned a clean pair of gloves. She reached into the container of Alginate and tore off a small piece. Her hands were in contact with the remaining Alginate in the container and she touched the container itself. She applied the Alginate to the sound, applied betadine, and covered the wound. RN #1 then gathered the package of gauze, wound cleanser, the packet of Alginate, betadine, and the hand sanitizer and exited the room. She took the supplies into the hallway and placed them back in the treatment cart. On 8/10/23 at 10:15 AM, in an interview with RN	F 684	* All residents have the potential to be effected. * In-service education regarding Handwashing and Hand Hygiene was provided to Registered Nurses and Licensed Practical Nurses 08/10/23 through 08/25/23 and ongoing for all staff to be completed 08/31/23, by Director of Nursing (DON). Skill performance check offs will be conducted 08/14/23 through 08/25/23 by Director of Nursing (DON) or Registered Nurse (RN) and ongoing until all Nurses completed with Registered Nurses and Licensed Practical Nurses to assure staff can demonstrate the correct procedure. Wound Care Nurse Practitioner(NP-C) provided in-serviced education to Registered Nurses and Licensed Practical Nurses on 08/24/23 for proper wound care procedures including hand washing and infection control. All New licensed nursing staff will be in-serviced on Handwashing and Hand Hygiene and checked off on proper wound care procedures before starting on the floor * All Licensed Nurses will be observed individually between 08/14/23-08/31/23 performing wound care by Director of Nursing (DON) or Registered Nurse (RN). Nurses will be chosen randomly for observation of wound care two (2) times a week for four (4) weeks then one time a week for four (4) weeks than one time monthly for three months. Observations up to 08/24/23 were brought to Quality Assessment and performance	

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F 684	Continued From page 2 #1, she confirmed that she should not have taken all the supplies into the resident's room and brought them back out and placed them in the treatment cart. She said she thought she should have only taken what was needed into the room but had understood she was supposed to take in all the supplies. She also confirmed that cleaning the wound improperly could have caused the wound to become infected. On 8/10/23 at 10:20 AM, in an interview with the Director of Nursing, she stated that she expected the nurses to complete wound care without contaminating the supplies. She stated that the facility currently has an outside wound care service that comes into the facility weekly to measure, assess, and treat resident wounds. Record review of the "Order Summary Report" with "Active Orders as of: 08/10/2023" revealed Resident #1 had a Physician's Order, dated 7/22/23, for "Cleanse wound to midline abdomen with wound cleanser, pat dry, apply alginate, paint wound with betadine, cover with bordered gauze, change drsg (dressing) every other day and prn (as needed) ..." Record review of the "Admission Record" revealed the facility admitted Resident #1 on 8/19/20 with diagnoses that included Fistula of Stomach and Duodenum. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/17/23, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated he was cognitively intact.	F 684	Improvement committee. Nurses that failed to correctly perform procedure will be required to repeat it. If Licensed Nurses fail second attempt, further education will be provided by Wound care Nurse Practitioner (NP-C) and wound care check offs will be repeated. Any other observations will be discussed 08/31/23 at our Quality Assessment Performance Improvement Committee to discuss findings and if further training or action is necessary and will continue each month until no areas of concern are noted.	
F 880 SS=D	Infection Prevention & Control	F 880		9/1/23

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F 880	Continued From page 3 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; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 4 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 observation, staff interview, record review, and facility policy review, the facility failed to prevent the possible spread of infection during wound care for one (1) of two (2) residents reviewed with wounds. Resident #1 Findings Include: Review of the facility's policy, "Infection Control Program", dated 7/16/22, revealed, " ...The facility	F 880	*Resident #1 was assessed 08/10/23 by Director of Nursing (DON) with no adverse findings. The package of gauze, spray container of wound cleanser, container of betadine, package of Alginate and container of hand sanitizer that the Registered Nurse #1 put back in wound cart was removed on 08/10/23 by Director of Nursing (DON)and wound cart was disinfected .	

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F 880	Continued From page 5 will establish and maintain an Infection Control Program focused on preventing the transmission of infectious disease ...Purpose ...Decrease the risk of infection for residents ...Insure compliance with federal and state infection control guidelines ..." Review of the facility's policy, "Handwashing/Hand Hygiene", dated June 2010, revealed, "...Policy Interpretation and Implementation...6. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. IF hands are not visibly soiled, use an alcohol-based hand rub...for all of the following situations:...before handling clean or soiled dressings...after removing gloves..." During an observation of wound care on 8/10/23 at 10:05 AM, for Resident #1 with Registered Nurse (RN) #1 revealed RN #1 gathered supplies for wound care that included a package of gauze, spray container of wound cleanser, container of betadine, package of Alginate, and container of hand sanitizer. All items were gathered in her arms and held against her chest and in contact with her clothing. RN #1 did not wash or sanitizer her hands before applying gloves and initiating wound care. RN #1 removed and discarded the soiled dressing, but did not wash or sanitize her hands before applying a clean pair of gloves. RN #1 returned unused supplies from Resident #1's room to the treatment cart. In an interview with RN #1, on 8/10/23 at 10:15 AM, she confirmed that not sanitizing her hands could have caused the wound to become infected. She confirmed that she should not have taken all the supplies into the resident's room and brought them back out and placed them in the	F 880	* All residents have the potential to be effected. * In-service education regarding Handwashing and Hand Hygiene was provided to Registered Nurses and Licensed Practical Nurses 08/10/23 through 08/25/23 and ongoing for all staff to be completed 08/31/23, by Director of Nursing (DON). Skill performance check offs will be conducted 08/14/23 through 08/25/23 by Director of Nursing (DON) or Registered Nurse (RN) and ongoing until all Nurses completed with Registered Nurses and Licensed Practical Nurses to assure staff can demonstrate the correct procedure. Wound Care Nurse Practitioner(NP-C) provided in-serviced education to Registered Nurses and Licensed Practical Nurses on 08/24/23 for proper wound care procedures including hand washing and infection control. All New licensed nursing staff will be in-serviced on Handwashing and Hand Hygiene and checked off on proper wound care procedures before starting on the floor * All Licensed Nurses will be observed individually between 08/14/23-08/31/23 performing wound care by Director of Nursing (DON) or Registered Nurse (RN). Nurses will be chosen randomly for observation of wound care two (2) times a week for four (4) weeks then one time a week for four (4) weeks than one time monthly for three months. Observations up to 08/24/23 were brought to Quality	

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F 880	Continued From page 6 treatment cart. During an interview with the Director of Nursing on 8/10/23 at 10:20 AM, she stated that she expected the nurses to sanitize their hands during wound care. Record review of the "Order Summary Report" with "Active Orders As Of: 08/10/2023" revealed Resident #1 had a Physician's Order, dated 7/22/23, for "Cleanse wound to midline abdomen with wound cleanser, pat dry, apply alginate, paint wound with betadine, cover with bordered gauze, change drsg (dressing) every other day and prn (as needed) ..." Record review of the "Admission Record" revealed the facility admitted Resident #1 on 8/19/20 with diagnoses that included Fistula of Stomach and Duodenum.	F 880	Assessment and performance Improvement committee. Nurses that failed to correctly perform procedure will be required to repeat it. If Licensed Nurses fail second attempt, further education will be provided by Wound care Nurse Practitioner (NP-C) and wound care check offs will be repeated. Any other observations will be discussed 08/31/23 at our Quality Assessment Performance Improvement Committee to discuss findings and if further training or action is necessary and will continue each month until no areas of concern are noted.	