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	255115	A. BUILDING _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTER LLC	4540 MANHATTAN RD JACKSON, MS 39206

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F 000	INITIAL COMMENTS A Covid-19 Focused Emergency Preparedness Survey and Complaint Investigation (CI) MS#17289, CI MS#17909, CI MS#17923, CI MS#17968, and MS#17979 was conducted by the State Agency (SA) from 8/9/2021 through 8/13/2021. The facility was found to not be in compliance with the requirements for participation in Medicare and Medicaid. The SA determined the facility was not in compliance with 42 CFR 483.73 related to E-0024(b)(6) CFR 42.483.80 infection control and sited F880. The SA did not substantiate CI MS#17909 Resident/Patient Neglect, Quality of Care, CI and MS#17923 Quality of Care/Treatment, CI MS#17289 Admissions/Transfer and Discharge, and CI MS17979 Quality of Care/Treatment with no citations noted to complaint. The SA substantiated the complaint for CI MS#17968 Quality of Care/treatment and cited F600, F656,and F677. The facility has a license for 180 with a census of 147.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		

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

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physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on observations, staff and resident interviews, record review, and facility policy review, the facility failed to protect Resident #13 from neglect that resulted in Moisture Associated Skin Damage to the sacral area for one (1) of seven (7) residents reviewed for abuse and neglect. Resident #13.

Findings include:

Record review of the facility policy titled Abuse Prevention with revised date of 11/2017 revealed, "Definitions... f) Neglect: A failure of the facility, its employees, or service providers to provide goods and services necessary to avoid physical harm, mental anguish, emotional distress, or pain..."

Observation on 8/10/21 at 1:17 PM revealed Certified Nursing Assistant (CNA) #4 check and provide incontinent care to Resident #13. CNA #4 opened the front of the brief. Resident #13 was wet and dirty with bowel movement (BM). The resident was noted with two (2) briefs on. When CNA #4 opened the brief, she rolled the 2 briefs down and BM was noted all over Resident #13's perineal area. CNA #4 cleaned Resident #13's buttocks using wipes. Resident #13's entire buttocks appear red.

Interview on 8/10/21 at 1:32 PM, with CNA #4 confirmed that Resident #13 had on two (2) briefs and that her bottom was red.

Interview on 8/10/21 at 2:30 PM, with Registered Nurse (RN) #2 revealed that it is unacceptable for

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a resident to have two (2) briefs on because that can cause skin issues. She stated all residents get a bath or shower on the 7/3 shift and that Resident #13 should have gotten a bed bath today.

Interview on 8/10/21 at 2:33 PM, with CNA #3 revealed that she was the assigned CNA for Resident #13 today. She stated she did not put 2 briefs on the resident and that the 11/7 shift must have done it. CNA #3 stated she went into the resident's room this morning and she did not look wet, and that the resident told her that she did not need anything. She just pulled the cover back and looked at her brief and she did not realize she had 2 briefs on. CNA #3 admitted that she had not changed the resident or given her a bath today because they were short of linen. She stated she has been at work all day. The State Agency (SA) asked her what linen had to do with keeping the resident clean and turned. CNA #3 shrugged her shoulders and did not reply. CNA #3 stated that not changing and turning the resident and not giving her a bath could cause her to have more breakdown. CNA #3 did not respond when the SA asked if she considered not providing incontinent care, turning the Resident, and not bathing the Resident to be neglect of the resident.

Observation on 8/11/21 at 8:25 AM, during Resident #13's Activity of Daily Living (ADL) care, the SA asked Resident #13 if her bottom hurt and she shook her head up and down for yes. When asked if it hurt or burned, Resident #13 shook her head up and down for yes.

On 8/11/21 at 8:45 AM, the SA asked RN #2 would she come look at Resident #13's bottom

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with the SA and she stated that she had looked at it yesterday after she had observed CNA #4's care for Resident #13 and she had on two (2) briefs. RN #2 stated that she saw that Resident #13's bottom was red. The SA asked RN #2 to go look at Resident #13's bottom today as she had just been changed. CNA #3 and RN #2 turned Resident #13 over and opened the brief and RN #2 stated that she could see how red her bottom was and the two (2) open areas on the right buttock. RN #2 stated that the wound doctor is scheduled to see her this afternoon. RN #2 agreed that the dried, scaly skin that was around the open areas appeared as dried cream.

Observation on 8/11/21 at 3:24 PM, revealed the Wound Physician was present to perform a wound assessment on Resident # 13. The Wound Physician confirmed the entire buttocks is Moisture Associated Skin Damage (MASD) with a denuded area on the right buttock. He stated he recommended to consult with the attending physician to place a foley catheter in the resident to keep the urine from this area and to stop the calazinc treatment and begin using zinc to the entire bottom area. He stated he would not do a separate treatment for the denuded area on the right buttock because it would require a dressing and due to the skin damage on the buttocks and the need for the Zinc, it would be difficult to do this, and he would reassess it next week.

Interview on 8/12/21 at 9:10 AM with the Administrator (ADM) revealed he terminated CNA #3 yesterday afternoon, 8/11/21, due to her negligence to provide adequate care to Resident #13.

Phone interview on 8/12/21 at 12:10 PM, with the

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Wound Physician related to the new diagnosis of Moisture Associated Skin Damage (MASD) to the sacrum on Resident #13 revealed the Wound physician confirmed that being left double briefed and wet and soiled for a long period of time could have caused the MASD to the resident's sacrum. He stated he recommended to apply Zinc and to consult with the attending physician to place a foley catheter for a few days to allow the area to be free of as much moisture as possible.

Phone interview on 8/12/21 at 12:34 PM, with the attending physician for Resident #13revealed the attending physician confirmed and agreed with the wound physician's diagnosis of MASD and that the cause could be from the resident being doubled briefed and left wet and soiled for a long period of time.

Interview on 8/12/21 at 12:40 PM, with the Director of Nursing (DON) revealed that ADL care and incontinence care is part of the CNA orientation.

Record review of the personnel record for CNA #3 revealed competencies completed on 10/14/2020 for the following: Bath/shower, Bed bath, Handwashing, Incontinence care.

Interview on 8/12/21 at 1:05 PM, with the DON revealed that she is aware of the MASD diagnosis on Resident #13 and that she knows that being left wet and soiled and wearing two (2) briefs can cause this. She stated this is unacceptable care and this is the reason why CNA #3 was terminated.

Record review of the facility Weekly Skin Audit dated 8/11/21 revealed Resident #13 with a new

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skin issue on her sacrum compared to the weekly skin audit documented on 8/4/21.

Record review of the facility Wound Evaluation Form dated 8/11/21 revealed, a circle on the body diagram of the sacrum, "Wound Type: MASD...Treatment reviewed and ordered "clean with normal saline (NS), apply Zinc oxide every (q) shift.....Size: length 24 centimeters by width of 24 centimeters...Comments: MASD noted during care...Document care plan interventions: incontinent care as needed, weekly body audit, and turn every two (2) hours and PRN (as needed)."

Record review of the Physician Orders dated August 2021 for Resident #13 revealed a new order dated 8/11/21 to "Clean MASD to bilateral buttock with normal saline, pat dry, apply zinc oxide every shift until healed."

Record review of the (Proper Name) Surgical Note dated 8/11/21 by the Wound Physician revealed, "Wound Location: sacrum, Etiology: Moisture Associated Skin Damage... Provider comments: area of central denudation."

Record review of Resident #13's Care Plan, updated 8/3/21, "Problem/Need: Resident is incontinent of bowel and bladder, and requires assistance with immobility, Risk for impaired skin integrity related to incontinence, immobility and wears large brief, nutritional deficiency. Goal and Target Date: Resident will have no complications to episodes of incontinence thru 10/2021. Skin will remain intact without reddened or open areas thru 10/2021. Approaches:... incontinent checks/care every 2 hours and prn (as needed)..."

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F 600	Continued From page 6 Record review on 8/11/21 of the Daily Unit Management, revealed CNA #3 was assigned to care for Resident #13. Record review of the Face Sheet for Resident #13 revealed an admission date of 1/23/2020 with diagnoses of Type 2 Diabetes Mellitus without complications, Paroxysmal Atrial fibrillation, Anorexia, Gastro-Esophageal Reflux Disease without esophagitis, and Essential (primary) Hypertension. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/13/21 for Resident #13 revealed, Section C-Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of twelve (12) indicating Resident #13 had moderate cognitive impairment. Section G for Functional Status revealed requires limited assist of one person for bed mobility with 1 person physical assistance; and extensive assistance of 1 person for personal hygiene. The MDS revealed that toilet use occured only once or twice during the lookback period and required 1 person physical assistance.	F 600		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		

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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 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interview, record review and facility policy review, the facility failed to follow the care plan for one (1) of six (6) residents reviewed for Activities of Daily Living (ADL) care and incontinence care. Resident #13.

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Findings include:

Record review of the facility policy titled Comprehensive Person Centered Care Plans with a history date of 3/18, revealed, "POLICY: Each resident will have a person centered care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care."

Record review of Resident #13's Care Plan, updated 8/3/21, "Problem/Need: Resident is incontinent of bowel and bladder, and requires assistance with immobility, Risk for impaired skin integrity related to incontinence, immobility and wears large brief, nutritional deficiency. Goal and Target Date: Resident will have no complications to episodes of incontinence thru 10/2021. Skin will remain intact without reddened or open areas thru 10/2021. Approaches:... incontinent checks/care every 2 hours and prn (as needed)..."

Record review of Resident #13's Care Plan, updated 8/3/21, "Problem/Need: Risk for further decline in self care r/t (related to) dx (diagnosis) of arthritis.Goal and Target Date: Resident will have no further decline in ADLs thru 10/2021. Approaches:.. provide incontinent check/care every two (2) hours and as needed..."

Observation on 8/10/21 at 1:17 PM, revealed Certified Nursing Assistant (CNA) #4 check and provide incontinent care for Resident #13. CNA #4 opened the front of the brief. The resident was wet and dirty with bowel movement (BM). The resident was noted with two (2) briefs on. Resident #13 entire buttocks appeared red.

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Interview on 8/10/21 at 1:32 P.M. with CNA #4 confirmed that the Resident #13 had on two (2) briefs and that her bottom was red.

Interview on 8/10/21 at 2:30 P.M. with Registered Nurse (RN) #2 revealed that it is unacceptable for a resident to have two (2) briefs on because that can cause skin issues. Stated all residents get a bath or shower on the 7/3 shift and that Resident #13 should have gotten a bed bath today.

Interview on 8/10/21 at 2:33 P.M. with CNA #3 revealed that she was the CNA for Resident #13 today. Stated she did not put 2 briefs on the resident and that 11/7 must have done it. Stated she went in the resident's room this morning and she did not look wet, and that the resident told her that she did not need anything. Stated she just pulled the cover back and looked at her brief and she did not realize she had 2 briefs on. CNA #3 admitted that she had not changed the resident or given her a bath today because they were short of linen. Stated she has been at work all day. The State Agent (SA) asked her what linen had to do with keeping the resident clean and turned, CNA #3 shrugged her shoulders and did not reply. CNA #3 stated that not changing and turning the resident and not giving her a bath could cause her to have more breakdown. CNA #3 did not respond when the SA asked if she considered not providing incontinent care, turning the Resident, and not bathing the Resident to be neglect of the resident.

Observation on 8/11/21 at 8:25 A.M. of CNA #3 provide ADL care to Resident #13. CNA #3 prepared a pan of soapy water and sat it on the over bed table. CNA #3 used a soapy cloth to wash the resident's face. CNA #3 put the cloth

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back in the same pan and squeezed the cloth and washed the resident's upper arms, axilla, and the upper chest area. CNA #3 placed the cloth back in the pan of water and took a towel and dried the resident's arms, CNA #3 did not rinse the soapy water off the Resident #13 face, arms, axilla, and upper chest area. CNA #3 opened the brief and folded the brief down between the resident's legs. CNA #3 used the same cloth and squeezed the soapy water out and began to wash the resident's front peri area. CNA #3 told the resident that she needed her to turn to the right and the resident turned with physical help from CNA #3 and held onto the siderail. CNA #3 used a couple wipes to clean BM off the rectal area. CNA #3 used the same cloth and squeezed the soapy water off and washed the buttocks area. After CNA #3 washed the resident's buttocks, she placed a clean brief on the resident and did not rinse or dry her skin. CNA #3 then placed a clean gown on the resident. CNA #3 confirmed that she had completed the resident's bath and care for the morning, when asked by this SA.

Interview on 8/11/21 at 8:25 A.M. during Resident #13 ADL care this SA asked Resident #13 if her bottom hurt and she shook her head up and down for yes. When asked if it hurt or burned, Resident #13 shook her head up and down for yes.

Interview on 8/11/21 at 8:40 AM with CNA #3 confirmed that the bath she gave just now to Resident #13 was a complete bath. Stated she thought she washed everything when she gave the bath. Stated the water had very little soap in it and she used the towel to dry her off. Stated she guessed that the soap could irritate the skin if not rinsed off.

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On 8/11/21 at 8:45 A.M. this SA asked RN #2 would she come look at Resident #13 bottom with this SA and she stated that she had looked at it yesterday after she had observed CNA #4's care for Resident #13 and she had on two (2) briefs. RN #2 stated that she saw that Resident #13's bottom was red. This SA asked RN #2 for us to go look at Resident #13 bottom today as she had just been changed. CNA #3 and RN #2 turned the Resident #13 over and opened the brief and RN #2 stated that she could see how red her bottom was and the two (2) open areas on the right buttock. RN #2 stated that the wound doctor is down to see her this afternoon. RN #2 agreed that the dried scaly skin that was around the open areas appeared as dried cream.

Observation on 8/11/21 at 3:24 P.M. revealed wound physician present to perform a wound assessment on Resident # 13. Wound physician the entire buttocks is moisture associated skin damage (MASD) with a denuded area on the right buttock. Stated he recommended to consult with the attending physician to place a foley catheter in the resident to keep the urine from this area and to stop the calazinc treatment and begin using Zinc to the entire bottom area. Stated he will not do a separate treatment for the denuded area on the right buttock because it would require a dressing and due to the skin damage on the buttocks and the need for the Zinc, it would be difficult to do this, and he will reassess it next week.

Interview on 8/12/21 at 9:10 A.M. with the Administrator revealed he terminated CNA #3 yesterday afternoon, 8/11/21, due to her negligence to provide adequate care to the Resident #13.

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Observation on 8/12/21 at 9:35 AM of Resident #13 fingernails remain with dirty substance under all her fingernails.

Interview on 8/12/21 at 9:36 A.M. with RN #2 revealed that any nurse can do nail care. RN #2 stated the CNA should ensure the nails are cleaned during their bath. Stated the RN is responsible for keeping the nails trimmed.

Observation on 8/12/21 at 9:40 A.M. with RN #2 as she examined Resident #13 fingernails. Stated all her fingernails have a dirty substance under them and need to be cleaned.

Interview on 8/12/21 at 9:42 A.M. with CNA #5 while in Resident #13 room revealed she had already completed the bed bath on Resident #13. CNA #5 confirmed that Resident #13 fingernails have a dirty substance under every one of them. Stated she does need to have them cleaned and that she should have done this with her bath. Stated she has been ripping and running today and just got back to work off vacation.

Interview on 8/12/21 at 11:40 A.M. with the Director of Nursing (DON) revealed that nail care is part of the AM care, and that no resident should have dirty fingernails, especially after their bath.

Phone interview on 8/12/21 at 12:10 P.M. with the wound physician related to the new diagnosis of Moisture Associated Skin Damage (MASD) to the sacrum on Resident #13. Wound physician confirmed that being left double briefed and wet and soiled for a long period of time could have caused the MASD to the resident's sacrum. Stated he recommended to apply Zinc and to

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consult with the attending physician to place a foley catheter for a few days to allow the area to be free of as much moisture as possible.

Phone interview on 8/12/21 at 12:34 P.M. with the attending physician for Resident #13. The attending physician confirmed and agreed with the wound physician's diagnosis of MASD and that the cause could be from the resident being doubled briefed and left wet and soiled for a long period of time.

Interview on 8/12/21 at 12:40 P.M. with DON revealed that ADL care and incontinence care is part of the CNA orientation and that it is part of the resident's care plan. Stated they are taught bed baths and incontinence care in orientation.

Record review of the personnel record for CNA #3 revealed competencies completed on 10/14/2020 included incontinence care.

Interview on 8/12/21 at 1:05 P.M. with DON revealed that she is aware of the MASD diagnosis on Resident #13 and that she knows that being left wet and soiled and wearing two (2) briefs can cause this. Stated this is unacceptable care.

Record review of the facility Weekly Skin Audit dated 8/11/21 revealed Resident #13 with a new skin issue on her sacrum compared to the weekly skin audit documented on 8/4/21.

Record review of the facility Wound Evaluation Form dated 8/11/21 revealed, a circle on the body diagram of the sacrum, "Wound Type: MASD...Treatment reviewed and ordered "clean with normal saline (NS), apply Zinc oxide every

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F 656	Continued From page 14 (q) shift.....Size: length 24 centimeters by width of 24 centimeters...Comments: MASD noted during care...Document care plan interventions: incontinent care as needed, weekly body audit, and turn every two (2) hours and PRN (as needed)." Record review of the Physician Orders on Resident #13 revealed a new order dated 8/11/21 to clean MASD to bilateral buttock with normal saline, pat dry, apply zinc oxide every shift until healed. Record review of the (Proper Name) Surgical Note dated 8/11/21 by wound physician under wound location: sacrum, under etiology; Moisture Associated Skin Damage, under provider comments: area of central denudation. Record review of the Face Sheet for Resident #13 revealed an admission date of 1/23/2020 with diagnoses of: Diabetes type two (2), Paroxysmal Atrial fibrillation, anorexia, Gastro Esophageal Reflux Disorder, and Essential Hypertension. Record review of the Minimum Data Set (MDS) dated 7/13/21 for Resident #13 revealed under Section C-Cognitive Pattern revealed a BIMs score of twelve (12) and under section G for Functional statues revealed requires extensive assist of one person for personal hygiene.	F 656		
F 677 SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		

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This REQUIREMENT is not met as evidenced by:
Based on observations, staff and resident interviews, record review and facility policy review, the facility failed to provide incontinent care in a manner to prevent the occurance of Moisture Associated Skin Damage (MASD), and failed to ensure fingernails were cleaned and skin was rinsed after a bed bath for one (1) of six (6) residents reviewed for Activities of Daily Living (ADL). Resident #13.

Findings include:

Record review of the facility policy titled Bed Bath with a date of 8/11 revealed "POLICY: Bedfast residents will receive a bed bath daily. A bed bath also provides a mild form of exercise and allows observation of the resident to meet his psychosocial and physical needs... Procedure: ...10. Bathe, rinse and dry face, ears, and neck. Ask resident if soap is desired. Give special attention to eyes, nose, and corners of mouth. After washing one eye, fold the washcloth over before washing other eye. 11.Remove gown.12. Bathe, rinse, and dry farther arm, axilla, and hand; pay particular attention to nail beds and between fingers.13. Bathe, rinse, and dry nearer arm, axillar and hand. 14. Place bathe towel over chest and fold bath blanket to abdomen. Avoid exposing resident. 15.Place bath towel, wash, rinse, and dry chest. 16.Fold blanket to pubis region. 17.Bathe rinse and dry abdomen. Give special care to umbilicus and deep folds of skin ....19. Wash legs and feet. Bathe, rinse and dry ...21. Bathe, rinse, and dry back from hairline to waist, then buttocks."

Record review of the facility policy titled A.M.

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Care with a History: Comm 10/09 policy E.1 revealed "POLICY: A.M. Care will be given to residents daily. RESPONSIBILITY: All nursing assistants ... PROCEDURE: ...10.Provide nail care as needed.

Observation on 8/10/21 at 1:17 PM revealed Certified Nursing Assistant (CNA) #4 check and provide incontinent care to Resident #13. CNA #4 opened the front of the brief. Resident #13 was wet and dirty with bowel movement (BM). The resident was noted with two (2) briefs on. When CNA #4 opened the brief, she rolled the 2 briefs down and BM was noted all over Resident #13's perineal area. CNA #4 cleaned Resident #13's buttocks using wipes. Resident #13's entire buttocks appear red.

Interview on 8/10/21 at 1:32 P.M. with CNA #4 confirmed that the Resident #13 had on two (2) briefs and that her bottom was red.

Interview on 8/10/21 at 2:30 P.M. with Registered Nurse (RN) #2 revealed that it is unacceptable for a resident to have two (2) briefs on because that can cause skin issues. Stated all residents get a bath or shower on the 7/3 shift and that Resident #13 should have gotten a bed bath today.

Interview on 8/10/21 at 2:33 P.M. with CNA #3 revealed that she was the CNA for Resident #13 today. Stated she did not put 2 briefs on the resident and that 11/7 must have done it. Stated she went in the resident's room this morning and she did not look wet, and that the resident told her that she did not need anything. Stated she just pulled the cover back and looked at her brief and she did not realize she had 2 briefs on. CNA #3 admitted that she had not changed the

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resident or given her a bath today because they were short of linen. Stated she has been at work all day. The State Agent (SA) asked her what linen had to do with keeping the resident clean and turned, CNA #3 shrugged her shoulders and did not reply. CNA #3 stated that not changing and turning the resident and not giving her a bath could cause her to have more breakdown. CNA #3 did not respond when the SA asked if she considered not providing incontinent care, turning the Resident, and not bathing the Resident to be neglect of the resident.

Observation on 8/11/21 at 8:25 A.M. of CNA #3 provide ADL care to Resident #13. CNA #3 prepared a pan of soapy water and sat it on the over bed table. CNA #3 used a soapy cloth to wash the resident's face. CNA #3 put the cloth back in the same pan and squeezed the cloth and washed the resident's upper arms, axilla, and the upper chest area. CNA #3 placed the cloth back in the pan of water and took a towel and dried the resident's arms, CNA #3 did not rinse the soapy water off the Resident #13 face, arms, axilla, and upper chest area. CNA #3 opened the brief and folded the brief down between the resident's legs. CNA #3 used the same cloth and squeezed the soapy water out and began to wash the resident's front peri area. CNA #3 told the resident that she needed her to turn to the right and the resident turned with physical help from CNA #3 and held onto the siderail. CNA #3 used a couple wipes to clean BM off the rectal area. CNA #3 used the same cloth and squeezed the soapy water off and washed the buttocks area. After CNA #3 washed the resident's buttocks, she placed a clean brief on the resident and did not rinse or dry her skin. CNA #3 then placed a clean gown on the resident. CNA #3 confirmed that she had

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completed the resident's bath and care for the morning, when asked by this SA.

Interview on 8/11/21 at 8:25 A.M. during Resident #13 ADL care this SA asked Resident #13 if her bottom hurt and she shook her head up and down for yes. When asked if it hurt or burned, Resident #13 shook her head up and down for yes.

Interview on 8/11/21 at 8:40 AM with CNA #3 confirmed that the bath she gave just now to Resident #13 was a complete bath. Stated she thought she washed everything when she gave the bath. Stated the water had very little soap in it and she used the towel to dry her off. Stated she guessed that the soap could irritate the skin if not rinsed off.

On 8/11/21 at 8:45 A.M. this SA asked RN #2 would she come look at Resident #13 bottom with this SA and she stated that she had looked at it yesterday after she had observed CNA #4's care for Resident #13 and she had on two (2) briefs. RN #2 stated that she saw that Resident #13's bottom was red. This SA asked RN #2 for us to go look at Resident #13 bottom today as she had just been changed. CNA #3 and RN #2 turned the Resident #13 over and opened the brief and RN #2 stated that she could see how red her bottom was and the two (2) open areas on the right buttock. RN #2 stated that the wound doctor is down to see her this afternoon. RN #2 agreed that the dried scaly skin that was around the open areas appeared as dried cream.

Observation on 8/11/21 at 3:24 P.M. revealed wound physician present to perform a wound assessment on Resident # 13. Wound physician the entire buttocks is moisture associated skin

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damage (MASD) with a denuded area on the right buttock. Stated he recommended to consult with the attending physician to place a foley catheter in the resident to keep the urine from this area and to stop the calazinc treatment and begin using Zinc to the entire bottom area. Stated he will not do a separate treatment for the denuded area on the right buttock because it would require a dressing and due to the skin damage on the buttocks and the need for the Zinc, it would be difficult to do this, and he will reassess it next week.

Interview on 8/12/21 at 9:10 A.M. with the Administrator revealed he terminated CNA #3 yesterday afternoon, 8/11/21, due to her negligence to provide adequate care to the Resident #13.

Observation on 8/12/21 at 9:35 AM of Resident #13 fingernails remain with dirty substance under all her fingernails.

Interview on 8/12/21 at 9:36 A.M. with RN #2 revealed that any nurse can do nail care. RN #2 stated the CNA should ensure the nails are cleaned during their bath. Stated the RN is responsible for keeping the nails trimmed.

Observation on 8/12/21 at 9:40 A.M. with RN #2 as she examined Resident #13 fingernails. Stated all her fingernails have a dirty substance under them and need to be cleaned.

Interview on 8/12/21 at 9:42 A.M. with CNA #5 while in Resident #13 room revealed she had already completed the bed bath on Resident #13. CNA #5 confirmed that Resident #13 fingernails have a dirty substance under every one of them.

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Stated she does need to have them cleaned and that she should have done this with her bath. Stated she has been ripping and running today and just got back to work off vacation.

Interview on 8/12/21 at 11:40 A.M. with the Director of Nursing (DON) revealed that nail care is part of the AM care, and that no resident should have dirty fingernails, especially after their bath.

Phone interview on 8/12/21 at 12:10 P.M. with the wound physician related to the new diagnosis of Moisture Associated Skin Damage (MASD) to the sacrum on Resident #13. Wound physician confirmed that being left double briefed and wet and soiled for a long period of time could have caused the MASD to the resident's sacrum. Stated he recommended to apply Zinc and to consult with the attending physician to place a foley catheter for a few days to allow the area to be free of as much moisture as possible.

Phone interview on 8/12/21 at 12:34 P.M. with the attending physician for Resident #13. The attending physician confirmed and agreed with the wound physician's diagnosis of MASD and that the cause could be from the resident being doubled briefed and left wet and soiled for a long period of time.

Interview on 8/12/21 at 12:40 P.M. with DON revealed that ADL care and incontinence care is part of the CNA orientation. And that this includes the fingernails.

Interview on 8/12/21 at 1:05 P.M. with DON revealed that she is aware of the MASD diagnosis on Resident #13 and that she knows that being left wet and soiled and wearing two (2)

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briefs can cause this. Stated this is unacceptable care and this is the reason why CNA #3 was terminated.

Record review of the facility weekly skin audit dated 8/11/21 revealed Resident #13 with a new skin issue on her sacrum compared to the weekly skin audit documented on 8/4/21.

Record review of the facility wound evaluation form dated 8/11/21 revealed MASD noted during care to the scrum area with dimensions documented at length of twenty-four (24) centimeters by width of twenty-four (24) centimeters. With treatment review and order documented to clean with normal saline (NS), apply Zinc oxide every (q) shift. Under care plan interventions documented incontinent care as needed, weekly body audit, and turn every two (2) hours and as needed (PRN).

Record review of the physician orders on Resident #13 revealed a new order dated 8/11/21 to clean MASD to bilateral buttock with normal saline, pat dry, apply zinc oxide every shift until healed.

Record review of the titled surgical note on 8/11/21 by wound physician under wound location: sacrum, under etiology; Moisture Associated Skin Damage, under provider comments: area of central denudation.

Record review of the facility care plan on Resident #13 under problem: Risk for impaired skin integrity related to incontinence, immobility and wears large brief, nutritional deficiency. Under approaches: incontinent checks/care every 2 hours and prn.

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F 677	Continued From page 22 Record review of the facility care plan on Resident #13 under problem: Risk for further decline in self care related to diagnosis or arthritis. Under approaches: provide incontinent check/care every two (2) hours and as needed. Record review on 8/11/21 of the Daily Unit Management revealed CNA #3 was assigned rooms 216D through 223D on 8/10/21 and rooms 216D through 223D on 8/11/21. Resident #13 room number is 218W. Record review of the face sheet for Resident #13 revealed an admission date of 1/23/2020 with diagnoses of: Diabetes type two (2), Paroxysmal Atrial fibrillation, anorexia, Gastro Esophageal Reflux Disorder, and Essential Hypertension. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/13/21 for Resident #13 revealed, Section C-Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of twelve (12) indicating Resident #13 had moderate cognitive impairment. Section G for Functional Status revealed requires limited assist of one person for bed mobility with 1 person physical assistance; and extensive assistance of 1 person for personal hygiene and bathing. The MDS revealed that toilet use occured only once or twice during the lookback period and required 1 person physical assistance. Record review of the bathing report for Resident #13 for 8/10/21 is left blank with no documentation.	F 677		
F 880 SS=D	Infection Prevention & Control	F 880		

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F 880	Continued From page 23 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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resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, interview, and record review of facility policy, the facility failed to follow infection control practices in a manner to prevent the spread of infection for one (1) of (9) observations for resident care.

Facility Policy titled "Standard Precautions" revised September 2019 revealed Standard precautions will be utilized to provide a primary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255115	A. BUILDING _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTER LLC	4540 MANHATTAN RD JACKSON, MS 39206

(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 880	Continued From page 25	F 880		

strategy for the prevention of healthcare-associated infectious agents among patients and healthcare personnel. Number (six) 6 Environmental control- Follow procedures for routine care, cleaning and disinfection of environmental surfaces, especially frequently touched areas.

On 08/12/2021 at 11:00 AM an observation of Incontinent care for Unsampled Resident room 320W with Certified Nurse Assistant (CNA #2) and CNA #1 revealed CNA #1 remove Body wash, Liquid soap, personal cleanser in a bottle, and hand gel from a gray bag and set them up on the overbed table next to the pan of water for peri care. Peri care performed by CNA #1 with assist of CNA #2 using good technique, hand hygiene, appropriated Personal Protective Equipment (PPE), and persevered Resident dignity. Repositioned the Resident. CNA #1 repacked supplies into the gray bag. CNA #2 cleared the pan of water and straightened bedside table placed within reach of Resident. CNA #1 picked up the gray bag and left the room.

On 08/12/2021 at 11:20 AM an Observation of Incontinent care for Resident #2 room 316A with CNA #1 and CNA #2 revealed CNA #1 entered Room 316 A placed the gray bag on the seat of a Geri-Chair and removed body wash, liquid soap, personal cleanser, and hand gel placing items on overbed table along with a pan of water for incontinent care. CNA #2 notified the nurse to turn off feeding for peri-care as the head of the bed required to be lowered during care. Incontinent care performed utilizing good hand hygiene, appropriate PPE and preserving

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Resident dignity. Infection control issue noted carrying gag of supplies from room to room, did not disinfect bottles of body wash, liquid soap, personal cleanser, or hand gel, before returning to the gray bag, and taking bag from room 320W to room 316A.

On 08/12/2021 at 11:40 an interview with CNA #1 revealed, when asked what the outcome of sharing and carrying supplies from one room to another could be she voiced it could cause spread of disease or infection.

On 08/12/2021 at 11:45 an interview with CNA #2 revealed, when asked what the outcome of sharing and carrying supplies from one room to another could be she voiced it could cause spread of germs or infection.

On 08/13/2021 at 10:45 AM an interview with RN #1 nurse revealed carrying items from room to room that have not been disinfected could cause spread of infection. She voices she will talk to the CNA's and plan an in-service on the topic of room to room contamination and not sharing personal items.

Record review of Facility Policy titled "Standard Precautions" revised 9/19 revealed Standard precautions will be utilized to provide a primary strategy for the prevention of healthcare-associated infectious agents among patients and healthcare personnel. Number (six) 6 Environmental control- Follow procedures for routine care, cleaning and disinfection of environmental surfaces, especially frequently touched areas.