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 11/02/2020

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 The State Agency (SA) conducted an unannounced COVID-19 Focused Infection Control Survey and six (6) complaint investigations from 10/26/20 to 11/2/20. The SA determined that the facility was not in compliance with 42 CFR 483.80 infection control regulations for Medicare and Medicaid and cited the regulatory deficiency F880. CI # 16854 related to pressure ulcers, CI # 16728 related to hydration with peg tube, CI # 17209 related to pressure ulcers, wound care, and catheter care, CI # 16977 related to pressure ulcers, CI # 16903 related to dietary concerns and CI # 16980 related to personal hygiene and hydration were determined by the SA to be unsubstantiated. At the time of survey the facility was licensed for 180 beds and had a census of 115.	F 000		
F 880 SS=E	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,	F 880		12/2/20

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

Electronically Signed | 12/03/2020

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F 880	Continued From page 1	F 880		

reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility 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

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F 880	Continued From page 2 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, staff interviews, record reviews and facility policy reviews the facility failed to follow guidelines to prevent the spread of infection during the COVID-19 pandemic as evidenced by: A Dietary Aide failed to wear a face mask in the kitchen while preparing resident lunch plates for one (1) of two (2) kitchen observations; A nurse failed to don a gown prior to entering a droplet precaution resident room for one (1) of four (4) staff observed entering rooms on the observation hallway; and a Certified Nurse Assistant (CNA) failed to wash hands and prevent contamination of clean linens for one (1) of five (5) care observations. Findings Include: A review of the facility's policy titled "Proper Mask Use Guidelines", undated, revealed all employees were to wear a procedure/surgical mask while on duty. A review of the facility's policy titled "Coronavirus (COVID-19)", with a revision date of 10/7/20, revealed Personal Protective Equipment (PPE) including gloves, gown, face mask or respirator, and eye protection (goggles or face shield) were	F 880	Please consider this Plan of Correction as Manhattan Nursing and Rehabilitation Center, LLC credible allegation of compliance. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare & Medicaid requirements. Submission o this plan of correction is not an admission that a deficiency exist or that the facility agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents and are submitted solely as a requirement of the provisions of Federal and State law. The Dietary Aide was immediately trained on the guidelines to prevent the spread of infection by wearing a mask, proper Personal Protective Equipment (PPE), and social distancing at all times within the facility by the Dietary Manager on 10/27/2020. The Registered Nurse was immediately trained 10/27/2020 by the	

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F 880	Continued From page 3 to be utilized for any healthcare worker entering the residents room for suspected or confirmed cases. A review of the facility's policy titled," Management Of Communicable Diseases", revision date 9/2019, Standard Precautions are intended to be applied to the care of all patients in a healthcare settings, regardless of the suspected or confirmed presence of an infectious agent and employees were to utilize precautions during patient care as determined by the nature of the interaction and extent of exposure. On 10/27/20, at 11:30 AM, an observation of the kitchen revealed Dietary Aide # 3 on the tray line preparing plates for residents wearing a face mask pulled below her nose and mouth under her chin. Dietary Aide #3 was not six (6) feet apart from coworkers and was talking to coworkers while preparing the residents plates. On 10/27/20, at 12:20 PM, in an interview with Dietary Aide # 3, she acknowledged she was not wearing her mask over her mouth and nose and stated she thought she was supposed to pull the mask up if she left the kitchen. Dietary Aide #3 did acknowledge that by wearing her face mask pulled down below the nose, it could spread infection to coworkers and residents. Dietary Aide #3 stated she had not had in-service how to properly wear a face mask. On 10/27/20, at 12:36 PM, in an interview with Dietary Manager (DM) #2, she acknowledged Dietary Aide #3 was not wearing her mask properly and should have known to wear the face mask over her mouth and nose. DM #2 stated she had not noticed Dietary Aide #3 was not	F 880	Director of Nursing on the guidelines to prevent the spread of infection by the proper PPE, including the donning procedure, prior to entering a droplet precaution resident room. The Certified Nursing Assistant was immediately in-serviced by the Staff Development Nurse on 10/29/2020 on proper hand washing and prevention of contamination of clean linens. The Department Heads monitored beginning 10/27/2020 their staff for proper social distancing and wearing a mask to see if other staff was deficient in this practice. The Director of Nursing monitored nursing staff for wearing a mask, social distancing, proper PPE, and the handling of linen. No other staff were found to be deficient. All residents have the potential of being impacted by this deficient practice. Training of facility staff on the guidelines to prevent the spread of infection by wearing a mask and social distancing at all times within the facility by the Staff Development Coordinator began on 10/27/2020. Nursing staff, laundry, housekeeping, dietary, therapy, maintenance, and office staff were trained on the guidelines to prevent the spread of infection by the donning procedure prior to entering a droplet precaution resident's room by the Staff Development Nurse. The RN Supervisor trained the Certified Nursing Assistants on the proper handling of linens and hand washing on	

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F 880	Continued From page 4 wearing her mask over her nose and mouth. DM #2 stated all staff were trained in an in-service on proper mask use at the beginning of COVID-19. A review of the facility's in-service sign in sheet with a topic of "Proper Mask Use Guidelines", dated 5/8/2020 revealed Dietary Aide #3 had signed the in-service sign in sheet. On 10/27/20, at 2:10 PM, in an interview with Certified Dietary Manager # 1 she stated that not wearing a mask properly could cause an infection control issue and could potentially infect staff and residents with COVID-19. On 10/27/20, at 12:00 PM, an observation of staff passing out lunch trays to residents on the COVID-19 observation hall passing out lunch trays revealed Registered Nurse (RN) # 3 went in Resident # 11's room without donning an isolation gown. There was a sign on Resident # 11's door reading the resident was on transmission-based droplet precautions. On 10/27/20, at 5:26 PM, an interview with RN # 3 revealed that she thought that because she entered Resident #11's room to deliver her food tray and not to provide resident care, she did not need to don a gown. RN #3 stated that if she went to feed a resident she would put on a gown. On 10/27/20, at 5:35 PM, in an interview with the Director of Nursing (DON), she stated the facility policy was to wear 2 layers of gowns when entering a room for a resident on transmission-based droplet precautions. Staff was to don a gown prior to entering the resident room on transmission-based droplet precautions for any reason. If doing direct care, staff was to	F 880	10/29/2020. Procedural change of increase in staff surveillance. The week of 10/27/2020 guidelines for wearing a mask, social distancing at all times within the facility began being monitored by the use of a monthly calendar with each shift designated, by management/supervisory staff, which could include the Administrator, Director of Nursing, Dietary Manager, and the licensed nurses. The proper PPE including the donning procedure as indicated by the CDC guidelines will be monitored by the use of a monthly calendar with each shift designated, by the Staff Development Nurse, Assistant Director of Nursing, and the Director of Nurses. The proper hand washing and prevention of contamination of handling clean linen by infection control guidelines will be monitored by the use of a monthly calendar with each shift designated, by the licensed nurses. This monitoring will occur each shift daily x 2 weeks, then twice a week for 2 weeks, then 1 x a week, and then monthly, thereafter. The results of this monitoring will be reported to the Administrator, who will report to the Quality Assurance and Performance Improvement Committee monthly for three months for further recommendations. 12/2/2020	

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F 880	Continued From page 5	F 880		

don a second gown once in the resident's room prior to completing care. They should have first layer gown on even if they were not doing care in the observation unit before entering a room. The DON stated staff were in-serviced on this.

Review of the facility policy did not address staff donning two gowns before entering the room of a resident on transmission based droplet precautions.

On 10/28/20, at 3:25 PM, an interview with RN # 3 revealed she should don a gown prior to entering a resident's room on transmission-based droplet precautions and she would wear a gown from now on when entering observation rooms for residents on transmission-based precautions. RN #3 confirmed infections could be spread by not using transmission-based precautions.

An observation on 10/29/20, at 9:50 AM, upon entering a resident's room revealed CNA #1 picked up the dirty linen from the floor with gloved hands and placed the linen on Resident #3's bedside table. CNA #1 then quickly removed the linen from the bedside table and put it in a plastic bag. CNA #1 then picked up clean linen and covered Resident #3 without changing gloves or washing hands.

On 10/29/20, at 1:15 PM, in an interview with CNA # 1, she stated she should have washed hands and changed gloves after she picked up linen off the floor. She further stated it was an infection control issue when you transferred linen from the floor to the bedside table which could result in spreading infection. CNA #1 stated she had training on Infection Control.

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F 880	Continued From page 6 On 11/2/20, at 3:40 PM, in an interview with Assistant Director of Nursing (ADON), she stated she had spoken with CNA #1 and understood the CNA picked up dirty linen from the floor, and touched a clean sheet and put it over the resident without changing gloves or washing hands. The ADON stated dirty sheets should have not been on the floor and after handling the dirty sheets the CNA should have washed her hands and changed her gloves. The ADON also stated the Dietary Aide in kitchen should have worn her mask properly and the RN#3 should have had a gown on before entering an observation room. The ADON stated these were all infection control problems and could result in the spread of infection in the facility.	F 880		