

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER Courtyard Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 501 South Locust Street McComb, MS 39648	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>48669</p> <p>Based on observations, staff interview and record review, the facility failed to ensure that the dignity and respect of residents are upheld when feeding during mealtimes for one (1) of 26 sample residents reviewed. Resident #3</p> <p>Findings includes:</p> <p>An observation and interview on 1/06/25 at 1:30 PM, revealed Certified Nursing Assistant #1 (CNA) assisting Resident #3 with lunch. This observation revealed CNA #1 was standing up while feeding the resident. During an interview with CNA #1 stated that she did not know that she was not supposed to stand up when feeding residents.</p> <p>On 01/07/25 at 12:50 PM, Charge Nurse #1 stated during an interview that she was unaware that staff should sit down when feeding residents. She acknowledged that standing while assisting a resident with meals could raise dignity concerns.</p> <p>On 1/7/25, at 1:04 PM, during an interview with the Director of Nursing (DON) emphasized that CNAs should always sit at eye level when assisting residents with meals. She explained that sitting down prevents residents from feeling intimidated by staff who are standing over them and this approach enables eye contact which helps residents feel more comfortable. She noted that this practice is important as it maintains the residents' dignity.</p> <p>A record review of Resident #3's Admission Record revealed the facility admitted the resident on 1/22/24 with diagnoses including Primary Generalized Osteo Arthritis and Cognitive Communication Deficit.</p> <p>A record review of Resident # 3's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 10/25/24 revealed a Brief Interview for Mental Status (BIMS) of 03 indicating the resident was severely cognitively impaired. Section GG revealed substantial maximum assistance with eating.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41680</p> <p>Based on observation, interviews, record review, and facility policy reviews, the facility failed to implement care plan interventions related to wound care when a nurse cleaned a resident's pressure ulcer wound without patting it dry for one (1) of 43 resident care plans reviewed (Resident #64)</p> <p>Findings included:</p> <p>Record review of the facility's policy titled Plans of Care, revised 9/25/2017, revealed, The Individualized Person-Centered plan of care may include .Services are provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .</p> <p>Record review of Resident #64's comprehensive care plan revealed . Interventions/Task .Cleanse Stage 4 sacrum with wound cleanser and 4 x 4 gauze. Pat dry with 4 x 4 gauze .</p> <p>During an observation on 1/8/2025 at 12:03 PM, Registered Nurse (RN) #2 did not pat the wound dry with gauze on the sacral region as described in Resident #64's care plan.</p> <p>On 1/8/2025 at 2:20 PM, during an interview, RN #2 admitted she did not pat the sacral region dry with gauze as per Resident #64's care plan.</p> <p>On 1/9/2025 at 12:00 PM, during an interview, RN #3 Minimum Data Set (MDS/Care Plan) nurse, stated that care plans are created to inform staff of residents' care needs and should be followed by all staff. She emphasized the importance of adhering to the care plan when providing care.</p> <p>Record review of Resident #64's Admission Record revealed an admitted [DATE] with diagnoses including Pressure Ulcer of Right Heel, Stage 2 and Pressure Ulcer of the Sacral Region, Stage 4.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47873</p> <p>Based on observation, staff interview, and facility policy review, the facility failed to securely safeguard hazardous chemicals in two unlocked janitor's closets for one (1) of four (4) days of survey.</p> <p>Findings Include:</p> <p>Review of the facility ' s policy, Overview of Proper Chemical Use, revised 6/2016, revealed, In order to help prevent accidents from occurring you must follow the following guidelines: 6. If you leave chemicals in the janitor's closet the door must be locked .</p> <p>An observation on 01/06/25 at 10:30 AM, revealed the Janitor Closet on the 200 hall was unlocked and there was a full bottle of 3M Concentrated Glass Cleaner in the closet.</p> <p>An observation on 01/06/25 at 11:19 AM, revealed the Janitor Closet on the Intermediate Care (IC) Hall was unlocked and unattended and there were containers of 3M Concentrated Glass Cleaner and 3M Quat Disinfectant.</p> <p>On 01/07/25 at 3:19 PM, during an interview, Housekeeping Supervisor #2 confirmed that the Janitor Closet's were unlocked. She also confirmed that these rooms were used to store housekeeping carts containing chemicals and cleaning supplies, posing a potential safety hazard, especially for cognitively impaired residents. She disclosed the Janitor Closet doors were keyed. However, she did not possess keys to ensure they remained locked. She revealed that maintenance issues are usually given to maintenance verbally, but she had not notified maintenance of these doors being unlocked but would ask a nurse to notify them.</p> <p>An interview on 01/07/25 at 3:37 PM, with Maintenance Staff #1 revealed that he was unaware of the problems with janitor closets not locking until today. He confirmed that the janitor closets were used to store carts containing chemicals and cleaning supplies, emphasizing the potential safety concern this posed, particularly for residents that are cognitively impaired.</p> <p>An interview on 01/08/25 at 1:45 PM, the Director of Nursing (DON) confirmed that unlocked rooms storing cleaning supplies was a safety issue for residents particularly those that were identified as wanderers and should remain locked.</p> <p>An interview on 01/09/25 at 10:00 AM, the Administrator confirmed not properly securing the janitors closets that housed chemicals posed a potential hazard, especially for cognitively impaired residents. She continued by admitting that any maintenance issue should be clearly communicated and corrected.</p> <p>A record review of the Safety Data Sheet, dated 6/5/24, revealed Glass Cleaner Concentrate had a Hazard identification classification that indicated Serious Eye Damage/Irritation. Review of Handling and storage revealed Precautions for safe handling included Keep out of reach of children .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of the Safety Data Sheet, dated 10/9/18, revealed Quat Disinfectant Cleaner Concentrate ' had a Hazard identification classification that indicated Serious Eye Damage/Irritation and Skin Corrosion/Irritation and May cause chemical gastrointestinal burns. Review of Handling and storage revealed Precautions for safe handling included Keep out of reach of children .</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>48669</p> <p>Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure dietary staff supported and respected a resident's right to make choices about his or her meal preferences for one (1) of twenty-six (26) sampled residents. Resident #40.</p> <p>Findings Include:</p> <p>Record review of the facility policy Menus revised 10/2022, revealed, .Procedures .2. Menus will be periodically presented for resident review, including the resident council, menu review meetings, or other review board as indicated by the center. The menu will identify the primary meal, the alternate meal, and any always offered food and beverage items .</p> <p>An observation on 1/6/25 at 10:52 AM, revealed a menu hanging in both dining areas that did not include alternate options.</p> <p>An interview on 01/7/25 at 11:13 AM, with Resident #40 indicated that alternate meals are never posted or available for selection. She stated that this situation upsets her because she feels they have no choice but to eat what is provided. Resident #40 explained that, as a diabetic, she may not particularly like the food being served, but she must eat something to avoid getting sick.</p> <p>An interview on 1/8/25 at 7:52 AM, with the Dietary Manager confirmed that the menus were outdated and did not contain alternate options at this time plus their system does not allow them to consider any alternates or individual preferences for the residents. She confirmed that residents should have current menus available, however, they do not provide alternate options for residents because the computerized system formulates their menu for the month based on the resident's allergies, likes and dislikes as identified on admission. She continued by admitting since it included so much information then there was no room for alternative or individual preferences. The Dietary District Manager confirmed that the residents should have the choice of an alternate meal by at least providing an always available menu.</p> <p>A record review of the Admission Record reveals the facility admitted the Resident on 12/9/2016 with diagnoses including Type 2 Diabetes and Hypertension.</p> <p>A record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/3/25 revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>50751</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interviews, record review, and facility policy review, the facility failed to provide palatable, appropriately temperature-controlled foods for one (1) of (43) sampled residents. Resident #40</p> <p>Findings included:</p> <p>A review of the facility's policy titled Food Quality and Palatability Policy (HCSG Policy 006), revised February 2023, revealed, Policy Statement: Food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive, and served at a safe and appetizing temperature. Food and liquids are prepared and served in a manner, form, and texture to meet the residents' needs .</p> <p>During an interview on 1/7/2025 at 11:19 AM, Resident #40 complained the food served was usually cold.</p> <p>An observation and interview on 1/7/2025 at 12:09 PM, a meal tray was provided, and temperatures were evaluated by the Dietary Manager. The temperatures were as follows: white rice, 122 F (Fahrenheit); spinach, 122 F; and egg noodles with gravy, 109 F. A sampling of the meal tray revealed that the food was bland and not served at a palatable temperature. During an interview at this time the Dietary Manager agreed that these temperatures were unacceptable and noted that residents might not want to eat food at such temperatures.</p> <p>A record review of the Admission Record revealed the facility admitted Resident #40 on 12/09/2016 with diagnoses including Type 2 Diabetes Mellitus.</p> <p>A record review of the Minimum Data Set (MDS) with an Assessment Reference date of 1/3/2025 revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41680</p> <p>Based on observation, interviews, record review, and policy review, the facility failed to prevent the possibility of the spread of infection as evidenced by improper hand hygiene practices and wound care for three (3) of six (6) direct care observations. (Resident #3, Resident #64 and #66)</p> <p>Findings included:</p> <p>Record review of the facility's Handwashing Hand Hygiene policy, revised August 2019 revealed Policy Statement The facility considers hand hygiene the primary means to prevent the spread of infection. Policy Interpretation and Implementation . 2. All personnel shall follow the handwashing hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 3. Hand hygiene products and supplies (sink, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use .</p> <p>Record review of the facility's policy titled Dressing, Dry Clean, revised September 2013, revealed, . Steps in the Procedure .15. Cleanse the wound with the ordered cleaner. If using gauze, use a clean gauze for each cleaning stroke. Clean from the least contaminated to the most contaminated area (usually, from the center outward). 16. Use a dry gauze to pat dry .</p> <p>Resident #3</p> <p>On 1/6/2025 at 11:00 AM, Certified Nursing Assistant (CNA) #1 and CNA #2 both entered the room, applied gloves, and began perineal care for Resident #3 without performing hand hygiene prior to applying clean gloves. CNA #1 pulled six (6) premoistened wipes from the packet and began cleaning the perineal area. When she ran out of wipes, she retrieved additional wipes from the packet twice with unclean gloves, touching the outside of the wipe packet during care.</p> <p>On 1/6/2025 at 11:29 AM, during an interview, CNA #1 confirmed that she forgot to wash her hands before starting care on Resident #3. She acknowledged that her actions could cause infection for the resident and that her failure to remove all needed wipes before starting care was an infection control issue, as she had touched the container with unclean gloves.</p> <p>On 1/6/2025 at 11:32 AM, during an interview, CNA #2 confirmed that she forgot to wash her hands before beginning perineal care for Resident #3. She confirmed her actions were an infection control issue.</p> <p>On 1/7/2025 at 12:52 PM, during an interview, Registered Nurse (RN) #1 stated the CNAs should have washed their hands before providing perineal care for Resident #3. She explained that CNA #1 should not have retrieved additional wipes with dirty gloves. RN #1 stated the CNAs caused cross-contamination and risked the spread of infection.</p> <p>On 1/7/2025 at 1:07 PM, during an interview, the Director of Nursing (DON) confirmed that the CNAs actions represented an infection control issue. She emphasized that staff must wash their hands prior to care, when transitioning from dirty to clean tasks, and after care. She added that failure to follow these practices could result in the spread of infections</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of the Admission Record revealed the facility admitted Resident #3 on 1/22/2024 with diagnoses including Primary Generalized (Osteo) Arthritis and Cognitive Communication Deficit.</p> <p>A record review of Resident # 3's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 10/25/24 revealed a Brief Interview for Mental Status (BIMS) of 03 indicating the resident was severely cognitively impaired. Section GG indicated the resident was dependent for toileting hygiene.</p> <p>Resident #64</p> <p>On 1/8/2025 at 12:03 PM, during an observation, Registered Nurse (RN) #2 was observed providing wound care to Resident #64. RN #2 washed her hands and applied gloves. She removed a soiled dressing from the resident's right heel, did not change her gloves and then cleaned the wound. While cleaning the wound she used normal saline and a gauze in a circular motion five times, alternating between dirty to clean and clean to dirty without changing the gauze. She removed a heavily soiled dressing from the sacral area and placed it in a biohazard bag. She then cleaned the sacral wound in the same circular motion six times with the same gauze, again alternating between dirty to clean and clean to dirty and did not pat dry after cleaning as indicated in the physicians order.</p> <p>On 1/8/2025 at 2:20 PM, during an interview, RN #2 confirmed that she should have performed hand hygiene and applied clean gloves after removing the soiled dressing. She also confirmed that she should not have cleaned the wound in a circular motion multiple times with the same gauze. She acknowledged that her actions could increase the risk of infection and delay wound healing.</p> <p>A record review of Resident #64's Order Listing Report revealed a physician order dated 12/7/2024, Wound care: Cleanse stage IV (4) pressure ulcer to sacrum with Dakins, pat dry with 4x4 gauze. Apply silver alginate to the wound bed, and cover with bordered gauze daily and prn (as needed.) Physician orders dated 12/13/2024 revealed Wound care to Stage II (2) ulcer to R (right) heel with NS (normal saline), apply medi honey to the wound bed, cover with an ABD (abdominal) pad, and wrap with Kerlix. Changed daily and PRN (as needed.)</p> <p>A record review of the Admission Record revealed the facility admitted Resident #64 on 1/24/2024 with diagnoses including Pressure Ulcer of the Right Heel, Stage 2 and Pressure Ulcer of the Sacral Region, Stage 4.</p> <p>A record review of the MDS with an ARD of 11/28/2024 revealed Resident #64 was severely impaired for cognitive skills for daily decision making.</p> <p>Resident # 66</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation and interview on 01/08/25 at 10:59 AM, with RN #2 performing wound care on Resident #66 revealed that she donned clean gloves without performing hand hygiene prior to removing and performing wound care to the resident's right knee abrasion. Upon finishing this wound, she rolled resident to his right side, removed a dressing with a moderate amount of foul-smelling purulent discharge on a sacral unstageable pressure ulcer with the same gloves used to dress and undress the first wound. She then walked to the resident's door, turned open the doorknob with the soiled gloves. An interview with RN #2 confirmed that she had not changed gloves or performed hand hygiene throughout the two procedures and that she opened the door with unclean gloves. She confirmed that infection could be spread from one wound to the other making it harder to heal and that wearing gloves to open the door could spread infection.</p> <p>An interview on 01/09/25 at 11:50 AM, with the DON confirmed that hand hygiene should be performed before and after completing wound care and before and after removing gloves. She confirmed that not doing this put the resident at risk of infection as well as increased difficulty in wound healing. She also confirmed that gloves should have been removed before touching a doorknob as that could increase the spread of infection throughout the facility. She further stated that it was her expectation that wound care would be performed according to guidelines for infection control and prevention.</p> <p>Record review of Admission Record revealed the facility admitted Resident #66 on 02/23/23 with medical diagnoses that included Pressure Ulcer of Sacral Region Unstageable.</p> <p>Record review of Resident #66's MDS with an ARD of 10/19/24 revealed Section M revealed the resident has 2 pressure ulcers.</p> <p>50751</p>		