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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Humphreys CO Nursing Center	500 CCC Road Belzoni, MS 39038

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 47874 Based on staff interview, record review, and facility policy review, the facility failed to ensure a resident's code status was accurate in the physician orders for one (1) of 24 sampled residents. Resident # 31 Findings Include: Review of the facility policy titled Advance Directives with a revision date of 7/15 revealed under, Procedure: . All staff providing care for the residents will: Review the Advance Directive and clarify any discrepancies between the Directive and current treatment plan. Record review of the Physician Order Details dated 8/27/24 revealed, Resident #31 was a full code. Record review of the Advance Directive Consent dated 9/11/24 revealed, Resident #31 signed a Do Not Resuscitate (DNR) in case of cardiac arrest. An interview with Licensed Practical Nurse (LPN) #2 on 12/11/24 at 10:40 AM revealed, in the event of an emergency they (the staff) look for the code status in the computer under the physician orders. She confirmed there was a discrepancy between the code status consent and the physician order, and that this discrepancy could cause confusion in determining if the resident wanted to be resuscitated. An interview with Social Services (SS) #1 on 12/11/24 at 10:48 AM revealed, she was responsible for updating the advance directive consents and Medical Records was responsible for updating the physician orders. She confirmed Resident #31's discrepancy between the consent and the physician order and stated that it must have just been missed. Record review of the Admission Record revealed the facility admitted Resident #31 on 3/06/23 with a medical diagnosis that included Chronic Obstructive Pulmonary Disease.

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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47158 Based on staff interview and record review the facility failed to accurately code the Minimum Data Set (MDS) Assessment for discharge disposition for one (1) of 24 resident MDS assessments reviewed. Resident #47. Findings Include: Review of the facility policy, titled Resident Assessment, latest revision 09/19 revealed Any healthcare professional that completes a portion of the assessment must sign and certify the accuracy of the portion of the assessment that they have completed. Record review of the Discharge-Return Not Anticipated MDS with an Assessment Reference Date (ARD) of 10/18/24 for Resident #47 revealed Item A2105 Discharge Status was coded as Short-Term General Hospital. Record review of Progress Notes for Resident #47, dated 10/18/24 revealed Resident discharged home. An interview and record review of the 10/18/24 Discharge-Return Not Anticipated MDS and Progress Note for Resident #47 with MDS nurse on 12/11/24 at 2:47 PM, she confirmed that Resident #47 was discharged home and the MDS assessment was coded incorrectly. She stated the importance of coding the discharge MDS correctly is to identify the correct placement of the resident. An interview with the Director of Nursing (DON) on 12/11/24 at 2:50 PM, she verified that it was her expectation that Resident #47's MDS would have been coded correctly and stated that it was probably a data entry error. Record review of the Admission Record revealed the facility admitted Resident #47 on 9/26/24 and the date of discharge was 10/18/24 to home.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. 47157 Based on staff interview, record review, and facility policy review the facility failed to submit a Pre-admission Screening and Resident Review (PASRR) status change for a resident with a change in mental status for (1) one of four (4) residents reviewed for PASRR. Resident #38 Findings include: Review of the facility policy titled, Pre-admission Screening PAS/PASRR revised 8/24 revealed, The facility is required to complete and submit Mississippi PASRR Level II Change in Status Request for residents with a Level II experiencing a significant change in status . indicators which may constitute a significant change and require submission of a Resident Review (Status Change) . includes residents previously identified by PASRR to have mental illness . who demonstrate increased behavioral, psychiatric, or mood-related symptoms . Record review of the Status Change Review Outcome report for Resident #38 dated 10/18/23, revealed no further PASRR was required unless a significant change occurs in behavioral health needs. Record review of the Departmental Notes for Resident #38 dated 2/16/24 at 2:32 PM revealed that the resident stated I just can 't do this anymore .I am so depressed, I can 't do this anymore . I just want to stop, go somewhere and just end it .If I could get out the back door, I would find a way to do something or take some pills to end it . In an interview with Social Services on 12/11/24 at 11:16 AM, she revealed she submits PASRR's and the status change submissions. She confirmed she could not find a change of status submission for Resident #38s episode of suicidal ideations and worsening depression in February 2024 and confirmed the resident should have had a status change submitted. In an interview with the Minimum Data Set (MDS) Nurse Coordinator on 12/11/24 at 11:25 AM, she confirmed that a Level II status change for Resident # 38 should have been submitted after the resident's significant change in behavior of increased depression and suicidal ideations in February 2024. She revealed that the purpose of the change in status referral is to see if the resident may require additional services to meet her psychiatric needs. In an interview with the Director of Nursing (DON) on 12/12/24 at 8:17 AM, she confirmed that a Level II status change should have been submitted when Resident #38 had an episode of increased depression and suicidal ideations revealing this was a new behavior for the resident. She then revealed that when Resident #38 made the statement of wanting to hurt herself on 2/16/24, she required one-on-one supervision, the provider and the psychiatric nurse practitioner that follows her were notified and instructed to send her out for treatment. The DON then stated the facility had to send her to the Emergency Department for evaluation and returned the following day remaining on one-on-one supervision. The DON revealed the psychiatric nurse practitioner increased the frequency of her visits with Resident #38, increased her Zoloft and stated it was okay to stop the one-on-one supervision. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #38 Psych (psychiatric) Progress Note dated 2/21/24, revealed, Case Conceptualization: early visit due to resident's recent report of wanting to die. Note: next appointment (1) one week. Recommendations: increase Zoloft to 100 mg (milligrams) daily . Review of a form titled, One-on-One Supervision, revealed Resident #38 was on one-on-one supervision from 2/16/24-2/21/24 while in the facility. Record review of the EMAR (Electronic Medication Administration Record) for February 2024 for Resident #38 revealed Zoloft 50 mg once daily for depression/withdrawn, discontinued 2/19/24. Zoloft 100 mg once daily for depression, crying, thoughts of harming self/thoughts not of not wanting to live with an order date of 2/19/24. Record review of the Admission Record revealed the facility admitted Resident #38 on 6/16/23. Review of the active diagnoses included Visual and Auditory Hallucinations, Psychotic Disorder with Hallucinations, and Major Depressive Disorder. Record review of Resident #38s MDS with an Assessment Reference Date (ARD) of 9/12/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact. Section I: Active Diagnosis: Depression and psychotic disorder were coded.

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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. 47874 Based on observation, resident and staff interviews, record review, and facility policy review the facility failed to implement a person-centered care plan for providing nail care for two (2) of 24 sampled residents. Resident #8 and #30. Findings include: A review of the facility's Care Plan Process policy, with a revision date of 08/17, revealed, Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to a number of specified areas (e.g., customary routine, vision, and continence).The care plan is driven not only by identified resident issues and/or conditions but also by a resident's unique characteristics, strengths, and needs. Resident #8 Record review of Resident #8's Care Plans with a problem onset date of 3/1/18 revealed under, Problem/Need: Resident requires extensive to total assistance with ADL (Activities of Daily Living) . Also revealed under, Approaches: . Assist with personal grooming as needed, nail, bathing, shaving etc . An observation on 12/10/24 at 9:34 AM of Resident #8 revealed a left-hand contracture, with long nails meeting the inner palm. The right-hand revealed long nails measuring approximately (3/8) three-eighths of an inch in length past the tip of the fingers with a thick, black substance underneath the nails. An observation and interview with the Director of Nursing (DON) on 12/11/24 at 9:36 AM, confirmed Resident #8 had long dirty nails. An interview with the Minimum Data (MDS) Nurse on 12/12/24 at 8:40 AM revealed, the purpose of the care plan was to alert the staff to the needs of the residents. She confirmed the nail care plan was not followed for Resident #8. Record review of the Admission Record revealed the facility admitted Resident #8 on 3/01/18 with a medical diagnosis that included Hemiplegia and Hemiparesis following Cerebral Infarction. 46013 Resident #30 (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 #30's care plans revealed an Activities of Daily Living (ADL) care plan initiated on 11/5/24, that indicated Focus: The resident has left sided hemiplegia/hemiparesis related to late effects of CVA (Cerebrovascular Accident) which affect resident ADL's. Resident requires extensive to total assistance with ADL bed mobility, transfer and toileting with an intervention to assist with ADLs as required . An interview and observation on 12/10/24 at 12:05 PM, revealed Resident #30's left hand was contracted and the resident stated that he really needed his fingernails cut especially on his left hand. He revealed that his left hand is contracted and during the day he can keep it more relaxed but when he goes to sleep at night it cramps, and his fingernails dig into his palm. The fingernails on the right hand were approximately one-half (1/2) inch past the tips of the fingers with a brown substance noted underneath the nails. Resident #30 was able to extend open the contracted left hand which revealed his fingernails were approximately three fourths (3/4) of an inch long and jagged with a brown substance under the nails. During an interview on 12/11/24 at 1:15 PM, the MDS Coordinator revealed the care plan is to be developed and implemented so that the staff will know how to take care of each resident's individual needs. She revealed the care plan must be resident specific and confirmed Resident #30's ADL care plan was not implemented, because his grooming and hygiene needs which would include nail care was not addressed. Record review of Resident #30's Admission Record revealed the facility admitted the resident on 4/18/2017 with medical diagnoses that included Hemiplegia and Hemiparesis following Nontraumatic Subarachnoid Hemorrhage affecting Left Non-Dominant side, and Epilepsy, Unspecified, not Intractable, without Status Epilepticus. Record review of Resident #30's MDS with Assessment Reference Date (ARD) of 10/31/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.

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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 interviews, record reviews and facility policy reviews, the facility failed to provide personal hygiene as evidenced by long, jagged nails with brown substance underneath nails for two (2) of 24 sampled residents. Resident #8 and #30. Findings include: Record review of facility policy titled, Nail Care, with a revision date of 07/10, revealed, Purpose .To promote cleanliness, safety and a neat appearance Resident #8 On 12/10/24 at 9:34 AM, observation revealed a left-hand contracture with long nails meeting the inner palm. The right-hand revealed long nails measuring approximately (3/8) three-eighths inches in length with a thick, black substance underneath the nails. On 12/11/24 at 9:36 AM, an observation and interview with the Director of Nursing (DON) confirmed Resident #8 had long dirty nails. She revealed the nurses were responsible for cutting his nails because he was a diabetic. She revealed long nails, and the hand contracture could result in a wound inside the palm, or the resident could scratch himself and cause infection. Record review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 11/13/24 revealed, under section GG, Resident #8 was dependent on staff for personal hygiene. Record review of the Admission Record revealed the facility admitted Resident #8 on 3/01/18 with a medical diagnosis that included Hemiplegia and Hemiparesis following Cerebral Infarction. 46013 Resident #30 On 12/10/24 at 12:05 PM, an interview and observation with Resident #30 revealed the resident's left hand was contracted. Resident #30 stated that he really needed his nails cut and particularly on his left hand. He revealed that during the day he can keep his hands relaxed but when he goes to sleep it cramps, and his fingernails dig into his palm. The fingernails on the right hand were approximately (approx.) one-half (1/2) inch long with a brown substance noted underneath the nails. Resident #30 was able to extend open the contracted left hand which revealed his fingernails were approximately three fourths (3/4) of an inch long and jagged with a brown substance under the nails. On 12/11/24 at 8:25 AM, an observation revealed Resident #30's fingernails remain unchanged. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and observation on 12/11/24 at 11:16 AM, Certified Nurse Aide (CNA) #1 confirmed that Resident #30's fingernails were long and jagged with a brown substance under them, and needed to be cleaned and trimmed. She stated that the CNAs do fingernail care on shower days, but we only do Resident #30's fingernails on one hand. She revealed that the CNAs don't do the fingernails on the stroke hand, the nurses do that hand. During an interview and observation on 12/11/24 at 11:25 AM, Licensed Practical Nurse (LPN) #1 confirmed that the residents' nails were long and jagged with a dirty substance under them. She revealed that with them being long and dirty the resident could scratch himself and cause an infection and that the longer fingernails on the left contracted hand could cause a pressure area to develop. She revealed the weekend supervisor usually cuts and cleans Resident #30's fingernails, but his wife has also come in before and cleaned and cut them. Record review of Resident #30's Admission Record revealed the facility admitted the resident on 4/18/2017 with medical diagnoses that included Hemiplegia and Hemiparesis following Nontraumatic Subarachnoid Hemorrhage affecting Left Non-Dominant Side, and Epilepsy, Unspecified, not Intractable, without Status Epilepticus. Record review of Resident #30's MDS with an ARD of 10/31/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 47157 Based on observation, staff interview, record review, and facility policy review, the facility failed to provide appropriate care and services for resident with an indwelling catheter for one (1) of two (2)residents with indwelling catheters. Resident # 10 Findings include: A review of the facility policy titled, Perineal Care, revision date 01/24 revealed Resident with Catheter: 4.) Using a clean washcloth or wash wipe, start at the meatus and wash the tubing in a circular motion away from the body. Rinse using the same method . An observation on 12/11/24 at 10:55 AM revealed Certified Nurse Assistant (CNA) #2 performed hand hygiene, applied gloves and provided incontinent and catheter care to Resident #10. This observation revealed CNA #2 washed, rinsed and dried the urinary meatus and catheter tubing without hand hygiene and changing gloves between each aspect of care. In an interview with CNA #2 on 12/11/24 at 11:10 AM, she confirmed she failed to change her gloves and perform hand hygiene after cleaning the urinary meatus/catheter tubing area and then rinsing and drying the urinary meatus/catheter tubing area. She then revealed that she contaminated the water in the basin when she failed to perform hand hygiene and change gloves and increased the resident's risk for obtaining an infection. In an interview with the Director of Nursing (DON) on 12/11/24 at 1:40 PM, she revealed she also acts as the infection control nurse. She then confirmed CNA #2 should have performed hand hygiene and applied clean gloves after cleaning the urinary meatus and catheter tubing before rinsing and drying the clean areas. She stated that failing to perform hand hygiene between a clean and dirty procedure and contaminating the clean water in the basin placed Resident #10 at increased risk of infection such as a urinary tract infection. Record review of the Admission Record revealed the facility admitted Resident #10 on 11/18/24 with diagnoses of Retention of Urine and Urinary Tract Infection. Record review of Resident #10's Minimum Data Set (MDS) with an Assessment Reference Date of 11/25/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact. Section H0100: Bladder and Bowel was coded resident having an indwelling urinary catheter. -

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47874 Based on observation, staff interview, and facility policy review, the facility failed to maintain a clean ice machine as evidenced by multiple areas of a black substance inside the area that contained the ice for one (1) of two (2) kitchen tours. Findings include: Review of the facility policy titled Ice Maker & (and) Dispenser Cleaning Instructions with a revision date of 8/21, revealed under, Policy: Equipment shall be maintained in a clean and sanitary condition. Maintenance staff will perform cleaning. An observation of the ice machine on 12/10/24 at 9:44 AM revealed seven (7) irregular shaped black spots measuring approximately 5 inches in length, on a white plastic strip in the upper portion of the inside of ice maker that held the ice. An observation and interview with the Dietary Manager (DM) on 12/10/24 at 10:26 AM confirmed there were black spots inside the ice machine and stated, No, it's not clean. She confirmed the ice was used for staff and residents and a dirty ice machine could make everyone sick. She revealed that maintenance was responsible for cleaning the ice maker once monthly. An interview with Maintenance on 12/10/24 at 10:43 AM revealed that he had not cleaned the ice machine since last month and did not know there were black spots inside.

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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. 47158 Based on staff interviews and record reviews, the facility failed to submit accurate direct care staffing information to the Payroll Based Journal (PBJ) for the fourth (4th) quarter of the fiscal year (FY) 2024 (July 1-September 30) for one (1) of four (4) PBJ quarter reports reviewed. Findings Include: Review of the typed statement on company letterhead dated 12/12/24 signed by the Administrator revealed that the facility does not have a policy on PBJ. A record review of the facility's PBJ Staffing Data Report for the 4th quarter of FY 2024 revealed that the facility triggered for excessively low weekend staffing. In an interview on 12/11/24 at 2:00PM, the Administrator confirmed that the facility had not submitted accurate PBJ staffing data for the fourth quarter of FY 2024. The Administrator explained that they have a Case Manager who is a Licensed Practical Nurse (LPN) with administrative duties, but that she also has direct care duties. He explained that they did not accurately report the hours that this LPN worked administrative duties separate from her direct care duties. He agreed that the hours reported for the LPN Case Manager were not accurate. In a further interview with the Administrator on 12/11/24 at 2:15 PM, he stated that the facility has a Certified Nursing Assistant (CNA) that serves as the van driver during the week and all the hours worked by this staff member are reported as direct care hours because they sometimes provided direct care. The Administrator agreed that the CNA van driver would be considered a universal care worker and hours spent driving the van should not be reported as direct care hours.

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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. 47874 Based on observation, staff interview, record review, and facility policy review, the facility failed to help prevent the possible transmission of infections when staff failed to perform hand hygiene during resident care observed for Resident #5 and #10 and failed to use Enhanced Barrier Pecautions (EBP) during catheter care for Resident #10 for two (2) of five (5) resident direct care areas observed. Findings include: A review of the facility policy titled, Perineal Care, latest revision 01/24 revealed Purpose: To prevent infection . Resident with Catheter . 4.) Using a clean washcloth or wash wipe, start at the meatus and wash the tubing in a circular motion away from the body. Rinse using the same method. Review of the facility titled, Enhanced Barrier Precautions, latest revision 03/24 revealed that Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of the spread of multi-drug-resistant organisms in nursing homes. EBP involves gown and glove use during high contact resident care activities. Example of high contact resident care activity: presence of indwelling medical device. Review of the facility policy titled Hand Hygiene with a revision date of 01/24 revealed, under, Purpose: To cleanse hands to prevent transmission of infection or other conditions. To provide a clean, healthy environment for residents, staff and visitors. Also revealed under, Procedure: Indications for Handwashing . 4. Before and after applying gloves. Resident #5 An observation of wound care with Licensed Practical Nurse (LPN) #1 on 12/12/24 at 8:51 AM revealed, she performed hand hygiene, applied gloves and removed the sacral wound dressing. LPN #1 removed the soiled gloves and applied a new pair of gloves without using hand hygiene. She followed by cleaning the wound, removing the soiled gloves and applied new gloves to finish the wound care. After completing sacral wound care, LPN #1 performed wound care to the pressure wound on the left heel without using hand hygiene in between wounds or glove application and removal. An interview with LPN #1 on 12/12/24 at 9:15 AM confirmed, she only used hand hygiene once during the process of treating Resident #5's wounds. She revealed she should have performed care to the cleanest wound first, and verbalized hand hygiene should have been done each time new gloves were applied. LPN #1 confirmed this should be done to prevent the contamination of the wounds and the spread of infection. An interview with the Director of Nursing (DON) on 12/12/24 at 9:22 AM confirmed the purpose of hand hygiene and to start with the cleanest wound first was to prevent cross contamination and the spread of infection. She revealed her expectations were for good hand hygiene to be performed during wound care and for residents with multiple wounds, the nurse should start care with the cleanest wound first. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Humphreys CO Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 500 CCC Road Belzoni, MS 39038	

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Order Summary Report for Resident #5 revealed an order dated 7/18/24, Gentamicin Sulfate External Cream 0.1% (percent) Apply to sacrum topically every day shift related to pressure ulcer of sacral region, stage 4: Clean with Vashe solution, pat dry, apply gentamicin and silver alginate to wound bed and cover with bordered foam dressing. Record review of the Order Summary Report for Resident #5 revealed an order dated 11/15/24, Clean pressure ulcer stage 3 to left heel with Vashe wound solution. Apply gentamicin and silver alginate to wound bed and wrap with kerlix and secure with tape daily until healed. Record review of the Admission Record for Resident #5 revealed the facility admitted the resident on 12/14/22 with a medical diagnosis that included Cerebral Infarction and Functional Quadriplegia. 47157 Cross-reference F690 Resident #10 An observation of catheter care for Resident #10 on 12/11/24 at 10:55 AM, revealed Certified Nurse Assistant (CNA) # 2 performed hand hygiene, applied clean gloves, did not apply a gown and dipped a washcloth in the clean water basin of water, applied soap and cleansed around the urinary meatus, and sides of the catheter tubing. She then placed another clean washcloth into that same water basin and rinsed the urinary meatus and catheter tubing while still wearing the same gloves. CNA# 2 then used a dry washcloth and dried around the urinary meatus and catheter tubing while continuing to wear the same gloves. In an interview with CNA #2 on 12/11/24 at 11:10 AM, she confirmed she failed to change her gloves and perform hand hygiene after cleaning the urinary meatus/catheter tubing area and then rinsing and drying the urinary meatus/catheter tubing area. She then revealed that she contaminated the water in the basin when she failed to perform hand hygiene and change gloves and increased the resident's risk for obtaining an infection. CNA #2 also confirmed that she failed to wear a gown for EBP but knew she was supposed to because Resident #10 has a catheter. In an interview with the DON on 12/11/24 at 1:40 PM it was confirmed that Resident #10 should be on EBP related to her having an indwelling urinary catheter to put an extra layer of protection to reduce the spread of bacteria. She also confirmed that CNA #2 should have performed hand hygiene and applied clean gloves after cleaning the urinary meatus and catheter tubing before rinsing and drying the clean areas. She stated that failing to perform hand hygiene between cleaning and rinsing contaminated the clean water in the basin and placed the resident at an increased risk of infection. Review of the Admission Record revealed the facility admitted Resident #10 on 11/18/24 with diagnoses that included Retention of Urine and Urinary Tract Infection. Record review of Resident #10's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/25/24 revealed in Section C a BIMS score was 15, indicating the resident was cognitively intact. Section H0100: Bladder and Bowel coded resident having a urinary catheter.