| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255213 | A. Building<br>B. Wing | 04/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Meadville Convalescent Home | 300 Hwy 556/Route 2 Box 66<br>Meadville, MS 39653 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>48669<br><br>Based on record review, interviews and facility policy review, the facility failed to ensure Advance Directives were completed according to the resident preference for two (2) of (2) residents reviewed for Advance Directives. This deficient practice had the potential to affect all residents who do not have an Advance Directive. Resident #7 and<br><br>Resident #41.<br><br>Findings Include:<br><br>Review of the facility's policy titled, Residents' Rights Regarding Treatment and Advance Directives Policy, revised 8/23/22, revealed, Policy: It is the policy of this facility to support and facilitate a resident's right .to formulate an advance directive. Policy Explanation and Compliance Guidelines: 1. On admission, the facility will determine if the resident has executed an advance directive and, if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about . an advance directive. 3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff .<br><br>Resident # 7<br><br>Record review of the Code Status form dated 7/17/23 revealed CODE CLASSIFICATION .CODE A- All resident are considered Code A unless otherwise specified and will receive .FULL RESUSCITATION .<br><br>Further record review revealed there was no documentation in the medical record that Resident #7 had an advance directive or had received information on formulating an advance directive.<br><br>Record review of the Admission Record revealed Resident #7 was admitted by the facility on 7/17/23. The resident's diagnosis included Unspecified Cord Compression, Muscle Weakness, Lack of Coordination and Osteoarthritis.<br><br>Record review of the Minimum Date Set (MDS) with Assessment Reference Date (ARD) of 1/9/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident #41<br><br>Record review of the Code Status for dated 6/26/23 revealed CODE CLASSIFICATION .CODE A- All resident are considered Code A unless otherwise specified and will receive .FULL RESUSCITATION .<br><br>Record review of the Admission Record revealed the facility admitted Resident #41 on 6/28/23 with diagnoses including Major Depressive Disorder.<br><br>A review of the MDS for Resident #41, with an ARD of 4/7/24, revealed a BIMS score of 13, which indicated the resident was cognitively intact.<br><br>Further record review revealed there was no documentation in the medical record that Resident #41 had an advance directive or had received information on formulating an advance directive.<br><br>On 4/22/24 at 11:22 AM, in an interview with the Social Service Director, she confirmed the current Code Status form on all resident files cannot be considered an Advance Directive. She revealed that when starting in the position two weeks ago, it came to her attention that there were no advance directives in the residents' charts or electronic records. She pointed out that since that time she has obtained the correct forms and is in the process of getting the correct forms signed and uploaded to the residents' charts.<br><br>On 4/23/24 at 8:48 AM, in an interview with the Administrator, he revealed he was made aware yesterday the current form being used, as an advance directive, was not correct. He confirmed that none of the residents in the facility have an Advance Directive in their chart. However, the correct form is currently being uploaded into every resident's chart. He pointed out that by not offering residents an Advance Directive, it could cause nursing staff to elect a treatment during an emergency that the resident may not prefer or desire. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>47873<br><br>Based on observations and staff interviews the facility failed to ensure tiles in the resident shower area were free from black grime and broken tiles were repaired and floors in three (3) common areas were free from cracked tiles and gaps in the floor for one (1) of four (4) days of survey.<br><br>Findings include:<br><br>During an observation and interview on 4/24/24 at 9:06 AM, of the resident shower, the floor was noted to have buckling floor tile near the entrance of the shower. Inside the shower, dark black grime was noted in the corners. An interview with Certified Nursing Aide (CNA) #1 revealed she was the shower aide. She explained that the floor tile has been buckling for a while and the tile near the toilet has been broken for a long time. She stated she had made previous maintenance staff aware of the tile, but it had not been repaired yet. She confirmed the black grime in the corners of the resident shower.<br><br>During an observation on 4/24/24 at 9:51 AM, of the resident shower and facility hallways with the Maintenance Director, he revealed that he was aware of the numerous cracked tiles and gaps in the floor throughout the facility in high traffic areas. He explained that he had been patching, as best he could. He revealed every time he replaced some of the tiles, more tiles became cracked and at this point, it's a no-win situation. The Maintenance Director stated he was not aware that the shower room had tile coming up and buckling. He confirmed that some of the cracks in the tile could be considered trip hazards and could cause injury to residents and employees, as they were large enough to cause an uneven surface.<br><br>On 4/24/24 at 10:51 AM, during an observation and interview with the Administrator revealed that he was aware of the numerous cracked tiles and gaps in the floor throughout the facility. He explained that the maintenance staff have been patching the broken tile as best they could, however the facility was old and needed updating throughout. The Administrator revealed he was not aware that the shower room had tile coming up and buckling throughout and confirmed that this could be a hazard that could cause injury to residents and staff. |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47873<br><br>Based on observations, staff interviews, record review and facility policy review the facility failed to ensure a resident was free from a physical restraint offer as evidenced by failure to identify a seatbelt as a restraint for one (1) of 15 sampled residents. Resident #1<br><br>Findings include:<br><br>Record review of facility's policy titled, Restraints, revised 11/28/17, revealed, Policy: . The use of restraint shall be based on comprehensive resident assessment that includes the physical assessment to identify medical conditions that may be causing behavior changes in resident. The assessment will also be performed to determine the safety and protective needs of the resident prior to the application of restraint . Documentation: Documentation in the medical record should include: Restraint order, including the rationale for the restraint, the type of restraint . the duration (timeframe) for the restraint application .Alternatives or less restrictive interventions attempted .The resident's medical conditions or symptoms that warranted the use of restraint, The resident's response to the restraint, including the rational for continued use of the intervention, Assessment and reassessments of the resident, Revision to the treatment plan, Unanticipated changes in residence condition, Condition/behavior required of the resident for release of restraints, The discussion with resident family regarding need for restraints .<br><br>During an interview on 04/21/24 at 12:53 PM, with Licensed Practical Nurse (LPN) #6, she revealed Resident #1 has always worn the seatbelt. LPN #6 confirmed there was not an order in place for the seatbelt. LPN #6 also revealed that there was no restraint flow sheet in place.<br><br>In an observation on 04/21/24 at 1:43 PM, Resident #1 was sitting in her wheelchair with a seatbelt intact and no one in the room with her. The resident was unable to demonstrate the ability to open the seatbelt on her own.<br><br>During an interview on 04/22/24 at 12:53 PM, the Director of Nursing (DON) stated the seat belt on the wheelchair met the definition of a restraint, as defined by facility policy. The DON revealed the facility had recently conducted an audit of restraints and had somehow missed the seatbelt used by Resident #1. The DON stated the facility's interdisciplinary team is responsible for collaborating with other facility staff regarding this issue and a physician's order, consent with reassessment and monitoring tools should be in place for all restraints.<br><br>During an interview with the Administrator on 04/24/24 at 1:07 PM, confirmed a physician's order, consent with reassessment, as well as a monitoring tool should be in place for all restraints.<br><br>Record review of the Order Summary Report, with active orders as of 4/23/24, revealed there was no physician order for the use of a seat belt as a restraint. Further review of the medical record revealed there was no documentation of an assessment regarding the use of a seat belt or the use of any type of least restrictive device, nor was there a restraint flowsheet in place for use.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of the Admission Record revealed Resident #1 readmitted on [DATE] with diagnoses that included Intracranial Injury with Loss of consciousness, status unknown and Other developmental disorders of speech and language.<br><br>Record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/16/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 02, which indicated the resident had severe cognitive impairment. Further review of the MDS revealed the resident was dependent on staff for assistance with all her activities of daily living. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47873<br><br>Based on observation, interviews, record review, and facility policy review, the facility failed to develop and implement a comprehensive person-centered care plan to reflect the use of restraints for one (1) of 15 sampled residents. Resident #1<br><br>Findings include:<br><br>Record review of facility policy titled, Comprehensive Plan of Care, revised 10/10/22, revealed, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .<br><br>In an observation on 04/21/24 at 1:43 PM, Resident #1 was sitting in her wheelchair with a seatbelt intact. The resident was sitting alone in her room. The resident was unable to demonstrate the ability to open the seatbelt on her own.<br><br>Record review of the care plan revealed Focus: Safety: Resident may have lap belt positioner . Goal . Resident will remain safe .Interventions .Monitor q (every) 2 (hours) while out of bed for proper application and correct if necessary. Perform safety risk evaluation .as needed . Further review of the care plan revealed there was not a restraint re-assessment since admission in February 2015 nor a physician's order for the use of a restraint or monitoring of the seatbelt restraint.<br><br>During an interview on 4/22/24 at 12:53 PM, with the Director of Nursing (DON), she confirmed upon review of the care plan for Resident #1, there was a need for goals and interventions related to the use of a seat belt. The DON revealed the resident was a longtime resident, and this was somehow missing. The DON stated the facility interdisciplinary team is responsible for collaborating with other facility staff regarding this issue and a physician's order, consent with reassessment and monitoring tools that should be in place for all residents who use restraints.<br><br>An interview was conducted with the Administrator on 4/24/24 at 1:07 PM, at which time the Administrator confirmed the care plans for Resident #1 did not reflect that the facility interdisciplinary team collaborated with other facility staff regarding the appropriateness of the use of a seatbelt for Resident #1, with a physician's order, consent with reassessment, along with a monitoring in place for the use of the restraint.<br><br>Record review of the Admission Record revealed Resident #1 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included Intracranial Injury with Loss of Consciousness, status unknown and Other developmental disorders of speech and language. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>41680<br><br>Based on interview, record review, and facility policy review, the facility failed to ensure physician orders were implemented and followed as ordered for one (1) of 15 sampled residents. Resident #11<br><br>Findings include:<br><br>Record review of facility's policy titled, Standard of Care, revised 9/15/22, revealed, POLICY: It is the policy of this facility to provide a standard of treatment and care most beneficial to residents and to offer the highest quality services in a caring atmosphere Regardless .all residents shall have access to the following: .Care that is timely. Care that meets their needs .<br><br>On 4/21/24 at 1:08 PM, in an interview with Resident # 11, he revealed he had been hospitalized because of low potassium.<br><br>Record review of the Progress Notes dated 10/14/23 revealed the resident was transferred to a local acute care hospital related to critical labs received related to the resident's potassium levels.<br><br>Record review of a Consultation Report dated 1/3/24 revealed . Renal U/S-(ultrasound) CKD 4 (chronic kidney disease) .<br><br>Record review of Progress Note dated 1/5/24 revealed related to Situation: Elevated BUN (Blood Urea Nitrogen)and creat (creatinine) remains after fluids .<br><br>Record review of a Consultation Report dated 2/12/24, from the office of the Nephrologist revealed . Order outpatient renal ultrasound .<br><br>Record review of the medical records for Resident #11 revealed there was no documentation that a renal ultrasound had been ordered by the facility on 1/3/24 or 2/12/24 for Resident #11 as recommended by the nephrologist. Further review indicated no results for a renal ultrasound were in the medical record.<br><br>On 4/23/24 at 1:37 PM, in an interview with the Director of Nursing (DON), she stated the Charge Nurse is responsible for taking off physician orders and following up with orders. She stated when the Charge Nurse is not here, the cart nurse is responsible for taking orders off. The DON revealed she was not aware the renal ultrasound had not been done, until it was brought to her attention. She stated it was just missed. She stated the resident sees a Nephrologist in a nearby town, as Resident #11 is in Renal Failure. The DON revealed renal ultrasounds are ordered to check the function of a resident's kidneys.<br><br>On 4/23/24 at 3:08 PM, in an interview with Licensed Practical Nurse (LPN)#1/Charge Nurse, she revealed she was not aware Resident #11 had an ordered renal ultrasound that was not done. She stated she is responsible for taking orders off and putting them on the calendar. LPN #1 revealed that she is the one that took the order off, but she must have not followed it through to make sure that it was done.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/24/24 at 11:20 AM, in an interview with the Nephrology Medical Assistant stated all test results are reviewed at the time they are received. She revealed Resident #11 was seen by the Nephrologist on 1/3/24 and 2/12/24, and both times, a renal ultrasound was ordered, but had not been done. She stated it's important that all orders are followed in a timely manner, so that the physician can review the results of the test and make medication changes, as needed.<br><br>On 4/24/24 at 12:34 PM, in an interview with DON, she stated the renal ultrasound from the 1/3/24 Nephrologist visit was scheduled, however, the resident got sick was hospitalized for an extended period of time and the renal ultrasound was not rescheduled when resident returned to facility.<br><br>On 04/24/24 at 12:56 PM, in an interview with the Administrator, he stated he expects the Charge Nurse to have a system in place to monitor and review orders to make sure they are followed.<br><br>Record review of the Admission Record revealed the facility originally admitted Resident #11 on 5/23/13 with current diagnoses that included Type 2 Diabetes Mellitus and Chronic Kidney Disease, Stage 4 (SEVERE).<br><br>Record review of the Minimum Data Set (MDS) for Resident #11, with an Assessment Reference Date (ARD) of 11/5/24, revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41680<br><br>Based on observation, interviews, record review, and facility policy review, the facility failed to monitor and record freezer and refrigerator temperatures daily and discard expired foods for one (1) of four (4) kitchen observations. This has the potential to affect 48 of the 52 residents that reside in the facility.<br><br>Findings include:<br><br>Review of facility's policy titled, Food Safety Requirements, dated [DATE], revealed Policy: .Food will also be stored, prepared, disturbed, and served in accordance with professional standards for food service safety . Policy Explanation and Compliance Guidelines: 1. Food safety practices shall be followed throughout the facility's entire food handling process . Elements of the process include the following: b. Storage of food in a manner that helps prevent deterioration or contamination of the food including from growth of microorganisms . 3 . c. Refrigerated storage . c . Practices to maintain safe refrigerated storage include: i. Monitoring food temperatures and functioning of the refrigeration equipment daily and at routine intervals during all hours of operation . iv. Labeling, dating, and monitoring refrigerated food, including but not limited to leftovers, so it is used by its use-by-date or frozen (where applicable) discarded; and v. Keeping foods covered or in tight containers .<br><br>On [DATE] at 11:35 AM, the initial tour of the kitchen with the Dietary [NAME] (DC), revealed seven (7) 32-ounce bottles of a browning and seasoning sauce, with an expiration date of [DATE]. One of these bottles was opened and in the kitchen area. The was also a 32-ounce carton of opened liquid eggs, without a legible opened date.<br><br>On [DATE] at 11:47 AM, while continuing the kitchen tour with the Dietary Manager (DM), review of the refrigerator/freezer/temperature logs, revealed the logs were pre-filled with temperatures for the entire month of [DATE] for three (3) of the six (6) units that required temperature checks. The logs for the additional three (3) units revealed no record of daily temperature checks. Review of the [DATE] refrigerator/freezer temperature logs revealed only five (5) of the six (6) units were monitored.<br><br>On [DATE] at 11:58 AM, in an interview the DM, she stated staff know better. She confirmed all expired items are to be pulled on their expiration date. She stated Dietary Aid (DA) #1 is responsible for removing expired items from the storage. She stated staff should check the temperature on all units daily and record, as that lets staff know that the units are functioning properly.<br><br>On [DATE] at 12:15 PM, in an interview with DA #1, stated she is responsible for checking all the freezer and refrigerator temperature logs. She admitted she pre-filled the refrigerator/freezer temperature logs due to trying to catch up on the logs, because there are times when she does not check them.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On [DATE] at 10:50 AM, in an interview with the DM, stated all the unit's refrigerator/freezer temperature logs should be checked daily and revealed that it is her responsibility to check the logs. She confirmed that they did not have documentation of all the units being checked daily.<br><br>On [DATE] 1:00 PM in an interview with Administrator stated he expects DM and staff to know and understand the regulations and requirements and follow them. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0851<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.<br><br>47873<br><br>Based on staff interview, record review, and facility policy review, the facility failed to accurately submit direct care staffing information based on payroll data to the Centers for Medicare and Medicaid (CMS) as required for the first quarter of Fiscal Year (FY) 2024 (October - December 2023) for one (1) of four (4) quarters reviewed.<br><br>Finding include:<br><br>Record review of facility's policy titled, Nursing Services and Sufficient Staff, revised 10/12/22, revealed, Policy: It is the policy of this facility to provide sufficient staff .The facility's census, acuity, and diagnoses of the resident population will be considered based on the facility assessment. Policy Explanation and Compliance Guidelines . 7. The facility is responsible for submitting timely and accurate staffing data through the CMS Payroll-Based Journal (PBJ) system.<br><br>Record review of the Payroll Based Journal (PBJ) Staffing Data report from the Certification and Survey Provider Enhanced Reports (CASPER) database revealed the facility failed to have Licensed Nursing Coverage 24 Hours/Day. The dates were identified as 10/29 Sunday (SU), 10/31 Tuesday (TU), 11/26 SU, 11/27 Monday (MO), 11/28 TU and 11/29 Wednesday (WE).<br><br>The Administrator stated in an interview on 4/21/24 at 12:16 PM, that he was aware that the facility failed to electronically submit PBJ staffing data to CMS accurately. He revealed that the inaccurate submission was related to a glitch in the software that was being utilized by the corporation. The Administrator stated that the Human Resources Coordinator (HRC) was responsible for submitting the PBJ staffing data for the facilities. He stated that he thought the glitch had been corrected but failed to follow up.<br><br>The Director of Nursing (DON) revealed in an interview on 4/22/24 at 9:15 AM, that she was not aware of the PBJ staffing error that had been submitted to CMS. The DON deferred to the HRC as to why this error occurred.<br><br>The Licensed Practical Nurse (LPN) #5/Educator revealed in an interview on 4/22/24 2:48 PM, that she was not aware that the facility failed to electronically submit PBJ staffing data to CMS accurately in the first quarter of FY 2024. Upon review of the staffing grids, LPN #5 revealed there was documentation that 10/29 (SU); 10/31 (TU); 11/26 (SU); 11/27 (MO); 11/28 (TU); 11/29 (WE) were appropriately staffed.<br><br>The Human Resource Coordinator (HRC) revealed in an interview on 4/22/24 at 2:55 PM, that she was not aware that the facility failed to electronically submit PBJ staffing data to CMS accurately in the first quarter of FY 2024, but was aware that there had been an error in last quarter of 2023. The HRC stated that she was responsible for submitting the PBJ staffing data for the facility. She stated that the facility utilized a payroll software that at times did not accurately pull numbers. Upon review of the submitted data, it was noted that the reported information was not accurate, as it failed to account for salaried personnel that had worked, thus creating a shortage. The HRC confirmed that she had not been rechecking numbers, as she thought glitch had been corrected. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255213 | A. Building<br>B. Wing | 04/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Meadville Convalescent Home | 300 Hwy 556/Route 2 Box 66<br>Meadville, MS 39653 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>41680<br><br>Based on observation, interviews, record reviews, and facility policy review, the facility failed to ensure that a resident's CPAP (Continuous positive airway pressure) mask was properly stored, when not in use, for one (1) of (1) residents reviewed that required respiratory care. Resident #11.<br><br>Findings include:<br><br>Review of facility's policy titled, Oxygen, Nebulizer, CPAP/BIPAP (Bilevel positive airway pressure), with a revision date of 6/14/23, revealed, It is the policy of this facility to clean, disinfect, label and store supplies, nebulizer supplies, CPAP and BIPAP supplies appropriately . 3.vi. While not in use, store oxygen tubing, mask/cannula, nebulizer mask and tubing, and CPAP/BIPAP mask and tubing in a labeled (date) storage bag .<br><br>On 04/21/24 at 1:08 PM, during an interview and observation with Resident #11, a CPAP mask was lying on table by the resident's bed. It was not in a labeled storage bag. Resident #11 stated it is never put in a bag.<br><br>On 04/21/24 at 1:30 PM, in an interview with Licensed Practical Nurse (LPN) #1/Charge Nurse confirmed Resident #11's CPAP mask should be in a bag to keep it clean, as the bag will prevent germs from getting in it.<br><br>On 04/24/24 10:26 AM, in an interview with LPN #3/IP (Infection Preventionist) stated when not in use, Resident #11's CPAP mask should be in a bag to prevent bacteria from getting on the mask and causing infection. She IP confirmed the staff should make sure this is done.<br><br>On 4/24/24 at 12:56 PM, in an interview the Administrator stated he certainly expected staff to have knowledge of CPAP care and staff to monitor usage and follow protocol for safe storage when not in use.<br><br>Record review of the Order Summary Report, with active orders as of 4/24/24 revealed an order dated 3/7/24 Wear CPAP @ (at) night . related to Sleep Apnea, Unspecified.<br><br>Record review of the Admission Record for Resident #11 revealed the facility admitted the resident on 5/23/13 .Current diagnoses included sleep apnea.<br><br>Review of the Minimum Data Set (MDS), for Resident #11, with an Assessment Reference Date (ARD) of 4/4/24, revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident is cognitively intact. |