STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grenada Rehabilitation and Healthcare Center	1966 Hill Drive Grenada, MS 38901

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)
F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on record review, staff interview, and facility policy review, the facility failed to complete an Annual Minimum Data Set (MDS) no later than 14 days of the Assessment Reference Date (ARD) for one (1) of 19 assessments reviewed. Resident # 24 Findings include Record review of the facility policy CMS's (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) . Chapter 5: Submission and Correction of the MDS Assessment, dated October 2023, revealed .5.2 Completion Timing: For all non-Admission OBRA (Omnibus Budget Reconciliation ACT) and PPS (Prospective Payment System) discharge assessments, the MDS Completion Date (Z0500B) must be no later than 14 days after the Assessment Reference date (ARD) (A2300) . Review of the Centers for Medicare & Medicaid Services (CMS) Submission Final Validation Report revealed Resident #24 's Annual assessment was completed more than 14 days after the assessment reference date. Record review of the annual Minimum Data Set for Resident #24 revealed in Section A2300- the Assessment Reference Date was documented as 6/06/2024. Section Z0500-Assessment Completion was documented as 7/01/24. In an interview with the MDS Coordinator on 7/17/24 at 10:53 AM, she confirmed after review of the CMS submission final validation report, Resident #24 's MDS was completed late. She revealed she was aware that the facility has previously had late assessments and revealed the MDS department has been placed on an action plan for about a year to address the problems, but confirmed the problems still exist. She stated she felt time management was part of the reason the assessments were late. In a phone interview with the MDS Consultant on 7/17/24 at 11:08 AM, she confirmed she was aware the facility was having issues with the MDS's being completed and submitted. She stated the facility had put a plan of action in place a few months ago to stop the late completion of the assessments, but confirmed the plan needed to be altered. She revealed the purpose of completing and transmitting the MDS timely is to ensure billing is correct and ensure the correct resident information is submitted to complete the residents' plan of care. (continued on next page)

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Record review of the Admission Record revealed the facility admitted Resident #24 to the facility on [DATE] with current diagnoses that included Transient Cerebral Ischemic Attack.

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on record review, staff interview, and facility policy review, the facility failed to complete a Quarterly Minimum Data Set (MDS) no later than 14 days of the Assessment Reference Date (ARD) for one (1) of 19 assessments reviewed. Resident # 49 Findings include Record review of the facility policy CMS's (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) . Chapter 5: Submission and Correction of the MDS Assessment, dated October 2023, revealed .5.2 Completion Timing: For all non-Admission OBRA (Omnibus Budget Reconciliation ACT) and PPS (Prospective Payment System) discharge assessments, the MDS Completion Date (Z0500B) must be no later than 14 days after the Assessment Reference date (ARD) (A2300) . Review of the CMS Submission Final Validation Report revealed Resident #49 ' s Quarterly assessment was completed more than 14 days after the assessment reference date. Record review of the quarterly Minimum Data Set for Resident #49 revealed in Section A2300- the Assessment Reference Date was documented as 6/07/2024. Section Z0500-Assessment Completion was documented as 7/03/24. During an interview with the MDS Coordinator on 7/17/24 at 10:53 AM, she confirmed after review of the CMS submission final validation report that Resident #49's MDS was completed late. She revealed she was aware that the facility has previously had late assessments and the MDS department has been placed on an action plan for about a year to address the problems, but confirmed the problems still exist. She stated she felt time management was part of the reason for the assessments were late. During a phone interview with the MDS Consultant on 7/17/24 at 11:08 AM, she confirmed she was aware the facility was having issues with the MDS's being completed and submitted. She stated the facility had put a plan of action in place a few months ago to stop the late completion of the assessments, but confirmed the plan needed to be altered. She revealed the purpose of completing and transmitting the MDS timely is to ensure billing is correct, and the correct resident information is submitted to complete the resident's plan of care. Record review of the Admission Record revealed the facility admitted Resident #49 to the facility on [DATE] with diagnoses that included Cerebral Palsy.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 46013 Based on staff interviews and record review, the facility failed to ensure staff completed competency skills check-off and completed Enhanced Barrier Precautions training prior to caring for residents with a tracheostomy for one (1) of four (4) respiratory staff personnel files reviewed. Respiratory Therapist (RT) #1 Findings include: Record review of a type statement on facility letterhead dated 7/19/24 and signed by the facility Administrator revealed (Facility proper name) does not have a policy for competency skills checkoffs. While observing tracheostomy care for Resident #53 on 7/17/24 at 10:00 AM, revealed an Enhanced Barrier Precaution sign on the resident's outer door. RT #1 performed tracheostomy care without proper Personal Protective Equipment, which included a gown. In an interview on 7/17/24 at 10:35 AM, RT #1 revealed that she wasn't sure if Resident #53 was under the enhanced barrier precautions or not and stated, No, I don't think he is he doesn't have an infection. RT #1 glanced at the resident's door and then stated, Oh yes, he has one of those signs on the door, I was supposed to wear a gown into his room. RT #1 revealed that she had not been trained in enhanced barrier precautions. In an interview on 7/17/24 at 10:50 AM, the Director of Nurses (DON) revealed all nursing staff were to be trained on enhanced barrier precautions and she was not aware that RT #1 was not trained. In an interview on 7/17/24 at 1:40 PM, the Assistant Director of Nurses (ADON) revealed she is the backup Infection Preventionist and confirmed that RT #1 had not been in-serviced on enhanced barrier precautions and confirmed that all staff was to be in-serviced. She revealed it is the responsibility of the Infection Preventionist and Staff development nurse to provide in-service to all staff, and they failed to ensure the in-service was completed for RT #1. In an interview on 7/18/24 at 8:32 AM, the DON confirmed RT #1 had not been trained on Enhanced Barrier Precautions. She revealed they had training in September 2023, with the epidemiologist involved, and that RT #1 was not trained at that time either. In an interview on 7/18/24 at 9:00 AM, the Respiratory Therapist Director revealed he has only been in the role of Director for about a month. He revealed he was unaware that RT #1 was not adequately trained on enhanced barrier precautions. During an interview on 7/18/24 at 9:56 AM, the DON revealed that RT #1 did not have a competency skill checkoff for tracheostomy care. She confirmed the RT had been employed part-time since 2022 and usually worked one day a week.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 46013 Based on staff interview and record review the facility failed to submit accurate data into the Payroll-Based Journal (PBJ) system for one (1) of four (4) quarters reviewed. Second quarter 2024. Findings include: Record review of PBJ Staffing Data Report CASPER Report 1705D FY (Fiscal Year) Quarter 2, 2024 (January 1-March 31), revealed Excessively Low Weekend Staffing-Triggered. Triggered=Submitted Weekend Staffing data is excessively low. During an interview on 07/16/24 at 9:30 AM, the Human Resources/Payroll Coordinator revealed the corporate office submits the payroll-based journal. The Human Resources/Payroll Coordinator stated, If one of the administrative nurses works a weekend shift, they are supposed to submit a form to me so I can manually change their hours. An interview on 07/17/24 at 3:45 PM, the Director of Nurses (DON) revealed regarding the low weekend staffing for the second quarter, I worked a lot of those weekends to cover shifts and revealed she wasn't sure if she had submitted the forms like she was supposed to. An interview on 07/17/24 at 4:05 PM, the Corporate Consultant confirmed the hours worked by the DON and the treatment nurse were not captured correctly on the PBJ report and were done so in error. She revealed the shifts for the second quarter of 2024 were covered, however, the data was entered incorrectly and did not capture the direct care on the PBJ. An interview on 07/18/24 at 8:24 AM, the DON revealed they were adequately staffed for the second quarter weekends, however after auditing revealed there were inconsistencies in reporting to the PBJ.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observation, staff interviews, record review, and facility policy review, the facility failed to prevent the possibility of the spread of infection, as evidenced by failing to ensure Enhanced Barrier Precautions (EBP) and proper hand hygiene during resident care treatment for one (1) of four (4) resident care treatments observed. Resident #53 Findings include: Record review of the facility policy titled, Enhanced Barrier Precautions dated 4/1/2024 revealed .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove used during high contact resident care activities. Record review of the facility policy titled, Handwashing/Hand Hygiene with a revision date of 3/1/2020 revealed, Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections . Record review of the facility policy titled, Tracheostomy Care with a revision date of March 2024 revealed . General Guidelines . 3. Disposable gown must be worn as part of Enhanced Barrier Precautions .Preparation and Assessment . 9. Remove old dressings. Pull soiled glove over dressing and discard into appropriate receptacle. 10. Wash hands. Clean the Removable Inner Cannula.8. Put on sterile gloves .14. Remove and discard gloves into appropriate receptacle .15. Wash hands and put on fresh gloves. Observation of tracheostomy (trach) care for Resident #53 on 7/17/24 at 10:00 AM, revealed an Enhanced Barrier Precaution sign on the resident's outer door. Respiratory Therapist (RT) #1 washed her hands briefly with an antiseptic hand sanitizer, applied gloves, and entered the resident's room without applying a protective gown. The RT cleaned the overbed table and set up her barrier, discarded her gloves, and applied new gloves without washing her hands. She then proceeded to perform tracheostomy care. The RT removed sterile gloves from the suction catheter kit and applied the sterile gloves over her soiled gloves. The RT suctioned the resident and then removed her sterile gloves leaving her soiled gloves intact, failing to wash her hands. The RT opened the tracheostomy care tray with the soiled gloves, removed the sterile gloves, placed them over the non-sterile gloves, and continued tracheostomy care. The RT removed her gloves, packaged up the unclean trach supplies, and placed them in a red biohazard bag, she removed a soiled washcloth that was saturated with fluids that had been placed under Resident #53's trach for any excessive secretions and stated I'm not supposed to put this on the floor, but I don't have anywhere to place it. There should be a container in here. RT #1 then placed the soiled washcloth on the floor and exited the room. She tucked the red biohazard bag under her arm and briskly applied antiseptic hand sanitizer from a bottle on the top of her treatment cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/17/24 at 10:35 AM, Respiratory Therapist #1 revealed that she wasn't sure if Resident #53 was under enhanced barrier precautions or not and then stated, No, I don't think he is he doesn't have an infection. The RT glanced at the resident's door and then stated, Oh yes, he has one of those signs on the door, I was supposed to wear a gown into his room. She confirmed she had not worn the proper personal protective equipment into the room to render care to the resident. She revealed that she had not been trained in enhanced barrier precautions. RT #1 revealed that during her tracheostomy care, she was taught in school to keep her gloves on and put the sterile gloves over top of them and wasn't aware that she had to remove the soiled gloves and wash her hands during the dirty and clean process of rendering tracheostomy care. The RT revealed that she understood where it could be an infection control issue and confirmed that she had not used proper hand hygiene while performing tracheostomy care on Resident #53, and by not doing so, it's possible the resident could get an infection. An interview on 7/17/24 at 10:50 AM, the Director of Nurses (DON) confirmed that the respiratory therapist was supposed to wear a gown into the room as part of the enhanced barrier precautions and to change out her gloves and wash her hands between the dirty and clean trach care and revealed that is our standards of practice for tracheostomy care. The DON confirmed the resident could get an infection from the lack of proper hand hygiene and lack of proper personal protective equipment (PPE) during his tracheostomy care. In an interview on 7/18/24 at 9:00 AM, the Respiratory Director confirmed that the standard of tracheostomy care to possibly prevent infections is to wear a gown and perform appropriate hand hygiene. A record review of Resident #53's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included Pneumonitis due to inhalation of food and vomit, Cerebral infarction, and Encounter for attention to tracheostomy.