STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Myrtles Nursing Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1018 Alberta Avenue Columbia, MS 39429	

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41680 Based on interview, record review, and facility policy review, the facility failed to provide the Resident, or the Resident Representative (RR), written notification of the bed hold policy at the time of transfer for one (1) of 19 sampled residents. (Resident #60) Findings Include: A review of the facility's policy tiled, Bed Hold Notice Upon Transfer/Leave, dated 12/23, revealed, Bed Hold Agreement . If bed-hold due to hospital transfer or therapeutic leave becomes necessary, the facility will notify the resident or resident's representative of the bed-hold option . A review of the Progress Notes, dated 7/21/24 for Resident #60, revealed that the resident was transferred to the local hospital at 6:13 PM per local ambulance, due to bleeding from the dialysis shunt. On 10/02/24 at 2:14 PM, during an interview, the Accounts Manager (AM) stated that if the resident is their own Responsible Representative (RR), she provides the bed-hold and transfer letter to the resident. She further explained that if a resident is on Medicare, they must pay the facility for each day they are hospitalized . The AM emphasized the importance of residents receiving both letters each time they are transferred to the hospital, as Medicare will not pay both the hospital and the facility. The AM confirmed that she did not provide Resident #60 with the bed-hold letter for their hospitalization on [DATE], stating that she forgot to do it. She reiterated that residents must be informed each time they are hospitalized so they are aware that they must pay to hold their bed while in the hospital. On 10/03/24 at 3:30 PM, during an interview, the Licensed Nursing Home Administrator (LNHA) stated that she expects staff to follow the facility's policies and procedures regarding bed-hold notifications. A review of Resident #60's Admission Record revealed that the facility admitted the resident on 04/02/24 with current diagnoses that included End Stage Renal 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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 43283 Based on staff interviews, record reviews, and facility policy review, the facility failed to complete an annual comprehensive Minimum Data Set (MDS) assessment for one (1) of 19 residents reviewed. (Resident #77). Findings Include: A review of the facility's policy titled, Resident Assessment, with the revision date of 09/19, revealed, An assessment will be completed on each resident utilizing the MDS. The reason for assessment, schedule and timeframes will be according to the guidance of the Resident Assessment Instrument (RAI) Manual. The Registered Nurse (RN) is responsible for verifying the completion of the assessment. The completed assessment guide the staff in identifying key information about the resident and serves as a basis for identifying resident specific issues and objectives in order to develop a care plan. This process assists the resident in reaching the highest practicable physical, mental, and psychosocial well-being . A record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2019, revealed, The ARD (Assessment Reference Date) (item A2300) must be set within 366 days after the ARD of the previous OBRA (Omnibus Budget Reconciliation Act) comprehensive assessment (ARD of previous comprehensive assessment + 366 calendar days) AND within 92 days since the ARD of the previous OBRA Quarterly or SCQA (ARD of previous OBRA Quarterly assessment + 92 calendar days). The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) . A record review of Resident #77's Admission Record revealed the facility admitted the resident on 08/29/23 and had current diagnoses that included Essential (Primary) Hypertension. A record review of Resident #77's Admission MDS revealed an ARD of 09/07/23, and the last Quarterly MDS revealed an Assessment Reference Date (ARD) of 05/01/24. A record review of Resident #77's Annual MDS revealed Section A2300 with an ARD of 07/24/24 and Section Z0500B with a completion date of 09/17/24, which was more than 14 days after the ARD and greater than 366 days from the Admission MDS and greater than 92 calendar days from the last quarterly assessment. A record review of the facility's Final Validation Report, with a submission date of 10/02/24 for Resident #77, revealed, Assessment completed late: Z0500B (assessment completion date) is more than 14 days after A2300 (assessment reference date). (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/24 at 4:06 PM, during an interview with Licensed Practical Nurse (LPN) #1/MDS nurse, she explained that her corporate nurses had informed her that there was no such thing as a too early assessment. In August 2024, she realized Resident #77 had too many quarterly MDSs completed, and the quarterly assessment with an ARD of 07/04/24 was completed in error and inactivated, requiring her to redo the assessment as an annual assessment. She confirmed that Resident #77's Annual Assessment had an ARD of 09/07/23, and the last Quarterly Assessment had an ARD of 05/01/24. On 10/02/24 at 4:30 PM, during an interview with Registered Nurse (RN) #1, she confirmed that Resident #77's Annual Assessment was completed late. On 10/03/24 at 3:30 PM, during an interview with the Administrator, she explained that she was not aware of the late annual comprehensive MDS assessments. She explained that she expects her staff to follow the facility's policy and the RAI manual for completing and submitting MDS assessments on time and accurately, as this is critical to ensure that residents receive appropriate care, as well as reimbursement for services rendered.

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F 0640

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43283

Based on interviews, record reviews, and policy review, the facility failed to submit discharge and annual Minimum Data Set (MDS) assessments in a timely manner for three (3) of (19) resident MDSs reviewed. (Resident #55, #60, and #77).

Findings Include:

A review of the facility's policy titled, Resident Assessment, with the revision date of 09/19, revealed, An assessment will be completed on each resident utilizing the MDS. The reason for assessment, schedule and timeframes will be according to the guidance of the Resident Assessment Instrument (RAI) Manual. The Registered Nurse (RN) is responsible for verifying the completion of the assessment. The completed assessment guide the staff in identifying key information about the resident and serves as a basis for identifying resident specific issues and objectives in order to develop a care plan. This process assists the resident in reaching the highest practicable physical, mental, and psychosocial well-being .

A review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2019, revealed: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days).

Resident #55:

Rewritten

A record review of the Batch #13 report revealed Resident #55 was discharged on [DATE] with return not anticipated.

A record review of Resident #55's Discharge MDS with an Assessment Reference Date (ARD) of 05/06/24 revealed the discharge was completed on 10/02/24, more than 14 days after the required submission date.

A record review of the facility's Final Validation Report for Resident #55 revealed that the assessment had a target date of 05/06/24 and was marked as completed late due to the delayed submission.

A record review of Resident #55's Admission Record revealed the facility admitted the resident on 05/01/24 with diagnoses that included Heart Failure, Unspecified.

Resident #60:

A record review of Resident #60's Progress Notes dated 07/21/24 indicated the resident was transferred to the hospital.

(continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #60's Discharge MDS revealed that the assessment for the 07/21/24 discharge was in progress but had not yet been completed. A record review of Resident #60's Admission Record revealed the facility admitted the resident on 04/02/24 with diagnoses that included Diverticulitis of the Large Intestine without Perforation or Abscess, End-Stage Renal Disease, and Type 2 Diabetes Mellitus. Resident #77: A record review of Resident #77's Annual MDS Section A2300 revealed an ARD of 07/24/24, while Section Z0500B indicated a completion date of 09/17/24, more than 14 days after the required submission date. A record review of the facility's Final Validation Report revealed that the assessment was submitted on 10/02/24, well beyond the required timeframe. A record review of Resident #77's Admission Record revealed the facility admitted the resident on 08/29/23 and had current diagnoses that included Essential (Primary) Hypertension. On 10/02/24 at 4:10 PM, during an interview with Licensed Practical Nurse (LPN) #1/MDS nurse explained that Resident #55 was discharged to the hospital and passed away there. She confirmed that the discharge assessment was missed and that she planned to complete it that day. At 4:30 PM on 10/02/24, during an interview with Registered Nurse (RN) #1, she confirmed that the assessments for Resident #55 and Resident #77 were submitted late. On 10/03/24 at 3:00 PM, during an interview, LPN #1/MDS nurse confirmed that Resident #60's Discharge MDS with an ARD of 07/21/24 had not yet been completed, but she had started working on it. She emphasized that the facility follows the RAI manual for accurate and timely assessments. On 10/03/24 at 3:30 PM, during an interview with the Administrator, she explained that she was unaware of the missed and late MDS assessments. She stated that she expects staff to follow the facility's policy and the RAI manual for timely and accurate submission of MDS assessments, as they are critical to providing appropriate resident care and ensuring accurate reimbursement for services.

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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. 41680 Based on observations, staff interviews, record reviews, and facility policy review, the facility failed to implement residents' care plans for three (3) of (19) care plans reviewed. (Residents #9, #36, and #68) Findings Include: A review of the facility's policy titled Care Plan Process, with the latest 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 results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive person-centered plan of care . Care Area Assessments (CAA's) assist in guiding an individualized plan of care and should provide structure for the care and services that are needed . Resident #9: A record review of Resident #9's Comprehensive Care Plan with a problem onset date of 10/20/2023 revealed the resident had a suprapubic catheter with a diagnosis of urinary retention and bladder spasms, approaches included Secure cath (catheter) to prevent pulling. On 10/02/24 at 2:50 PM, an observation revealed Resident #9's suprapubic catheter was noted to be stretched and pulling taut on the skin over the resident's right flank. The catheter bag was hung on the wheelchair, and no catheter stabilizing device was in place to prevent pulling on the skin. At 3:15 PM on 10/02/24, during an interview, CNA #1 confirmed that the suprapubic catheter did not have a securement device, though it was required by the care plan. She explained that the device should have been in place. A record review of Resident #9's Admission Record revealed the facility admitted the resident on 10/26/23, with a diagnosis of Urinary Retention. Resident #36: A record review of Resident #36's Comprehensive Care Plan revealed care concerns related to an indwelling catheter due to urinary retention, with interventions including enhanced barrier precautions (gown and gloves) during high-contact resident care activities. On 09/30/24 at 10:29 AM, during an observation Resident #36 was noted to have a catheter with bedside drainage and cloudy, yellow urine. Enhanced barrier signage was observed on the door and above the headboard. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/30/24 at 11:30 AM, during an interview, Licensed Practical Nurse (LPN) #2 explained that Resident #36 had been using a catheter for as long as she had worked at the facility. She also mentioned that the resident was on medication for Urinary Tract Infection (UTI) prophylaxis but could not recall when the resident had last experienced an infection. On 10/02/24 at 9:35 AM, during an interview, Resident #36, who was alert and oriented, stated she did not have any issues with her catheter. On 10/02/24 at 10:45 AM, an observation CNA #3 performing catheter for Resident #36, revealed the CNA applied gloves, however, the CNA did not wear a gown. On 10/02/24 at 2:45 PM, during an interview with CNA #3, she stated that while providing catheter care, she only wore gloves and did not wear a gown. CNA #3 explained that gowns were only required for other residents on contact isolation. However, signage on Resident #36's door and above the headboard indicated the need for a gown and gloves. At 3:00 PM on 10/03/24, during a follow-up interview, CNA #3 confirmed that the enhanced barrier signage required the use of both gown and gloves, and she acknowledged that she should have worn a gown. She confirmed that she had been trained in enhanced barrier and infection control protocols. A record review of Resident #36's Admission Record revealed the facility admitted the resident on 02/17/21 with diagnoses that included Paraplegia. Resident #68: A record review of Resident #68's Comprehensive Care Plan with a date initiated of 8/18/24 revealed a plan for PEG tube care, with interventions including Enhanced Barrier Precautions to be worn during high-contact resident care activities. On 10/02/24 at 2:04 PM, during an observation of PEG (Percutaneous Endoscopic Gastrostomy) tube site care performed by Registered Nurse (RN) #3/Wound Care Nurse, the nurse gathered supplies in the hallway while wearing gloves but did not apply other Personal Protective Equipment (PPE), including a gown. Enhanced barrier signage was observed on the door. After completing the care, RN #3 disposed of the supplies and sanitized her hands in the hallway. On 10/02/24 at 4:24 PM, during an interview, RN #3 confirmed she had not worn a gown while providing PEG site care. She explained that she had not been trained in Enhanced Barrier Precautions and was unaware that gown use was required, despite the signage on the door indicating the need for both gown and gloves. A record review of Resident #68's Admission Record revealed the facility admitted the resident on 08/01/23. Current diagnoses included Dysphagia following an unspecified Cerebrovascular Accident (CVA) with Hemiplegia and Hemiparesis. On 10/03/24 at 10:30 AM, during an interview with the Director of Nursing (DON), she explained that all staff had been trained on catheter care and Enhanced Barrier Precautions. She emphasized that she expects staff to always follow the policies and the residents' care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/03/24 at 11:45 AM, during an interview with Registered Nurse (RN) #4/Care Plan Nurse, she confirmed that all residents with catheters have care plans requiring securement devices and enhanced barrier precautions, as indicated by signage on the resident's door. She emphasized that staff are expected to follow care plans while providing resident care, as the care plan provides essential interventions. 43283 50751

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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. 47873 Based on observation, interviews, and facility policy review, the facility failed to ensure medications were secured in a locked storage area and available to only authorized personnel when medications were left at a resident's bedside for one (1) of (19) sampled residents. (Resident # 47) Findings Include: A review of the facility's policy titled Medication Storage, with revision date of 11/17, revealed .Medication storage shall meet all applicable federal, state, and local guidelines . At 10:30 AM on 09/30/24, during the initial tour, Resident #47's door was open, but the resident was not in the room. An observation revealed two (2) medications in boxes, including nasal spray and an inhaler, on the bedside table. At 11:54 AM on 09/30/24, during an observation and interview, Resident #47 was observed sitting in a wheelchair, ready for lunch, with the bedside table in front of the resident. The two (2) medications, including nasal spray and an inhaler, were still on the bedside table. Resident #47 explained that the nurse had left the medications there earlier that morning and stated, This happens sometimes, but the nurse gives me the medications. At 12:35 PM on 09/30/24, during an observation and interview, Licensed Practical Nurse (LPN) #2 was seen with the medication cart outside Resident #47's door. LPN #2 confirmed that she had accidentally left the medications and boxes in the room. She had just removed the two (2) medications from the room. LPN #2 stated that medications are not to be left in any residents' rooms at any time. At 10:35 AM on 10/03/24, during an interview with the Director of Nursing (DON), she stated that she was not aware that medications had been left in Resident #47's room. The DON explained that all medications should only be stored on the medication cart, and she does not expect medications to be left in any resident's room. She confirmed that Resident #47 did not have orders for self-administration of medications and should not have medications at the bedside. At 3:50 PM on 10/03/24, during an interview, the Administrator stated that she had been made aware of the incident involving medications being left at a resident's bedside. She confirmed that this was not standard practice and emphasized that all nurses were expected to follow practice standards to avoid complications. A record review of Resident #47's Admission Record revealed that the facility admitted the resident on 07/13/22, with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) with Acute Exacerbation and Allergic Rhinitis, Unspecified. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #47's Order Summary Report, with active orders as of 10/02/24, revealed an order with a start date of 7/1/24 for Azelastine HCl Nasal Spray 0.15% (205.5 mcg (microgram)/spray), two (2) sprays in both nostrils twice daily, for allergic rhinitis and an order dated 7/23/24 for Advair HFA Inhalation Aerosol 230/21 mcg/act (Fluticasone-Salmeterol), two (2) puffs orally twice daily, for COPD. No orders were noted for self-administration of medications or for medications to be left at the bedside. A record review of Resident #47's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/03/24 revealed a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 41680 Based on interviews, observations, record review, and facility policy review, the facility failed to provide a resident with a physician-ordered diet of chopped bite-size meats for one (1) of (19) sampled residents. Resident #1. Findings Include: A review of the facility's policy titled Dental Soft Mechanical Soft Diet, revised 2016, revealed . The diet should be individualized to meet a particular patient's needs . meats may be ground or diced based on the individual's tolerance . On 09/30/24 at 11:40 AM, during an interview, Resident #1 stated that her meat was supposed to be served in bite-size pieces, but it was often pureed. She expressed that she disliked pureed meat and would refuse to eat it. Resident #1 further noted that her meal ticket specified bite-size meat, but it was not consistently provided. On 09/30/24 at 11:58 AM, an observation of Resident #1's food tray revealed a baked pork chop that was shredded instead of being cut into bite-size pieces, as ordered. On 10/02/24 at 11:53 AM, during an observation and interview, Resident #1 was served ham that was cut into bite-size pieces on her lunch tray. She stated that the meat had been shredded the day before and was typically shredded, except for today. She explained that she preferred bite-size pieces, saying, It feels different in my mouth. I won't eat it if it's shredded. The resident was observed eating the bite-size ham during the interview. On 10/02/24 at 3:01 PM, during an interview, the Dietary Manager (DM) explained that a mechanical soft diet included soft food with chopped meat, emphasizing that there was a difference between bite-sized chopped meat and shredded meat. The DM stated that the diet orders should be followed exactly as written and that she expected her staff to adhere to those orders. On 10/03/24 at 3:35 PM, during an interview, the Licensed Nursing Home Administrator (LNHA) stated that she expected the dietary staff to serve residents meat in bite-sized portions, as per the physician's order. A review of Resident #1's Admission Record revealed the resident was admitted by the facility on 02/10/22. The resident had diagnoses that included Dyspnea and Gastroesophageal Reflux Disease (GERD). A review of Resident #1's Order Summary Report, with active orders as of 10/3/23, revealed a diet order, with a start date of 7/1/24 revealed LCS/NSOT (low concentrated sweets)/(no salt on tray) Mechanical soft texture, Regular consistency, WITH BITE SIZED MEATS. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/26/24 revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact. A review of Resident #1's meal ticket dated 10/2/24 revealed the diet listed as LCS/NSOT/BITE SIZE Mechanical Soft.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 41680 Based on observations, staff and resident interviews, record review, plan of correction review, and facility policy review, the facility failed to sustain an effective Quality Assurance and Performance Improvement (QAPI) Program, as evidenced by one (1) re-cited deficiency originally cited in February 2023 on an annual recertification survey for (1) of two (2) annual recertification surveys reviewed. Findings Include: A review of the facility's policy titled Preface - QAPI, dated 11/22, revealed: Our residents are the primary concern of this facility. This facility is committed to providing the highest quality of life supported by quality care for the aged and convalescent resident. To ensure resident health, safety, and proper care and treatment, each facility shall maintain a manual consisting of policies and procedures to detail effectively the scope of services .This manual shall serve as a guideline for the staff to .accomplish the goals and objectives of the facility . During observation, interviews, and record review on 10/2/24, the facility failed to maintain proper infection control practices related to hand hygiene during percutaneous endoscopic gastrostomy (PEG) tube and catheter care. A record review of the facility's previous federal recertification survey, dated 02/02/2023, revealed the facility was cited for failing to follow hand hygiene guidelines during catheter care, and a plan of correction (POC) was developed and accepted. On 10/03/24 at 1:00 PM, during an interview with the Administrator, she explained that the Quality Assurance and Assessment (QAA) committee meets quarterly to discuss high-risk areas, including hand hygiene. She stated that the team regularly reviews concerns and develops action plans to address deficiencies. On 10/03/24 at 3:00 PM, during a follow-up interview with the Administrator, she confirmed that the facility had been cited for deficiencies in hand hygiene during the previous survey and acknowledged that while the facility implemented the POC, it failed to maintain compliance with the hand hygiene policy. She attributed the ongoing issue to high staff turnover, particularly among the Directors of Nursing (DON). The Administrator explained that the facility had employed five (5) different DONs in the past two (2) years, with the current DON previously serving as Assistant Director of Nursing (ADON) for six (6) months. The Administrator emphasized that training staff appropriately amid high turnover had been a challenge in implementing the corrections fully. The Administrator further confirmed that she reviewed the CMS-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction) and confirmed that while the facility completed all aspects of the correction plan, it failed to consistently implement the hand hygiene protocol.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Myrtles Nursing Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1018 Alberta Avenue Columbia, MS 39429	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41680 Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure infection control measures were followed to prevent the possible spread of infection as evidenced by, not following enhanced barrier precautions, improper hand hygiene and glove changes and allowing a urinary catheter bag to touch the floor for three (3) of (19) sampled residents. (Resident #9, Resident #36, and Resident #68) Findings Include: A review of the facility's policy titled Infection Control, revised on 04/21, revealed The facility will maintain an Infection Control Program, designed to provide a safe, sanitary, and comfortable environment where residents reside with minimal exposure to the development and transmission of disease and infection . Handwashing is the most to effective means of infection prevention . A review of the facility's policy titled, Hand Hygiene, revised on 01/24, revealed, Purpose: To cleanse hands to prevent transmission of infection or other condition . To provide clean, health environment for residents, staff and visitors .Indications for Hand Washing . 3. Before and after procedures. 4. Before and after applying gloves . A review of the facility's policy titled Enhanced Barrier Precautions, revised on 03/24, revealed, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices . A review of the facility's policy titled Urinary Catheter, revised 01/24, revealed, .25. Clip drainage tubing to edge of mattress. Position drainage bag lower than bladder by attaching to fixed part of bed frame. Do not attach to side rails of bed . Resident #9 On 10/2/24 at 2:50 PM, during an observation of catheter care and a suprapubic catheter flush for Resident #9, Certified Nurse Aide (CNA) #1 and CNA #2, as well as Licensed Practical Nurse (LPN) #2 placed the catheter drainage bag on the floor a total of seven (7) times. During an interview of 10/2/24 at 3:15 PM, CNA #1, confirmed that putting the resident's urinary drainage bag on the floor could possibly lead to a urinary tract infection for the resident and could also lead to possible spreading by infection through cross contamination. During an interview on 10/2/24 at 3:20 PM, CNA #2 confirmed that by placing the urinary drainage bag on Resident #9's floor, it could cause infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LPN #2 on 10/3/24 at 9:48 AM, she stated that she did not notice that the catheter drainage bag was allowed to touch the floor, however, she confirmed that allowing contact with the floor, it could cause complication for Resident #9 related to Urinary Tract Infections (UTI's) and other infections from contamination. During an interview with the Director of Nurses (DON) on 10/3/24 at 10:33 AM, the DON revealed that staff are in-serviced yearly and taught to avoid letting the urinary drainage bags touch the floor. The DON confirmed that allowing the urinary drainage bag to lay on the floor could increase the risk of complications related to increased urinary tract infections. A record review of the Admission Record revealed the facility admitted Resident #9 to the facility on [DATE]. The resident had diagnoses that included Infection and Inflammatory Reaction due to Cystostomy Catheter, Paraplegia, and Extended Spectrum Beta-Lactamase (ESBL) Resistance. A record review of the Quarterly Minimum Data Set (MDS), with Assessment Reference Date of 7/17/24, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. A record review of the Order Summary Report revealed an order for a Suprapubic Catheter 18 F (French) 30 cc (cubic centimeter), change as needed for malfunction, occlusion or leakage (urinary retention) every 24 hours as needed, dated 7/27/24. Resident #36 During an observation on 10/02/24 at 2:45 PM, during catheter care revealed CNA #3 did not put on a gown and wore only gloves, despite Enhanced Barrier signage requiring both gown and gloves. During care, CNA #3 failed to change gloves after cleaning the resident's bowel movement (BM) and continued to provide care with the same gloves. On 10/02/24 at 3:00 PM, CNA #3 confirmed she should have worn a gown and changed gloves between dirty and clean tasks. A record review of Resident #36's Admission Record revealed the facility admitted the resident on 02/17/21. The resident had diagnoses that included Retention of Urine, unspecified. A record review of Resident #36's Order Summary Report, with active orders as of 10/3/24, revealed an order, dated 10/3/24, for an indwelling catheter; 16 FR (French) 10 cc (cubic centimeter). Change as needed for malfunction, occlusion or leakage (Urinary retention) every 24 hours as needed for Urinary Retention. A record review of Resident #36's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/11/24, revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. Resident #68 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/02/24 at 2:04 PM, during an observation of Percutaneous Endoscopic Gastrostomy (PEG) tube care performed by Registered Nurse (RN) #3/Wound Care Nurse. During the procedure, the nurse did not wear a gown, despite Enhanced Barrier Precaution signage on the door, requiring the use of gown and gloves during high-contact. RN #3 also failed to perform hand hygiene between glove changes. During the procedure, RN #3 applied a clean dressing without changing gloves or performing hand hygiene. At 4:24 PM on 10/02/24, RN #3 confirmed that she had not followed the facility's infection control protocols and acknowledged that her actions posed a risk of infection to the resident. A record review of Resident 68's Admission Record revealed the facility admitted the resident on 08/01/23. The resident had diagnoses that included Dysphagia Following Cerebral Infarction (stroke). A record review of the Order Summary Report, with active orders as of 10/3/24, revealed an order dated 8/18/24 Clean PEG TUBE SITE to ABDOMEN with normal saline. Apply SPLIT GAUZE DAILY . A record review of Resident #68's MDS with an ARD of 08/23/24 revealed a BIMS score of three (3), which indicated the resident had severe cognitive impairment. On 10/03/24 at 9:55 AM, the Director of Nursing (DON) confirmed that the facility had conducted training on Enhanced Barrier Precautions and that staff should wear Personal Protective Equipment (PPE), including gowns, when providing care for residents with wounds, catheters, or PEG tubes 43283 50751