STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255206	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora Health and Rehabilitation	310 Emerald Drive Columbus, MS 39702

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39807 Based on observation, resident and staff interview, record review, and facility policy review the facility failed to properly code a resident for a restraint on the Minimum Data Set (MDS) for one (1) of 21 residents MDS assessments reviewed during survey. Resident #56 Findings Include. A review of the facility policy revised 04/2019 titled Resident Assessment Instrument (RAI)/CARE PLANNING MANAGEMENT revealed it is the practice of this facility to conduct a comprehensive, accurate assessment of each resident's functional capacity. A record review of Resident #56's Minimum Data Set (MDS) Quarterly assessment dated [DATE] section P revealed used a trunk restraint less than daily. An observation and interview, on 04/02/24 at 10:29 AM, of Resident #56 revealed the resident lying in bed resting. The observation revealed that the resident did not have a restraint on. The resident confirmed that he does not have any type of restraint. An interview, on 04/02/24 at 10:40 AM with Registered Nurse (RN) #1 confirmed that Resident #56 has not had a restraint on that she can remember. A record review of Resident #56's Physicians' Orders revealed there is no order for restraint. An interview, on 04/03/24 at 10:10 AM, with Certified Nursing Assistant (CNA) #2 confirmed that Resident #56 has not had a restraint for the seven (7) years that she has worked here. An interview on 04/03/24 at 10:20 AM, with the MDS Nurse confirmed that under Section P of the MDS completed on 03/12/24 that trunk restraint was marked by mistake. MDS Nurse confirmed that Resident #56 has never had a restraint and that it was marked in error and that she will have to complete a modification to remove it. She confirmed that the purpose of the MDS is to gather knowledge about the resident through an assessment to guide the care that the resident received and payment for resident services. The MDS Nurse confirmed that coding the MDS incorrectly can affect the resident's level of care. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 04/03/24 at 1:00 PM, with the Administrator confirmed that the purpose of the MDS is to determine the level of care that the resident needs and that coding it incorrectly could result in the resident receiving the wrong level of care. A review of the Admission Record for Resident #56 revealed that he was admitted to the facility on [DATE].

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 44804 Based on observation, staff interview, record review and facility policy review the facility failed to prevent the possibility of an infection as evidence by a suction connecting tubing not being replaced after making contact with a trash can during respiratory care for one (1) of seven (7) residents direct care observations. Resident #47 Findings Include Review of the facility policy titled, Infection Control with a revision date of 5/2023 revealed under Standard Explanation and Compliance Guidelines #11. Equipment Protocol: e. All contaminated disposable items shall be discarded in a waste receptacle lined with a RED plastic bag. An observation and interview on 4/3/24 at 8:12 AM, revealed the Respiratory Therapist (RT) performed suctioning and trachea care on Resident #47. After the RT suctioned the resident's tracheostomy, she removed the suction connecting tubing that was placed inside the resident's trachea and placed it in the trash, allowing the suction tubing to fall and lay on the side of the resident's trash can that was full of trash. The RT went to the restroom, washed her hands, returned, placed gloves on and poured sterile water into a cup, picked up the suction tubing from the side of the trash can, suctioned some of the sterile water through the tubing and then wrapped the tubing around the suction canister and covered it in plastic. This observation revealed the suction canister was labeled and dated 4/1/24. An interview with the RT revealed she covered it to be used for the next suctioning. She stated the suction tubing and canister get changed weekly and is due to be changed on 4/8/24. She confirmed that the end of the suction tubing that would have connected to the suction connector had touched the trash can and could have caused an infection. She revealed the tubing should have been changed, instead of wrapping it up for it to be used the next time. An interview on 4/3/24 at 9:30 AM, with the Infection Preventionist confirmed the suction tubing touching the trash can in the resident's room should have been changed, because that would have been a break in infection control. She stated it was dirty and could have caused a problem. An interview on 4/3/24 at 12:05 PM, with Director of Nurses (DON) confirmed that the suction tubing used to connect to the suction connector should have been changed after the tip of the suction tubing touched the resident's trash can because that could have caused an infection. Record review of Resident #47's Order Summary Report revealed a physician's order dated 9/30/21 to ensure proper storage, stocking and covering of respiratory therapy equipment in residents' room every shift. Record review of Resident #47's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Cerebral Infarction and Tracheostomy Status.