STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rest Haven Health and Rehabilitation	103 Cunningham Drive Ripley, MS 38663

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 0584 Level of Harm - Minimal harm or potential for actual harm 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. 46013 Based on observation and staff and resident interviews the facility failed to provide a safe clean environment as evidenced by a wheelchair with a torn armrest, a dirty oxygen concentrator, an overbed table with tattered and torn edging and overbed tables with a thick black substance on the metal base for three (3) of 44 residents rooms observed. Resident #13, Resident #31, and Resident #39 Findings include: An interview with the Administrator on 4/25/24 at 9:23 AM, revealed the facility did not have a policy addressing repairing and cleaning equipment. Resident #13 An observation and interview on 4/23/24 at 6:50 AM, revealed Resident #13 lying in bed with her overbed table pulled up to her. The overbed table edging was off around the table with exposed chipped wood. The metal base of the overbed table had a thick black substance. Resident #13 stated, I need a new table. It's been like this for a long time. During an interview and observation on 4/24/24 at 9:00 AM, Licensed Practical Nurse (LPN) #3 confirmed Resident #13's overbed table needed to be replaced because the edging around the table was tattered and torn and revealed the torn edging could cause a skin tear. Resident #31 An observation on 4/23/24 at 7:25 AM and again at 3:45 PM, revealed Resident #31's oxygen concentrator sitting by her bed with a brown and gray substance down the front and on top of the oxygen concentrator. Resident #31's overbed table had a thick brown and black substance on the metal base. During an observation and interview on 4/24/24 at 9:05 AM, LPN #3 revealed the cleaning of the oxygen concentrators is the responsibility of the nursing department but stated, really anyone who sees it can clean it. She confirmed that the oxygen concentrator was dirty and needed to be cleaned and that the metal base on the overbed table needed to be cleaned and revealed housekeeping usually does that. She revealed the metal base looks like it has rust, but it does need cleaning. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #39 Observation on 4/23/24 at 8:05 AM, revealed Resident #39 sitting in the dining room in a wheelchair with the left side armrest vinyl tattered and torn with jagged edges exposed where the resident's arm rested on the armrest Observation on 4/23/24 at 9:44 AM, revealed Resident #39's overbed table had a thick black substance scattered on the metal base. An interview and observation on 4/24/24 at 9:25 AM, Certified Nurse Aide (CNA) #1 revealed it is the CNA's responsibility to report any wheelchairs that are in disrepair to the Maintenance Director. She confirmed Resident #39's left armrest on his wheelchair needed to be repaired and revealed she had not reported the wheelchair to anyone. She confirmed the metal base on his overbed table was dirty and needed to be cleaned. She revealed housekeeping is responsible for cleaning the rooms. An observation and interview on 4/24/24 at 9:30 AM the Housekeeping Supervisor revealed that the nursing department is usually responsible for cleaning the oxygen concentrators and the housekeeping department is responsible for cleaning the overbed tables. She confirmed that the overbed tables for Resident #13, Resident #31, and Resident #39 had a thick substance on the metal base and the edging on Resident #13's overbed tabletop was torn and needed to be replaced. She revealed we can try and clean the metal bases on the overbed tables, but I think it's thick rust or old paint peeling. She confirmed the overbed tables looked bad and she would see what she could do to clean them. An observation and interview on 4/24/24 at 10:09 AM, the Administrator confirmed the left armrest on Resident #39's wheelchair was torn and tattered and needed to be repaired. He confirmed the overbed tables for Resident #13, Resident #31 and Resident #39 were in disrepair and needed to be either be cleaned, resurfaced, or replaced. He confirmed the tables did not look good.

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. 44804 Based on observation, staff interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan for a resident with an elopement bracelet (Resident #1) and a resident requiring nail care (Resident #24) for two (2) of 15 sampled residents reviewed during survey. Findings Include: Review of the facility policy titled Comprehensive Care Plan with a revision date of 3/2019 revealed under, Standard: 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. Record review of Resident #1's Care Plans, undated revealed Focus: (Proper name of Resident #1) is an elopement risk/wanderer .Interventions .Wanderguard at all times for safety . The care plan did not include any interventions to monitor the residents wanderguard bracelet. An observation on 04/23/24 at 12:49 PM revealed Resident #1 was wearing a wander guard bracelet on his left wrist. Record review of Resident #1's Elopement Evaluation dated 3/11/24 revealed the resident has a history of elopement or attempted elopement and wanders. Record review revealed that there was not any monitoring of the wander guard each shift on the Treatment Administration Record (TAR) or Medication Administration Record (MAR). Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/11/24 revealed in Section P the resident was coded for a wander/elopement alarm that was used daily. During an interview on 4/23/24 at 1:30 PM, with Registered Nurse (RN) #1 revealed Resident #1 wears a wanderguard because he has dementia and gets confused sometimes. She stated he says he wants to go home and does wander, but he has never eloped. During an interview on 4/25/24 at 8:20 AM, with the Director of Nurses (DON) revealed that it was her expectation that Resident #1's care plan would be implemented correctly because the purpose of the care plan was for staff to know what care the resident needs. She stated that the resident had gone out to the hospital and had returned and she thinks that the monitoring of the wander guard just got left off of his TAR. An interview on 4/25/24 at 9:00 AM, with Registered Nurse #1 confirmed Resident #1's care plan was not followed because the wander guard was not being monitored. Resident #24 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #24's care plan with an initiated date of 2/9/24 revealed Focus The resident has an ADL (Activities of Daily Living) self care performance deficit r/t (related to Dementia .Interventions . Personal Hygiene/Oral Care: The Resident requires (1) staff participation with personal hygiene and oral care . During an observation of Resident #24, on 4/23/2024 at 9:50 AM, revealed long thick discolored fingernails on the left hand that measured approximately three-eights (3/8) inch in length from the tip of the fingers. Also observed, the right fingernails measured approximately one-fourth (1/4) inch in length. During an observation and interview on 4/23/2024 at 2:39 PM, with Registered Nurse (RN) #1, confirmed Resident #24's nails were long and needed cutting. During an interview with the Director of Nursing (DON) on 4/25/2024 at 8:16 AM, revealed the purpose of the care plan was for the staff to know how to care for the resident. She revealed the personal hygiene care plan covered nail care and confirmed it was not done. 47874

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47874 Based on observation, resident and staff interview, and facility policy review, the facility failed to perform nail care for a resident that needed assistance, as evidence by long thick fingernails for one (1) of two (2) residents reviewed for activities of daily living (ADLs). Resident #24 Findings Include: Review of the facility policy titled Care of Fingernails/Toenails with a revision date of 06/2022 revealed under, Purpose: The purpose of this procedure is to clean the nail bed, to keep nails trimmed and to prevent infections. Nail care includes cleaning and trimming as needed. Proper nail care can aid in the prevention of skin problems around the nail bed. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his/her skin (unless medically contraindicated). Resident #24 An observation and interview on 4/23/2024 at 9:50 AM, with Resident #24, revealed long thick discolored fingernails on the left hand that measured approximately three-eights (3/8) inch in length from the tip of the fingers. The nails on the right hand measured approximately one-fourth (1/4) inch in length. The resident expressed he would like his nails cut. An observation and interview with Licensed Practical Nurse (LPN) #6 on 4/23/2024 at 2:20 PM, confirmed Resident #24's nails needed cutting. She revealed a Registered Nurse (RN) must cut his nails because he was a diabetic. An observation and interview with Registered Nurse (RN) #1 on 4/23/2024 at 2:39 PM, revealed she was responsible for trimming the diabetic nails. She confirmed Resident #24's nails were long, and he could scratch himself and cause skin concerns. An interview with the Director of Nursing (DON) on 4/24/2024 at 8:14 AM revealed the Registered Nurse (RN) on duty was responsible for doing nail care for the diabetics every Tuesday, and it should be documented on the Medication Administration Record (MAR). She confirmed Resident #24 did not have this task on his MAR. She confirmed that the long nails were an infection and a personal hygiene concern.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 accidents and hazards for a resident who was an elopement risk by failing to monitor placement and function of a wander guard (Resident #1) and failure to secure smoking supplies for one (1) of three (3) days of survey. Findings Include Record review of the facility policy titled, Wandering/Elopement Risk with a revision date of 11/2017 revealed STANDARD It is the standard of this facility to identify those residents at risk for wandering/elopement and to take the appropriate steps to minimize the risk of elopement . The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering . of 10/2017 revealed STANDARD This facility provides a safe and healthy environment for residents . including safety as related to smoking. Safety protections apply to smoking and non-smoking residents . Standard Explanation and Compliance Guidelines .13. Smoking material will be maintained and secured by nursing staff . Resident #1 An observation on 04/23/24 at 12:49 PM, revealed Resident #1 was wearing a wander guard bracelet on his left wrist. Record review of Resident #1's Elopement Evaluation dated 3/11/24 revealed the resident has a history of elopement or attempted elopement and wanders. Record review of Resident #1's Order Summary Report with active orders as of 4/24/24 revealed there was not an order for a wander guard bracelet. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/11/24 revealed in Section P the resident was coded for a wander/elopement alarm that was used daily. An interview on 4/23/24 at 1:30 PM, with Registered Nurse (RN) #1 revealed that Resident #1 wears a wander guard because he has dementia and gets confused sometimes. She stated he says he wants to go home and does wander, but he has never eloped. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview, observation, and record review on 4/24/24 at 4:30 PM, with Licensed Practical Nurse (LPN) #7 confirmed that Resident #1 had a wander guard bracelet on his left wrist. She stated he had worn it for a long time. She stated that anyone that has a wander guard bracelet should have an order and then it will show on either the Electronic Medication Administration Record (EMAR) or Electronic Treatment Administration Record (ETAR) to monitor it every shift. A record review of the resident's physician's orders with LPN #7 confirmed that Resident #1 did not have an order for a wander guard, and it was not triggered on the residents EMAR or ETAR to check for functioning or placement of the wander guard bracelet each shift. An interview and record review on 4/24/24 at 4:40 PM, with LPN #3 confirmed that Resident #1's wander guard bracelet had not been monitored each shift to make sure it was still on the resident and functioning. An interview on 4/25/24 at 8:20 AM with the Director of Nurses (DON), revealed it was her expectation that Resident #1's physicians order would have been put in the resident's record and triggered for the staff to monitor the resident's wander guard placement and function. She stated the residents order for a wander guard dropped off in December 2023 after he returned from a hospital stay. She confirmed a residents wander guard needs to be monitored for placement and function to prevent an elopement. Record review of Resident #1's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Schizoaffective Disorder, Bipolar Type. Smoking: An observation on 4/23/24 at 6:38 AM, revealed the smoking supply closet on the resident hall that held residents smoking supplies was unlocked. Observed a sign on the smoking supply closet door Keep this door locked at all times. An interview and observation on 4/23/24 at 6:45 AM, with Housekeeping Staff #2 confirmed the smoking supply closet was unlocked and stated they are supposed to keep that door locked at all times. Housekeeping Staff #2 stated the key is kept behind the nurse's desk. An interview and observation on 4/23/24 at 6:50 AM, with Licensed Practical Nurse (LPN) #6 confirmed that the resident smoking supply closet was unlocked, held resident's smoking supplies including at least one lighter and that it was supposed to always be locked for safety. An interview on 4/23/24 at 6:55 AM, with Registered Nurse (RN) #1 confirmed that the residents smoking supply closet was supposed to be locked at all times and the key is kept behind the nurse's station. She revealed that the purpose of keeping the smoking supply closet locked was to prevent residents from having access to the smoking supplies and the lighter. She stated there is at least one lighter in there. If the residents got a hold of the supplies they'd be smoking in the rooms and we have oxygen in the building, so it's a safety issue. Record review of the List of Resident on Designated Smoking list undated, revealed there were 9 active smokers listed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Administrator on 4/25/24 at 11:00 AM, confirmed that the smoking supplies should always be locked up to prevent the residents from having access to the smoking supplies including the lighter for safety issues and that was the facilities policy.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 47874 Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide appropriate care and services for respiratory care, as evidenced by, failing to label and store an aerosol nebulizer mask device for one (1) of three (3) nebulizers in the facility. Resident #28 Findings Include: This citation is cross reference to: F867 Record review of the facility policy titled Respiratory System Management with a revision date of 1/2003 revealed Procedure, In Order: . 17. Rinse the nebulizer and mouthpiece. Shake to air dry and store in a plastic bag that is labeled with the resident's name and room number. Nebulizer and mouth piece may also be stored in the machine if storage shelf is available. 18. Change nebulizer set up-weekly. An observation and interview with Resident #28 on 4/23/2024 at 9:04 AM, revealed he was sitting on the edge of the bed. A nebulizer machine was sitting on a bedside table, with the nebulizer mask lying across the lower bed. The tubing and mask were undated, and the mask was unbagged. The resident revealed he used the nebulizer mask every day for his breathing and was not aware of a storage bag for the nebulizer mask. An observation of Resident #28's room on 4/23/2024 at 2:10 PM, revealed a nebulizer machine sitting on top of a bedside table with the nebulizer mask secured in an upright position on the side. The mask was not bagged, and the tubing had a piece of tape attached with a date of 4/23/2024. Record review of the Order Summary Report with active orders as of 4/24/24 revealed orders dated 3/21/24 for Arformoterol Tartrate Inhalation Nebulization Solution and Ipratropium Bromide Inhalation Solution for Chronic obstructive pulmonary disease. An observation and interview with Licensed Practical Nurse (LPN) #6 on 4/23/2024 at 2:25 PM, confirmed the nebulizer mask did not have a cover to protect it. She revealed the mask should be placed in a bag to prevent it from getting contaminated. She revealed she just changed out the nebulizer set-up and dated it. An interview with Registered Nurse (RN) #1 on 4/23/2024 at 2:42 PM, revealed the nebulizer mask should be stored in a plastic bag to prevent the formation of bacteria in the mask and the bag, mask and tubing should be changed out weekly and dated. An interview with the Director of Nursing (DON) on 4/24/2024 at 8:12 AM, revealed the nebulizer mask was to be placed in a bag when not in use to prevent infection. She revealed the bag, tubing, and mask were changed out weekly on the night shift and her expectation was for staff to do this and apply the date. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Admission Record revealed the facility admitted Resident #28 on 1/27/23 with medical diagnoses that included Chronic obstructive pulmonary disease and Schizophrenia.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure medications were stored appropriately and not left in the resident's room for one (1) of 15 sampled residents. Resident #31 Findings include: A review of the facility policy, titled 4.1 Storage of Medication with a date of 01/23 revealed, 4.1 STORAGE OF MEDICATION Policy: .The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . Procedures . 1. Medications are to remain in these containers and stored in a controlled environment. This may include such containers as medication carts, medication rooms, medication cabinets, or other suitable containers An observation and interview on 4/23/24 at 7:00 AM, revealed a prescription-labeled box of Latanoprost Solution eye drops and a prescription-labeled box of Cosopt Ophthalmic solution with medications inside of boxes sitting on Resident #31's overbed table. Licensed Practical Nurse (LPN) #1 entered the room and asked the resident, Why are these medications lying on your bedside table? Resident #31 revealed someone left them there. LPN #1 confirmed the medications were supposed to be locked up in the medication cart because the residents are not supposed to have medications in their rooms and revealed, the eye drop medication was given last night and should have been locked back up in the medication cart. An interview on 4/23/24 at 7:20 AM, Resident #31 revealed the nurse left the eye drops in here last night. In an interview on 4/23/24 at 2:22 PM, the Director of Nurses (DON) confirmed she was made aware of the eye medication left on the overbed table and revealed that is a no no. The DON stated, the nurses know that is not supposed to happen, all medication is to be kept locked up in the medication cart. She revealed a wandering resident could enter a resident's room and take the medications. A record review of Resident #31's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included Heart Failure and Chronic Kidney Disease, Stage 3. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/14/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #31 was cognitively intact.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 47874 Based on record review and staff interview, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor the interventions the committee put in place following the recertification survey of 2/2/2023. This was for a deficiency recited during a recertification and complaint survey on 4/23/2024 in the area of F695 Respiratory/Tracheostomy Care and Suctioning. The continued failure of the facility during two State Surveys of record shows a pattern of the facility to sustain an effective QAA program. This was for one (1) of eight (8) deficient practice citations. Findings Included: This citation is cross-referenced to: F695 Review of the facility policy titled Quality Assurance and Performance Improvement with a revision date of 8/2023 revealed Standard: It is the standard of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. Focused Rounds: Focused Rounds are intended to discover areas of concern before they become a problem for the facility. Focused Rounds take the form of short checklist devoted to specific practices and concerns and are conducted on a regular basis . An interview with the Administrator (ADM) on 4/25/2024 at 9:05 AM, revealed he was not aware that the nebulizer mask was not being stored appropriately and was a concern for the facility again. He revealed the interdisciplinary team (IDT) did discuss this in QAPI (Quality Assurance and Performance Improvement) after the facility was cited on this in February 2023. He revealed they implemented measures to ensure this did not happen again. The ADM explained that they made rounds to ensure all the nebulizers were stored in a bag, and they did in-services with the staff. He revealed the plan failed because they have a lot of new staff. He revealed the nurses should have been trained on hire that respiratory equipment was to be placed in a bag. The ADM revealed his expectation was for that information to be relayed to the new staff, but he stated, it must have fallen through. Record review of the Facility's Plan of Correction (POC) dated 3/10/2023 revealed under, 3. Education on Respiratory Management was provided to Nursing staff in person by our Nurse Educator on 2/03/2023 and assigned via (proper name) on 2/03/2023 with a completion date of 2/10/2023. Education on Infection Control was provided to clinical staff in person on 2/03/2023 by Nurse Educator and Via (proper name) on 2/03/2023 with a completion date of 2/10/2023. 4. Unit Manager/register nurse Supervisors to make daily audits using the Oxygen/Nebulizer audit form for 30 days beginning 2/03/2023 to ensure of proper storage of respiratory equipment. The Director of nursing /Nurse Educator will complete 5 audits using the Oxygen/Nebulizer audit form weekly x 4 weeks beginning 2/10/2023 then 5 audits biweekly for 60 days to ensure proper storage of respiratory equipment. The monitoring we have in place for this deficiency will be discussed at our monthly Quality Assurance and Performance Improvement meeting on 3/9/23 and then monthly for 2 months completing on 5/9/23. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rest Haven Health and Rehabilitation	103 Cunningham Drive Ripley, MS 38663

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Quality Assurance and Performance Improvement (QAPI) Meeting Notes dated 3/9/2023 revealed . Conclusions and Recommendations: . Plan of correction discussed with audit tools in place to monitor with no issues noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Rest Haven Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 103 Cunningham Drive Ripley, MS 38663	

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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** 46013 Based on observation, staff interviews, and facility policy review, the facility failed to prevent the possibility of the spread of infection as evidenced by failing to utilize proper hand hygiene and maintaining a clean barrier for one (1) of five (5) care observations. Resident #13 Findings include: Review of the facility policy titled, Infection Control Standard with a revised date of 05-2023 revealed, STANDARD It is our standard to assume that patients are potentially infected or colonized with an organism that could be transmitted during the course of providing patient care services and therefore our facility applies the Standard Precautions infection control practices . 1. Hand Hygiene: a. During the delivery of patient care services, avoid unnecessary touching of surfaces in close proximity to the resident to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . e. Staff must perform hand hygiene (even if gloves are used): iii .After contact with .nonintact skin, or wound dressing, visibly contaminated surfaces or after contact with objects in the resident's room . v . If hands shall be moving from a contaminated-body site to a clean-body site during resident care . Observation of wound care treatment for Resident #13 on 4/23/24 at 2:45 PM revealed Licensed Practical Nurse (LPN) #4 washed her hands applied clean gloves and assisted Certified Nurse Aide (CNA) #2 with turning Resident #13 to her left side. LPN #4 began removing the resident's brief and then cleaned the wound to her right buttock with wound cleanser and then applied the wound treatment without changing out her gloves and washing her hands. When the wound treatment to the right buttock was completed two unopened packages of abdominal (ABD) pads fell off the overbed table onto the floor, LPN #4 retrieved the unopened ABD packages off the floor while wearing her soiled gloves and placed the unopened ABD pads back on the clean barrier tray contaminating the clean barrier tray. LPN #4 then removed her gloves, washed her hands, and applied clean gloves. LPN #4 assisted CNA #2 with turning Resident #13 to her right-side, LPN #4 did not change her soiled gloves and proceeded to administer wound treatment to Resident #13's left outer thigh. An interview on 4/23/24 at 3:10 PM, LPN #4 confirmed she did not practice infection control measures by failing to change her gloves during wound treatment to both of the resident's wounds. She confirmed when she picked up the ABD packages from the floor while wearing her soiled gloves and laying them on the clean barrier that she contaminated her clean barrier. She confirmed that not practicing proper infection control measures could potentially cause an infection in the wound. During an interview on 4/23/24 at 3:45 PM, the Director of Nurses (DON) with LPN #4 present confirmed their policy regarding wound treatment is to make sure and change gloves and wash hands between soiled dressing and clean dressing care and confirmed by not doing so is an infection control issue and could delay healing. A record review of Resident #13's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included Pressure ulcer of right buttock and Type 2 Diabetes Mellitus with Hyperglycemia.