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	255140	A. BUILDING _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BLUFFS REHABILITATION AND HEALTHCARE CENTER	2850 PORTER'S CHAPEL ROAD VICKSBURG, MS 39180

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey with four (4) complaint investigations (CI) at the facility from 10/24/23 to 10/26/23, CI MS # 22832 related to notification of change in condition and injury of unknown origin. CI MS #22896 related to resident rights, CI MS # 23102 and CI MS# 23104 related to falls. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA identified non-compliance and cited F 580 for CI MS#22832 related to notification of change in condition. The SA also cited F 656 related to development and implementation of care plans, F 688 related to prevention of decreased range of motion, F761 related to medication storage, and F 880 related to infection control. There were no deficiencies cited for CI MS # 22896, CI MS #23102 or CI MS # 23104. The census at the time of the survey was 106 and the facility is licensed for 107 beds.	F 000		
F 656 SS=G	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 -	F 656		11/24/23

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

Electronically Signed | 11/10/2023

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F 656	Continued From page 1 (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 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, facility policy review, and record review, the facility failed to develop a care plan for placement of splints to maintain or prevent worsening of contractures for	F 656	1. Resident #26 and #56 care plans and orders reviewed by Minimum Data Set Coordinator on 10/25/2023 for verification of placement of splints to maintain or	

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F 656	Continued From page 2 two (2) of 22 resident reviewed with a contracture. Resident #26 and Resident #56 Findings include: Review of the facility policy titled, "Care Plans, Comprehensive Person-Centered", with a reviewed date of January 2023, revealed, "Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident....8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being....k. Reflect treatment goals, timetables, and objectives in measurable outcomes; l. Identify professional services that are responsible for each element of care; m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; n. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and o. Reflect currently recognized standards of practice for problem areas and conditions..." Resident #26 During an observation and interview with Resident #26 on 10/24/23 at 3:07 PM revealed a wrist and hand splint on the bed. He stated since he finished therapy they don't put it on much. There were no observations during the survey from 10/24/23 through 10/26/23 of the splint in place on Resident #26.	F 656	prevent worsening of contractures. On 10/25/23 care plans were developed for Res #26 and Res #56. 2. All residents with contractures and orders for splints have the potential to be affected. 3.On 10/25/2023, an audit was conducted by Minimum Data Set Coordinator on all current residents to ensure proper orders and care plans are in place for placement of splints to maintain or prevent worsening of contractures. No negative findings were identified. On 10/26/2023 a Quality Assurance Performance Improvement (QAPI) meeting was held for failure to develop a care plan for placement of splints to maintain or prevent worsening of contractures with the interdisciplinary team, including but not limited to Medical Director, Administrator, Respiratory Therapy Director, Social Services Director, Minimum Data Set (MDS), Director of Nursing (DON), Assistant Director of Nursing (ADON), RN Supervisor, Activities Director, Staff Development Coordinator (SDC), Medical Records LPN, and Business Office Manager (BOM). The results of the audits conducted by MDS were reviewed during this Quality Assurance Performance Improvement (QAPI) meeting. The facility care plans, Comprehensive person-centered Policy were reviewed with no changes. On 10/26/2023 the direct care staff was in serviced by Administrator, Director of Nurses (DON),	

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F 656	Continued From page 3 In an interview on 10/25/23 at 9:00 AM, Certified Nursing Assistant (CNA) #2 revealed Resident #26 has a splint and he wears it. She stated the CNA is responsible for putting it on. An interview on 10/26/23 at 7:40 AM with CNA #1 revealed she thought therapy was putting Resident #26's splint on. She thought he was still in therapy. She stated when the resident comes off therapy, therapy will pull whoever is working with the resident and instruct them on the splint. She stated the splint is supposed to be on the resident's care plan for the CNAs to see. Record review of the Admission Record Resident Information Sheet revealed Resident #26 was admitted to the facility on 3/1/22 with diagnoses that included Hemiplegia and Hemiparesis following Non traumatic Intracerebral Hemorrhage affecting left dominate side, Muscle wasting and atrophy, and Chronic Kidney Disease, Stage 5. Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/18/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Resident #56 During an observation on 10/24/23 at 11:35 AM, revealed Resident #56 had a left-hand contracture with fingers contracted but not pressed against his palm. During the survey from 10/24/23 through 10/26/23, observations revealed Resident #56 in	F 656	and Assistant Director of Nurses (ADON), Risk Manager, Staff Development Coordinator (SDC), MDS on implementation and following care plans. 4. Beginning 10/26/2023, an audit will be conducted weekly for four (4) weeks, then monthly for three (3) months by the Director of Nursing/Assistant Director of Nursing or Risk Manager to review three (3) residents care plans for implementation. Any negative concern will be immediately reported to the Administrator or Director of Nursing for further intervention. QA was held on October 26,2023. A report will be submitted to the Quality Assurance Performance Improvement committee on November 21, 2023, for review and recommendations then monthly for three (3) months by the Director of Nursing for review and further recommendations. The Director of Nursing is responsible for monitoring and compliance.	

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F 656	Continued From page 4	F 656		

his room and mobile in his wheelchair over the facility with no splint in place on his left hand.

An interview on 10/26/23 at 7:40 AM, with CNA #1 revealed she has not seen a splint for Resident #56 and doesn't remember seeing it on the care plan.

Review of the Admission Record Resident Information Sheet for Resident #56 revealed an admission date of 6/19/19 with diagnoses that included Unspecified Focal Traumatic Brain Injury, Stiffness of the left hand, Muscle Wasting and Atrophy.

Review of the quarterly MDS with and Assessment Reference Date (ARD) of 9/14/23 revealed a BIMS score of 10 which indicated Resident #56 had moderate cognitive impairment.

An interview on 10/26/23 at 8:45 AM, with the DON confirmed that neither Resident #26 nor Resident #56 had a care plan for hand splints. The DON stated the care plan should be in place to ensure orders are followed and managed.

An interview on 10/26/23 at 8:50 AM, with the Minimum Data Set (MDS) Nurse #2 revealed the purpose of the care plan is to provide person centered care and everyone knows collectively how to care for the resident.

An interview on 10/26/23 at 8:53 AM, with MDS Nurse #1 revealed care plans are triggered from the MDS and from information received in their morning meeting about changes in residents. She stated she did not know Resident #26 did not have an order for a splint. MDS Nurse #1 stated

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F 656	Continued From page 5 that even if the splint was applied by therapy, there should be a care plan. When the resident is discharged from therapy and the splint is active, it should be put on the activities of daily living (ADL) care plan and the Kardex for the staff to see, and there should be an order. MDS Nurse #1 confirmed there was a splint order for Resident #56 but no care plan. She stated she remembered looking at it and thought she put it in the ADL care plan, but she did not. Record review of Resident #26 and Resident #56's record confirmed there was no care plan in place for their splints.	F 656		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident	F 688	1. Resident #26 and #56 orders were	11/24/23

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F 688	Continued From page 6 interview, facility policy review, and record review, the facility failed to utilize splints for residents to maintain or prevent worsening of contractures for two (2) of 22 residents reviewed with contractures. Resident #26 and Resident #56 Findings include: Review of the facility policy titled, "Contracture Management Program", with a revision date of 1/23/23, revealed, "Intent: To have a program within the facility geared towards the prevention of new contractures and maintenance or improvement of range of motion ..." Resident #26 An observation and interview, on 10/24/23 at 3:07 PM, revealed a wrist and hand splint laying on Resident #26's bed. Resident #26 stated since he finished therapy, they don't put it on much. There were no observations during the survey of Resident #26's splint being in place. An interview, on 10/25/23 at 9:00 AM, with Certified Nursing Assistant (CNA) #2 revealed Resident #26 has a splint and he has worn it. She stated the CNA is responsible for putting it on. During an interview on 10/26/23 at 7:43 AM, Resident #26 stated that a man from therapy used to put his splint on and he took it off at night. He stated that he has not had it on any weekends. He stated that no nurse or CNA had put his splint on because they told him they didn't know how. In an interview on 10/26/23 at 7:40 AM, with CNA #1 revealed therapy was putting Resident #26's	F 688	reviewed by Director of Nursing and Minimum Data Set Coordinator for completion and accuracy to prevent worsening of contractures. Res #26 and #56 were assessed by Assistant Director of nursing on 10/26/2023. Issues were immediately corrected. Director of Nursing in-serviced all nursing staff on 10/26/2023 on proper utilization of splints and following orders for placing and removing splints. 2. All 22 residents with orders for splints had the potential to be affected. On 10/26/2023 the Minimum Data Set Coordinator audited all residents with orders for splints that had potential to be affected for accuracy and completion. No issues found. 3. Beginning on 10/26/2023, staff were in-serviced by Director of Nursing (DON), Director of Therapy and Staff Development Coordinator on implementing splint orders. Director of Therapy will communicate need for splint orders and the Minimum Data Set Coordinator to ensure splint orders reach the Medication Administration Record (MAR). 4. On 10/26/2023 the Quality Assurance Performance Improvement Committee was held with the Medical Director and Interdisciplinary team to address issues with splint orders. Beginning 10/30/2023, an audit will be conducted weekly for four(4) weeks, then monthly for three (3) months by the Minimum Data Set	

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F 688	Continued From page 7 splint on, she thought he was still in therapy. She stated when the resident comes off therapy, therapy will pull whoever is working with the resident and instruct them on the splint. She stated the splint is supposed to be on the resident's care plan for the CNAs to see. An interview with the Physical Therapy Assistant (PTA) on 10/26/23 at 8:15 AM, revealed Resident #26 was not on therapy case load. He was discharged on 10/13/23. The PTA confirmed staff should be trained when the resident is discharged from therapy. An interview on 10/26/23 at 8:17 AM, with the Certified Occupational Therapy Assistant (COTA) stated he works as needed (prn) and the therapist takes care of the orders. He stated he does train with the CNA's but cannot locate paperwork for Resident #26. He stated the facility does not have a restorative at present, so they catch the people working on the floor with the residents to teach them about the splints. Interview with the Director of Nursing (DON) on 10/26/23 at 8:35 AM, confirmed Resident #26 should have had an order in the computer for continued use of his splint after discharge from therapy. Record review of the Occupational Therapy discharge summary for Resident #26 dated 10/6/23 revealed patient will safely wear wrist cock-up splint on left hand and left wrist for up to eight hours with minimal signs/symptoms of redness, swelling, discomfort, or pain. Review of the Admission Record resident information sheet revealed Resident #26 was	F 688	Coordinator to review the comprehensive care plan and its implementation for five (5) residents with orders for splint use and Director of Nursing and Director of Therapy services will perform observation of (5) residents with orders for splint use to observe splint placement being completed as ordered for (4) weeks, then monthly for three (3) months. A report will be submitted to the Quality Assurance Performance Improvement committee on November 21, 2023, for review and recommendations then monthly for (3) months. The Director of Nursing is responsible for monitoring and compliance.	

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F 688	Continued From page 8	F 688		

admitted to the facility on 3/1/22 with diagnoses that included Hemiplegia and Hemiparesis following Non traumatic Intracerebral Hemorrhage affecting left dominate side, Muscle wasting and atrophy, and Chronic Kidney Disease, Stage 5.

Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/18/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #26 was cognitively intact.

Resident # 56

An observation, on 10/24/23 at 11:35 AM, revealed Resident #56 had a left-hand contracture with fingers contracted but not pressed against his palm.

Observations during the survey from 10/24/23 through 10/26/23 revealed Resident #56 in his room and mobile in his wheelchair over the facility with no splint in place on his left hand.

During an interview, on 10/25/23 at 1:20 PM, with Licensed Practical Nurse (LPN) #2, she stated she had not put a splint on Resident #56. She confirmed there was an order for the splint but stated there was nowhere in the computer to document it being put on or to document the skin assessment. LPN #2 also confirmed the Medication Administration Record (MAR) for Resident #56 did not have the splint listed on it for documentation.

An observation and interview, on 10/25/23 at 1:25 PM, with the Director of Nursing (DON) and Resident #56 confirmed the DON could not locate

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F 688	Continued From page 9	F 688		

Resident #56's splint. The DON stated that she didn't expect to find it. Resident #56 stated that it had been about a week since he had the splint on. The DON stated that this was probably because the order was put in incorrectly and did not pull over for the staff to see.

An interview on 10/25/23 at 1:55 PM, with the Director of Therapy revealed they do an evaluation on all residents who have a contracture quarterly. The Director of Therapy revealed therapy had Resident #56 for treatment on service from 3/13/23 to 5/2/23 and again from 6/8/23 to 7/17/23. The Occupational Therapist would have then given instructions to the staff on the application of the splint.

Record review of the Occupational Therapy evaluation and plan of treatment form dated 10/25/23 revealed Resident #56 under clinical impression presents with left upper extremity (LUE) wrist, decreased range of motion (ROM) of elbow, wrist and digits that affects ability to wear palm splint with finger separators as part of contracture management.

An interview on 10/26/23 at 7:40 AM, with CNA #1 revealed she has not seen a splint for Resident #56 and doesn't remember seeing it on the care plan.

An interview on 10/26/23 at 8:35 AM, with the Director of Nursing (DON) and the Administrator (ADM) confirmed they have not had a Restorative Program since COVID-19 started. The process is for the order to be written on the computer for the splint, it goes to the Medication Administration Record (MAR) and the nurses are responsible for applying splints and assessing skin. The DON

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F 688	Continued From page 10	F 688		

confirmed Resident #56's order was not on MAR and she was unable to find any documentation in the progress notes concerning the resident's splint. She stated this should be documented daily. The ADM stated she felt Resident #56's order was put in incorrectly by therapy which did not let it pull over to the MAR. The DON stated therapy can put the order in the que and nursing confirms it for accuracy and then it is pulled to the MAR for documentation. The DON stated that if the orders and treatments are not carried out for splints it could cause worsening of the contracture or skin breakdown.

An interview on 10/26/23 at 11:53 AM, with the Occupational Therapist (OT) revealed Resident #56 had a decline in his wrist flexion from -70 in March 2023 to -88 on 10/26/23 and had a decline of the contracture to the index finger from -70 in March 2023 to -79 on 10/26/23.

Record review of the OT Discharge Summary date of service 3/13/23 - 5/2/23 revealed "Short Term Goals (STG)...#2 Patient will increase AROM (active range of motion) left wrist to -40 degrees...Baseline 3/13/23 -70 degrees. Discharge 5/2/23 -30 degrees. STG #3. Patient will increase AROM left index finger PIP (proximal interphalangeal joint) extension to -45 degrees...Baseline 3/13/23 -80 degrees...Discharge 5/2/23 -45 degrees..."

Record review of a Order Summary Report dated 3/27/23 revealed Resident #56 to wear left (L) resting hand splint daily in morning (am) up to four (4) hours or as tolerated. Nurse to check skin prior to applying splint and after removal of splint and report any skin changes immediately.

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F 688	Continued From page 11 Record review revealed a Splint and Range of Motion (ROM) Competency and Discharge Planning Form: Care Giver and /or Resident for Resident #56 dated 3/29/23. The form has instructions concerning the splint placement and is signed by the therapist, but no caregiver or resident signatures are noted upon discharge. Review of the Admission Record resident information sheet for Resident #56 revealed an admission date of 6/19/19 with diagnoses that included Unspecified Focal Traumatic Brain Injury, Stiffness of the left hand, Muscle Wasting and Atrophy. Review of the quarterly MDS with and ARD of 9/14/23 revealed a BIMS score of 10 which indicated Resident #56 had moderate cognitive impairment.	F 688		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		11/24/23

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F 761	Continued From page 12 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review the facility failed to ensure a medication was properly stored as evidenced by a vial of Albuterol Sulfate being left on a resident's bedside table for (1) of 21 rooms viewed with respiratory treatments. Resident #252. Findings include: A review of the facility policy titled, "Storage of Medications", revised April 2019, revealed, "Policy Statement The facility stores all drugs and biologicals in a safe, secure, and orderly manner..." An observation of Resident #252's room on 10/24/23 at 10:30 AM, revealed a nebulizer machine and tubing stored on the bedside table with a vial of what read as Albuterol laying on the bedside table in plain view from the doorway entrance. An observation and interview with the Treatment Nurse on 10/24/23 at 2:20 PM, she verified the vial laying on the bedside table next to the nebulizer machine in Resident #252's room was Albuterol Sulfate and confirmed that Resident	F 761	F761 □ Medication storage 1. On 10/24/2023, an unopened medication vial was identified and removed from resident #252□s room by Assistant Director of Nursing. Resident #252 was assessed by Assistant Director of Nursing on 10/24/2023 with no negative findings. LPN #2 was educated by the Director of Nursing on medication storage immediately. 2. All residents in the facility have the potential to be affected by improper medication storage. 3. RN supervisors will monitor for medications being left unattended in resident's rooms during rounds being made throughout the day on 10/24/2023 and daily there after. Any adverse findings will be addressed, medication removed immediately and reported to Administrator or DON. Any issues regarding medication storage will be added to the daily stand-up meeting agenda on 10/25/2023 to be discussed. All nursing staff were in-serviced on 10/24/2023 by RN Staff Development Coordinator. Nursing staff	

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F 761	Continued From page 13 #252 does not administer his own medications. The Treatment Nurse confirmed the Albuterol should not have been left in the room by staff. An interview with Licensed Practical Nurse (LPN) #2 on 10/24/23 at 2:32 PM, she revealed she had administered Resident #252's Albuterol that morning and when the treatment was completed, she put the nebulizer mask in the clean bag on the bedside table and revealed she did not see a vial of Albuterol. LPN #2 revealed possible concerns from the Albuterol being left in the room is that it is possible that Resident #252 missed a dose of the Albuterol which could result in respiratory concerns. An interview with the Administrator on 10/25/23 at 9:38 AM, revealed she is also a Respiratory Therapist. She then confirmed the Albuterol Sulfate should not have been left in Resident #252's room and revealed possible concerns from the medication being left in the room is the resident possibly missed a dose of the Albuterol increasing risk of shortness of breath. Record review of the Order Summary Report for Resident #252, revealed an order dated 10/18/23 for Ipratropium-Albuterol Inhalation 0.5-2.5 (3) three MG (MILLIGRAM)/3 (three) ML (MILLILITER) inhale orally every (6) six hours related to Chronic Obstructive Pulmonary Disease. Record review of the Admission Record revealed that the facility admitted Resident #252 on 10/18/23 with diagnoses of Chronic Obstructive Pulmonary Disease and Pneumonia. A record review of the Minimum Data Set dated	F 761	were educated to remove unattended medications immediately and to notify Administrator/DON. 4. On 10/26/2023 the Quality Assurance Performance Improvement Committee was held with the Medical Director and Interdisciplinary team to address issues with medication storage. Beginning 10/30/2023 all residents□ rooms will be surveillance for medications being left unattended on a weekly basis for four (4) weeks, then monthly for three (3) months by the DON/Administrator or Risk Manager. The administrator will report findings of audits to the Quality Assurance Performance Improvement committee¿on November 21, 2023, monthly for three (3) months for further recommendations. The Director of Nursing is responsible for on-going monitoring and compliance.	

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F 761	Continued From page 14 10/25/23 revealed a Brief Interview for Mental Status (BIMS) score of 08 which indicated that Resident #252 was moderately cognitively impaired.	F 761		
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	F 880		11/24/23

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F 880	Continued From page 15 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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review the facility failed to perform hand hygiene after removing gloves during resident care for two (2) of seven (7) residents observed for staff performance of hand hygiene during	F 880	F880/M1570 □ Infection control 1. Respiratory Therapist (RT) was observed demonstrating tracheostomy care to resident #36 with improper hand hygiene practices. RT was immediately	

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F 880	Continued From page 16 resident care. Resident # 36 and Resident # 66. Findings include: Record review of facility policy "Handwashing-Hand Hygiene Policy and Procedures", with a revision date of 10/2020, revealed, "Policy Statement This facility considers hand hygiene the primary means to prevent the spread of infections...Policy Interpretation and Implementation... 7. Use an alcohol-based hand rub...for the following situations...f. Before donning sterile gloves... Applying and Removing Gloves 1. Perform hand hygiene before and after applying non-sterile gloves..." Resident #36 An observation of Resident #36 on 10/24/23 at 1:00 PM, revealed she had a tracheostomy. An attempted interview with Resident #36 revealed that she is unable to speak and does not respond to interview. A record review of Resident #36 's "Order Review History Report", revealed a physician's order, dated 9/4/23, for tracheostomy care every shift and as needed using aseptic technique. Remove inner cannula, clean with 1/2 strength hydrogen peroxide and sterile gauze and cotton swab. Re-insert inner cannula, turn to lock, clean outer cannula/stoma with sterile water, pat dry with sterile gauze. May use split sterile gauze as needed. An observation of Resident # 36's tracheostomy care on 10/25/23 at 9:00 AM, performed by the Respiratory Therapist (RT) revealed that she washed her hands, applied clean gloves,	F 880	in-serviced on 10/24/2023 by the DON and educated on proper hand hygiene and tracheostomy care procedures. LPN #1 was observed demonstrating wound care to resident #66 with improper hand hygiene practices. LPN #1 was immediately in-serviced on 10/24/2023 by the DON and educated on proper hand hygiene and wound care procedures. Resident #36 and #45 were assessed on 10/24/2023 by Director of Nursing with no adverse findings. 2. All current residents in the facility had the potential to be affected by this deficient practice. 3. RT and LPN #1 received one on one education, in-servicing, and skills check offs on Hand washing, and infection control policy on 10/24/2023 by Director of Nursing and Administrator. All licensed nursing staff attended review of wound care policy on 10/24/2023 and will be observed for skills check off for wound care by the Director of Nursing by 11/17/2023. All RT staff attended review of tracheostomy care policy on 10/24/2023 and will be observed for skills check off for tracheostomy care by Director of Respiratory by 11/17/2023. A handwashing policy review in-service was initiated on 10/24/2023 and is ongoing at this time to ensure 100% compliance of all staff. This will be completed by Staff Development Coordinator by 11/17/2023. Hands-on skills check off for handwashing was initiated on 10/24/2023 and is ongoing at this time to ensure 100%	

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F 880	Continued From page 17 removed the dressing around the tracheostomy site, removed the disposable inner cannula and her removed gloves. The RT did not perform hand hygiene after removing the dirty gloves. She then applied clean gloves, cleaned the tracheostomy site with the prescribed solution, removed her gloves, and failed to perform hand hygiene. The RT then applied sterile gloves, replaced disposable inner cannula, removed her gloves, and failed to perform hand hygiene. During an interview with the RT on 10/25/23 at 9: 20 AM, she verified that she did not perform hand hygiene after removing gloves and before applying clean gloves during tracheostomy care. She agreed that failure to perform hand hygiene could lead to the spread of infection and that she should have performed hand hygiene between glove changes. During an interview with the Administrator and Director of Nursing (DON) on 10/25/23 at 9:45 AM, they stated that the RT should have performed hand hygiene each time she removed her gloves during tracheostomy care. The Administrator and DON agreed that failure to perform hand hygiene after removing gloves could result in the spread of infection. Record review of Admission Record for Resident #36 revealed she was admitted to the facility on 6/28/2021 with diagnoses that include Chronic Respiratory Failure with Hypercapnia and Encounter for Attention to Tracheostomy. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/18/23, for Resident #36, revealed, under Section C Brief Interview for Mental Status	F 880	compliance of all staff. This will be completed by Staff Development Coordinator by 11/17/2023. 4. On 10/26/2023 the Quality Assurance Performance Improvement Committee was held with the Medical Director and interdisciplinary team to address issues of handwashing and infection control. Director of Nursing and Administrator will observe five (5) staff members perform handwashing/wound care/tracheostomy care weekly for four (4) weeks, monthly for (3) three months, and then quarterly for one (1) year. Handwashing compliance, infection control, tracheostomy care, and wound care will be reviewed, and a report will be submitted to the Quality Assurance Performance Improvement committee on November 21, 2023 QAPI meetings monthly for three (3) months and then quarterly thereafter. The Director of Nursing is responsible for monitoring and compliance.	

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F 880	Continued From page 18	F 880		

(BIMS), that Resident #36 is rarely/never understood.

Resident #66
A record review of Resident # 66's "Order Review History Report" revealed a Physician's Order, dated 9/6/23, for Wound # 1 Stage four (4) pressure injury left calf, clean with wound cleaner, pat dry apply xeroform daily, cover with rolled gauze, change daily or as needed for soilage until healed.

An observation of wound care performed by Licensed Practical Nurse #1 (LPN) on 10/25/23 at 9:22 AM, revealed that LPN #1 performed hand hygiene, applied clean gloves, removed the dressing from Resident # 66's left leg, removed her gloves and applied clean gloves without performing hand hygiene. LPN #1 then cleaned the wound with wound cleanser, picked up a xeroform gauze and applied it to the wound bed, without removing gloves or performing hand hygiene. LPN #1 stated "I was supposed to change my gloves there." LPN # 1 then applied the rolled gauze around Resident # 66's left leg and secured the dressing.

During an interview with LPN # 1 on 10/25/23 at 9:28 AM, she verified that she should have performed hand hygiene each time she removed her gloves during wound care. She stated failure to perform hand hygiene after removing gloves could cause the spread of infection.

During an interview with the Administrator and DON, on 10/25/23 at 9:43 AM, they stated that LPN #1 should have performed hand hygiene each time she removed her gloves during wound care. The Administrator and DON agreed that

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F 880	Continued From page 19 failure to perform hand hygiene after removing gloves could result in the spread of infection. Record review of Admission Record for Resident # 66 revealed she was admitted to the facility on 12/15/2022 with diagnoses that include Paraplegia and Pressure Ulcer of Left Ankle. A record review of the Quarterly MDS with an ARD of 9/14/23, for Resident # 66, revealed, under Section C Brief Interview for BIMS that Resident # 66 is rarely/never understood.	F 880		