STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255126	A. BUILDING _____ B. WING _____	02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKINSON COUNTY SENIOR CARE	116 SOUTH LAFAYETTE STREET CENTREVILLE, MS 39631

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and a complaint investigation (CI) MS 18551 at the facility from 2/7/22 through 2/11/22. During the survey the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F641, F656, F686, F690 and F880. CI MS#18551 was not substantiated however deficiencies were cited related to foley catheter care and the residents care plan. The SA returned to the facility on 2/24/22 for Complaint Investigation (CI) MS #18514. The complaint was not substantiated for neglect. The facility held a license for 90 beds and had a census of 67 at the time of the survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and facility policy review, the facility failed to accurately complete Minimum Data Set (MDS) assessments for one (1) of 20 MDS assessments reviewed. Resident #23. Findings Include: Review of the facility's policy, "MDS Assessment", dated 5/2006, revealed "It is the policy of this facility to follow the RAI (Resident Assessment	F 641	F641 SS = D Completed by 3-24-2022 A. The facility failed to accurately complete a comprehensive Minimum Data Set (MDS) assessment for one(1) of twenty (20) MDS assessments reviewed. Resident #23 was re-assessed on 3-14-2022 to include yes for major mental illness.	3/24/22

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

Electronically Signed | 03/17/2022

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F 641	Continued From page 1 Instrument) process as set forth by CMS (Centers for Medicare/Medicaid) protocol". Record review of Resident #23's "Admission Record" revealed the facility admitted her on 1/1/21 with diagnoses including Schizophrenia, Major Depressive Disorder, and Bipolar Disorder. Record review of the "Pre-Admission Screening (PAS) Application for Long Term Care" dated 1/1/21 for Resident #23, revealed the question of "Person has a diagnosis of a major mental illness?" was answered with "Yes" which confirmed Resident #23 had a major mental illness upon admission. Record review of the facility's "Order Summary Report" for Resident #23 with active physician orders as of 2/11/22 revealed current physician orders for Divalproex Sodium Extended-Release tablet 24-hour 500 MG (milligrams) give one tablet by mouth two times a day related to Schizophrenia, Trazodone HCl tablet 100 MG one tablet at bedtime related to Major Depressive Disorder, and Geodon capsule 20 MG give one tablet at bedtime by mouth related to Bipolar Disorder. Record review of Resident #23's MDS with an Assessment Reference Date (ARD) of 12/7/21 revealed for question A1500 "Is the resident currently considered by the state level II PASRR (Pre-Admission Screening and Resident Review) process to have serious mental illness and/or intellectual disability or a related condition?" was coded for "0" which indicated "No" and is inconsistent with Resident #23's PAS Application, state Level II PASRR, Admission Record, and Physician Orders.	F 641	B. The potential exists to affect 67 residents. C. The Director of Nursing in-serviced the Minimum Data Set Coordinator on 2-10-2022 to ensure that required assessments were completed timely and in accordance with the Resident Assessment Instrument (RAI) process. In the absence of the Minimum Data Set Coordinator, the Director of Nursing will complete the Minimum Data Set assessments according to the required schedule and in accordance with the Resident Assessment Instrument (RAI) process. The Director of Nursing will perform a review of the Minimum Data Set (MDS) assessment schedule weekly for 3 months starting on 2-25-2022 for all facility residents to ensure accurate and timely completion. D. The Director of Nursing will monitor the completion of Minimum Data Set (MDS) assessments for the facility residents weekly for 3 months starting on 3-01-2022, and report the findings to the Quality Assurance Performance Improvement Committee in the weekly meetings starting 3-02-2022. Necessary changes will be made to maintain sustained compliance.	

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F 641	Continued From page 2 On 2/10/22 at 2:20 PM, in an interview with the Assistant Director of Nurses (ADON), she stated that section A should have been coded yes for a major mental illness. She stated she guess it was maybe an oversight. On 2/10/22 at 2:40 PM, in an interview with Registered Nurse (RN) #1/MDS nurse, she confirmed MDS section A 1500 should have been coded "yes" for major mental illness. On 2/10/22 at 2:52 PM, in an interview with the Director of Nursing (DON), she confirmed that section A1500 on the MDS should been checked "yes".	F 641		
F 656 SS=D	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 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	F 656		3/24/22

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F 656	Continued From page 3 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, interviews, record reviews, and facility policy review the facility failed to develop and implement the care plan related to catheter care, wound care, pain, and behaviors for three (3) of 20 care plans reviewed. Resident #9, Resident #54, and Resident #63. Findings include: Record review of the facility's policy, Comprehensive Care Plan, dated 10/2016, revealed " ...Policy Interpretation and Implementation 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or resident representative, develop and maintains a	F 656	A. The facility failed to develop and implement the care plan related to catheter care, wound care, pain, and behaviors for three (3) of 20 care plans reviewed. Resident #9, Resident #54 and Resident #63. The Director of Nursing and Minimum Data Set Coordinator developed and implemented care plans related to catheter care, wound care, pain, and behaviors for three (3) of 20 care plans reviewed. Resident #9, 2-17-2022 Catheter Care, Wound Care, Resident #54 2-18-2022 Catheter Care and Wound Care, Resident #63 3-7-2022 Pain and Anticoagulant.	

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F 656	Continued From page 4 comprehensive care plan for each resident ...9. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans:" Resident #9 Record review of the facility's, "Comprehensive Care Plan", revealed Resident #9 had a Foley catheter related to Neuromuscular dysfunction of the bladder which included an intervention to assure that a catheter strap is secured per protocol to prevent the tubing and leg bags from catching or pulling with the resident's regular movement. During an observation on 02/08/22 at 01:22 PM, of catheter care with Certified Nursing Assistant (CNA) # 2 revealed CNA #2 failed to secure the tubing on the catheter while providing catheter care. CNA #2 held the sides of the penis and pulled the tubing outward. Resident #9 jumped when CNA #2 pulled on the tubing. CNA #2 also failed have a catheter strap in place to prevent friction. During an interview on 02/08/22 at 01:52 PM, CNA #2 acknowledged she failed to secure the tubing while cleaning Resident #9's tubing. CNA #2 said she did not realize that she caused tension and friction by pulling and tugging on the catheter. CNA #2 said she didn't realize she could pull the catheter out causing trauma to the meatus. During an interview on 02/08/22 at 01:55 PM, with the Director of Nursing (DON), she confirmed CNA #2 failed to follow the care plan and facility policy. The DON said CNA #2 should have made	F 656	In the absence of the Minimum Data Set Coordinator, the Director of Nursing will develop and implement care plans according to the required schedule and in accordance with the Resident Assessment Instrument (RAI) process. B. The potential exists to affect 67 residents. C. An audit of all care plans for residents with wounds, catheters, pain and behaviors was completed by the Director of Nursing and Minimum Data Set Coordinator on 3-14-2022 to ensure that required care plans were completed timely and in accordance with the Resident Assessment Instrument (RAI) process. The Minimum Data Set Coordinator was in-serviced by the Director of Nursing on 2/10/2022 on use of the RAI manual as a guide to develop and implement care plans for each resident. In the absence of the Minimum Data Set Coordinator, the Director of Nursing will develop and implement care plans according to the required schedule and in accordance with the Resident Assessment Instrument (RAI) process. The Director of Nursing will perform a review of the care plan schedule weekly for 3 months starting on 2-25-2022 for all facility residents to ensure accurate and timely completion. D. The Director of Nursing will monitor the completion of care plan development and for the facility residents weekly for 3	

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F 656	Continued From page 5 sure the resident had a leg strap on to keep the catheter from causing friction or trauma to the meatus. The DON also confirmed by not securing the tubing on the catheter, it could cause friction and or trauma to the meatus or infections. Record review of the "Admission Record" revealed the facility admitted Resident #9 on 08/09/2021 with diagnoses that included: Paraplegia, Urinary Tract Infection (UTI) and Neuromuscular Dysfunction of Bladder. Record review of the Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 11/16/21 revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated Resident #9 is cognitively intact. Resident #54 Record review of "Admission Record" revealed the facility admitted Resident #54 on 1/1/2021 with diagnoses including Pressure Ulcer of Right Heel (Stage 3), Pressure Ulcer of Sacral Region (Stage 3), and Pressure Ulcer of Right Buttock (Stage 3). On 2/9/22 at 10:20 AM, the State Agency (SA) observed wound care to Resident # 54's right heel by Licensed Practical Nurse (LPN) #2 and assisted by Registered Nurse (RN) #3. Record review of the "Order Summary Report" with active order as of 2/11/22 revealed there are current physician orders in place to clean wound to the right heel with Dakin's, apply Dakin's moistened gauze, wrap with kerlix and tape in place. Sacral wounds clean with Dakin's, pack as needed, cover with ABD pads, tape in place.	F 656	months starting on 3-01-2022, and report the findings to the Quality Assurance Performance Improvement Committee in the weekly meetings starting 3-02-2022. Necessary changes will be made to maintain sustained compliance.	

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F 656	Continued From page 6	F 656		

A record review of Resident #54's Comprehensive Care Plan revealed there was not a care plan that addressed her pressure injuries.

Resident #63

On 2/9/22 at 3:00 PM, in an interview with Resident #63, she stated she has chronic pain in her neck, and she takes Ultram, Lyrica, and Tylenol when she asks. She stated she gets her medications daily as needed.

Record review of the "Admission Record" revealed the facility admitted Resident #63 on 5/3/21 with diagnoses of Unspecified Injury at C5 Level of Cervical Spinal Cord, Sequela, Chronic Migraine without Aura, Chronic Embolism and Thrombosis of Unspecified Deep Vein of Left Lower Extremity.

Record review of Resident #63's "Order Summary Report" with active orders as of 2/11/22 revealed current physician orders for Lyrica capsule 150 MG (milligrams) by mouth two times a day for injury to cervical spinal cord, Ultram one tablet every 8 hours as needed by mouth for pain, Tylenol 8-hour pain tablet ER (extended release) 650 MG one tablet by mouth every 6 hours for pain, and Eliquis tablet 2.5 MG give one by mouth two times a day for Chronic Embolism and Thrombosis of Unspecified Deep Vein of Left Lower Extremity.

A record review of Resident #63's Comprehensive Care Plan revealed there was not a care plan developed by the facility that addressed her pain or anticoagulant therapy.

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F 656	Continued From page 7 Record review of the Minimum Data Set (MDS) with Assessment Record Date (ARD) dated 1/19/22 revealed Resident #63 had a Brief Interview of Mental Status (BIMS) score of 13, which indicated she was cognitively intact. On 2/10/22 at 1:53 PM, in an interview with Registered Nurse (RN) #1/MDS/Care Plan nurse confirmed care plans were not updated to include Resident #54's pressure injuries or Resident #63's pain or anticoagulants. She stated the purpose of the care plan is to help guide nurses and Certified Nursing Assistants with specific things with the patient. It is done so they know how to take care of the resident appropriately. She stated if the care plan is not updated the staff cannot give proper care. RN #1 stated she expects the staff to follow the care plan and policy for catheter and perineal care.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		3/24/22

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F 686	Continued From page 8 by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to clean a pressure wound in a manner to prevent the possible spread of infection for one (1) of four (4) pressure wound care observations. Resident #54 Findings Include: Record review of the facility's policy, "Clean Dressing Change", undated, revealed "It is the policy of the facility to provide wound care in a manner to decrease potential for infection and/or cross contamination...12. Cleanse the wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound (i.e clean outward from the center of the wound) ...". On 2/9/22 at 10:20 AM, the State Agency (SA) observed wound care to Resident # 54's right heel by Licensed Practical Nurse (LPN) #2 and assisted by Registered Nurse (RN) #3. During the observation, LPN #2 cleaned the wound with gauze and wiped in a circular motion from the center of the wound outward two times, using the same gauze. LPN #2 then disposed of the gauze and obtained clean gauze and repeated the same cleaning motion, wiping in a circular motion multiple times with the one gauze. On 2/9/22 at 10:45 AM, in an interview with LPN #2, she confirmed she should have used the gauze one time and disposed of it, and not used the gauze multiple times when cleaning the wound. She verified that her actions could have caused the resident to acquire a wound infection. On 2/9/22 at 10:55 AM, in an interview RN #3,	F 686	A. The facility failed to clean a pressure wound in a manner to prevent the possible spread of infection for one (1) of four (4) pressure wound care observations. Resident #54. On 2/9/2022, LPN #2 properly cleansed the wound on Resident #54 according to the facility□s Clean Dressing Change policy. On 2/9/2022, The Infection Preventionist in-serviced LPN # 2 on the proper way to perform wound care. Resident #54 was assessed on 2-11-2022 by the Infection Preventionist with no signs of infection noted. B. The potential exists to affect 67 residents. C. The Director of Nursing in-serviced All Nursing Staff on 2-24-2022 on performing wound care according to the Clean Dressing Change policy. On 2-24-2022, the Director of Nursing completed a validation checklist for each individual observed to determine if the individual was performing the procedure correctly. Findings were reviewed with each member of the Nursing Staff. D. The Director of Nursing or Assistant Director of Nursing will review staff for wound care according the Clean Dressing Change policy. This will be done by direct observation and documentation. These observations will occur weekly for four (4) weeks starting on 3-1-2022, then reduced to monthly for one (1) quarter or until substantial compliance is achieved. Three (3) care observations will be	

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F 686	Continued From page 9 she agreed LPN #2 should not have cleaned the wound multiple times with the same gauze. She stated LPN #2 should have wiped one time, disposed of the gauze, and used a clean gauze when cleaning the wound. She confirmed the resident could have acquired a wound infection due to LPN #2's failure to clean the wound appropriately. On 2/10/22 at 2:25 PM, in an interview with RN #2/Assistant Director of Nursing (ADON), she confirmed LPN #2 did not clean the wound correctly and her actions could have caused Resident #54 to acquire a wound infection. On 2/10/22 at 2:50 PM, in an interview with the Director of Nursing (DON) she confirmed LPN #2 did not clean the wound correctly and LPN #2's actions could have caused Resident #54 to acquire a wound infection. On 2/10/22 at 4:55 PM, in an interview with RN #4/ Infection Control Nurse, stated LPN #2 did not clean the wound correctly and her actions could have caused Resident #54 to acquire a wound infection. Record review of Resident #54's "Admission Record" revealed the facility admitted her on 1/3/22, with diagnoses including Pressure ulcer of right heel stage 3, Pressure ulcer of sacral region stage 3, and Pressure ulcer of right buttock stage 3. Record review of the "Order Summary Report" with active orders as of 2/11/2022 revealed Resident #54 has a current physician order with an order date of 2/10/2022 to "Cleanse wound to right heel with Dakins, apply Dakins and Santyl	F 686	monitored each week. Violations will be corrected, and addressed immediately. Any noted violations along with corrective action taken will be reported to the Quality Assurance Performance Improvement Committee in the weekly meetings starting 3-02-2022. Necessary changes will be made to maintain sustained compliance.	

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F 686	Continued From page 10 moistened gauze, wrap with Kerlix and tape in place daily and prn (as needed) until healed.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as	F 690		3/24/22

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F 690	Continued From page 11 possible. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review, the facility failed to anchor catheter tubing during catheter care to minimize movement or prevent possible friction or trauma and failed to ensure a catheter leg strap was in place for one (1) of three (3) catheter care observations. Resident #9. Findings Include: Review of the facility policy, "Catheter Care Policy", dated 8/20 revealed "It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care...Compliance Guidelines: ... 12. ... wipe the catheter making sure to hold and secure the catheter in place to not pull on the catheter..." Resident #9 Observation on 02/08/22 at 01:22 PM, of catheter care with Certified Nursing Assistant (CNA) # 2 revealed CNA #2 failed to secure the tubing on the catheter while providing catheter care. CNA #2 held the sides of the penis and pulled the tubing outward and did not hold the tubing secure. Resident #2 jumped when CNA #2 pulled on the tubing. Resident #9 also did not have a catheter leg strap in place to anchor the tubing to prevent friction. During an interview on 02/08/22 at 01:52 PM, with CNA #2, confirmed she failed to secure the tubing while cleaning the tubing. CNA #2 said she did not realize that she caused tension and friction by pulling and tugging on the catheter. CNA #2 said	F 690	A. The facility failed to anchor catheter tubing during catheter care to minimize movement or prevent possible friction or trauma and failed to ensure a catheter leg strap was in place for one (1) of three (3) catheter care observations. Resident #9. A catheter leg strap was applied 2-8-2022 by the Director of Nursing to anchor catheter tubing. The nursing assistant was in-serviced on 2-8-2022 by the Director of Nursing on the facility□s policy on catheter care. B. The potential exists to affect 67 residents. C. All certified nursing assistants were in-serviced on 2-24-2022 by the Director of Nursing on the facility□s policy on catheter care. In-service training included observation of each nursing assistant performing the procedure. On 2-24-2022, a validation checklist was completed by the Director of Nursing for each individual observed to determine if the individual was performing the procedure correctly. Findings were reviewed with each nursing assistant. Corrective action was provided as needed. D. The Director of Nursing Services, or Assistant Director of Nursing Services, will complete weekly Validation Checklists of nursing assistants performing Catheter Care for two (2) times per week (8) consecutive weeks to ensure nursing assistants are performing Catheter Care	

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	255126	A. BUILDING _____ B. WING _____	02/24/2022

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F 690	Continued From page 12 she didn't realize she could pull the catheter out causing trauma to the meatus. Record review of the Admission Record revealed Resident #9 was admitted to the facility on 08/09/2021 with diagnoses included Paraplegia and Neuromuscular Dysfunction of Bladder. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/16/21 revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #9 is cognitively intact. During an interview on 02/08/22 at 01:55 PM, with the Director of Nursing (DON) confirmed CNA #2 failed to follow the facility policy. The DON said CNA #2 should have made sure Resident #9 had a leg strap on to keep the catheter from causing friction or trauma. The DON also confirmed by the CNA not securing the catheter tubing, it could cause friction and or trauma to the meatus and increase the possibility for infections. The DON said the staff has been in-serviced on the correct way to provide catheter care. Record review of a facility record titled, "In-service Training" dated 9/30/21, revealed CNA #2's name was listed on the sign in sheet. Catheter care and Perineal care was included in the in-service.	F 690	in accordance with our facilities Practice Guideline beginning on 3-1-2022. Validation Checklists will be reviewed in the weekly Quality Assurance meetings starting on 3-1-2022 by the Quality Assurance Performance Improvement Committee. Necessary changes will be made to maintain sustained compliance.	
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	F 880		3/24/22

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F 880	Continued From page 13	F 880		

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 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

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F 880	Continued From page 14 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, interviews, record reviews and facility policy review the facility failed to prevent the possible spread of infection for one (1) of three (3) catheter care observations. Resident #59. Findings Include: Record review of the facilities "Infection Prevention and Control Program" dated 8/2017 revealed, "It is a policy of this facility to 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 ...4. Hand Hygiene	F 880	A. The facility failed to prevent the possible spread of infection for one (1) of three (3) catheter care observations. Resident #59. On 2-9-2022, resident #59 was assessed by the infection prevention nurse for any signs and symptoms of infection related to improper catheter care with no signs or symptoms noted. Urine was clear and no complaints of pain. On 2-9-2022, CNA #1 and CNA #2 were in-serviced by the Director of Nursing on proper hand hygiene and transmission based precautions and appropriate catheter care. B. The facility has determined that all (4)	

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F 880	Continued From page 15 Protocol a. All staff shall wash their hands when coming on duty, between resident contacts, after handling contaminated objects, after PPE (Personal Protective Equipment) removal, before and after eating, before and after toileting, and before going off duty. b. Staff shall wash their hands before and after performing resident care procedures. c. Hands shall be washed in accordance with our facilities established hand washing procedures. 5. Isolation Protocol: a. Standard precautions shall be observed for all residents. b. A resident with an infection or communicable disease shall be placed on isolation but cautions as recommended by current CDC (Centers for Disease Control) guidelines for isolation for cautions. A copy of these guidelines is available at each nurse station ..." Record review of the "Procedure for Handwashing" dated 4/2015, revealed " ...When to Wash Hands (at a minimum) ...When reporting to work and before going home ...Before and after each resident contact ...After handling any contaminated items such as linen, soiled diapers, are garbage ..." Observation of catheter care on 02/09/22 at 02:23 PM, revealed Certified Nursing Assistant (CNA) #1 pulled out five (5) large wipes from the pack and laid them on top of the wipe package without washing her hands. The CNA cleansed down the right side of the resident's peri area with the wipe and passed it to CNA #2. CNA #2 put the dirty wipe in the garbage bag. After doing this three (3) times CNA #1 asked CNA #2 to pull out some more clean wipes out of the package. CNA #2 used the same dirty gloves to remove clean wipes out of the package to cleanse the resident's peri area and provide catheter care.	F 880	residents with catheters present have the potential to be affected. C. On On 2-9-2022, all certified nurses assistants were in-serviced on on proper hand hygiene and transmission based precautions and appropriate catheter care. On 2-10-2022, The Director of Nurses, Infection Prevention Nurse and Staff Development completed Competency Checklists for proper hand hygiene and transmission based precautions and appropriate catheter care with all Certified Nurses Assistants. Beginning 2-9-2022 the monitoring of catheter care for proper infection control practice to prevent the spread of infection was initiated by the Director of Nursing, Staff Development nurse and Infection Control nurse. Observing of 2 residents for catheter care will continue 3 X week x 8 weeks from 2-9-2022 by the Director of Nursing, Infection Prevention nurse and staff development nurse. Infection Control Nurse will continue to monitor monthly infections on-going. On 3-21-2022, a root cause analysis was completed on infection prevention and control. A Directed Plan of Correction was began on 3-21-2022 to provide training to all staff on infection control and prevention. This Directed Plan of Correction included the staff viewing the training videos Clean Hands and Sparkling Surfaces. D. The Director of Nursing or Infection Control Nurse will present findings to the	

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F 880	Continued From page 16 During an interview on 02/09/22 at 02:37 PM, with CNA #1 confirmed she removed the wipes from the package before washing her hands. CNA #1 also confirmed she gave the dirty wipes to CNA #2 to place in the garbage bag. CNA #1 asked CNA #2 to give her clean wipes out of the clean pack. CNA #1 said she thought about it after it was done. During an interview with the Director of Nursing (DON) on 2/9/22 at 3:00 PM, confirmed CNA #1 failed to follow the infection control policies and procedures. The DON stated that CNA #1 should have washed her hands when entering the room prior to pulling the wet wipes out of the packet. The DON stated that she was going to have an in-service done with demonstration on hand washing practices to make sure that the staff knows how to prevent infections. The DON stated that by taking the wet wipes out with her dirty hands she could have caused the resident to have an infection. During an interview with Registered Nurse (RN) #4 on 2/9/22 at 3:15 PM, confirmed CNA #1 failed to follow the infection control policies and procedures. The Infection Control Nurse stated that she has only been in her position for one month and has not had time to do in services or train the staff on infection control procedures. Record review of the "Admission Record" revealed Resident #59 was admitted to the facility on 11/30/2017 with diagnoses that included Neuromuscular Dysfunction of Bladder. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date	F 880	Interdisciplinary team monthly x 3 months from 03/04/2022 for review, and any corrective actions needed. Necessary changes will be made to maintain sustained compliance	

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F 880	Continued From page 17 (ARD) of 10/01/21 revealed Resident #59 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated Resident #59 is cognitively intact.	F 880		