STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255276	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Madison Health and Rehab	111 Kelly Blvd Madison, MS 39110

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on resident and staff interview, record review, and facility policy review, the facility failed to honor resident's rights to make health care decisions for three (3) of 24 residents reviewed for advanced directives. Resident #10, #36, and #48 Findings Include: Record review of the facility policy titled Do Not Resuscitate No Code Status Policy dated ,d+[DATE] revealed, It is the policy of this facility to inform residents of the right to choose to have CPR (cardiopulmonary resuscitation) or no CPR to be performed at such time of imminent death. The code status form will be completed at the time of admission. Resident #10 Record review of Resident #10's Order Summary Report revealed, DNR (Do Not Resuscitate): Need for death with dignity related to choice of code status DNR per family/Resident Representative (RR) request. Record review of the Code Status form for Resident #10 revealed a family member signed the form dated [DATE], with no signature from the resident. An interview with Resident #10 on [DATE] at 10:35 AM revealed he can make his own decisions and sign his paperwork. He stated that when he was admitted to the facility, he did not recall anyone asking him whether he wanted to be a full code or DNR and admitted that he did not sign any paperwork on it. He stated that it should be his choice since I can make my own decisions. Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] for Resident #10 revealed, under Section C, a Brief Interview for Mental Status (BIMS) summary score of 13, which indicated the resident was cognitively intact. Record review of the Admission Record revealed the facility admitted Resident #10 on [DATE] with diagnoses that included Chronic Systolic (Congestive) Heart Failure, and Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation. Resident #36 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #36's Order Summary Report revealed full code related to family/Resident Representative choice of code status. Resident is a full code. Record review of the Code Status form for Resident #36 revealed a family member signed the form dated [DATE], with no signature from the resident. An interview with Resident #36 on [DATE] at 11:45 AM, revealed when she was admitted to the facility, she did not sign her code status form, and no one spoke to her about it. She stated that she can still make her own decisions, and even though she has Parkinson's, and it may take her a little longer, she can still sign. Record review of Resident #36's MDS with an ARD of [DATE] revealed, under Section C, a BIMS summary score of 14, which indicated the resident was cognitively intact. Record review of the Admission Record revealed the facility admitted Resident #36 on [DATE] with diagnoses that included Hypoglycemia, Unspecified, and Parkinson's Disease without Dyskinesia. Resident #48 Record review of Resident #48's Order Summary Report revealed, full code related to family/Resident Representative choice of code status. Resident is a full code. Record review of the Code Status form for Resident #48 revealed a family member signed the form dated [DATE], with no signature from the resident. In an interview on [DATE] at 8:50 AM, Resident #48 revealed that she did not sign her Advance Directives when admitted to the facility. She stated that no one at the facility had spoken with her about her code status. Record review of the MDS with an ARD of [DATE] for Resident #48 revealed, under Section C, a BIMS summary score of 14, which indicated the resident was cognitively intact. Record review of the Admission Record revealed the facility admitted Resident #48 on [DATE] with diagnoses that included Multiple Fractures of Pelvis without Disruption of Pelvic Ring, and Chronic Kidney Disease, Stage 3. An interview with the Social Services Director on [DATE] at 1:15 PM, revealed that when a resident was admitted to the facility, she had been discussing their code status with the family representative or power of attorney (POA) and had not been going over it with the resident. She confirmed that Residents #10, #36, and #48 did not sign their code status form, and they should have because it was their right. During an interview on [DATE] at 1:40 PM, the Administrator confirmed that the residents who were competent and able to sign their Advance Directive should be allowed to do so, and we should ensure that their wishes were honored. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 10:38 AM, the Director of Nurses (DON) confirmed that Residents #10, #36, and #48 were cognitive and able to make their own decisions and should have had the opportunity to decide what their end-of-life wishes were.

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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. 47874 Based on staff interview and record review, the facility failed to accurately code section A of the Minimum Data Set (MDS) for a resident with a serious mental illness for one (1) of 16 MDS reviewed. Resident #16 Findings Include: The facility provided a statement on letterhead dated 1/15/25 that read, It is the policy of Proper Name of the Facility to follow the RAI (Resident Assessment Instrument) manual for completion and accuracy of the MDS (Minimum Data Set) assessments. Record review of Resident #16's Preadmission Screening and Resident Review (PASRR) Summary of Findings Report dated 6/14/2017, revealed under, Mental Health . The individual meets criteria for having a diagnosis of mental illness as defined by PASRR. Also revealed under, Axis I primary: Schizophrenia was listed as the diagnosis. Record review of Resident #16's Annual MDS with an Assessment Reference Data (ARD) of 4/01/24 revealed, under section A1500, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? No was answered. An interview with the MDS Nurse on 1/15/25 at 2:35 PM, confirmed Section A of Resident #16's MDS was coded inaccurately. She confirmed that the resident had a serious mental illness, and the assessment should be accurate to develop a complete plan of care. An interview with the Director of Nursing (DON) on 1/15/25 at 2:52 PM revealed, his expectations were for the MDS assessments to accurately reflect each resident's status and plan of care. Record review of the Admission Record revealed the facility admitted Resident #16 on 5/03/17 with medical diagnoses that included Schizophrenia and Unspecified Psychosis.

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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. 45598 Based on observation, staff interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan for personal hygiene.(Resident #1, #2, #7) and adaptive equipment with meals (Resident #2) for three (3) of 16 care plans reviewed. Residents #1, # 2, #7 Findings Include: Review of the facility policy titled, Following the Care Plan Policy unrevised, revealed under, Policy: It is the Policy of this facility to follow a written and approved care plan for each resident. Resident #1 Record review of Resident #1's ADL (activities of daily living) Care Plan revealed under, Focus: The resident has an ADL self-care performance deficit r/t (related to) Dementia. Also revealed under, Intervention/Task: Personal hygiene/Oral care: The resident requires x (times) 1 (one) staff participation with personal hygiene . An observation on 1/14/25 at 9:20 AM revealed Resident #1 lying in bed with long facial hair on her chin, which was approximately three to four inches long. On 1/16/25 at 9:10 AM, an interview with the Director of Nursing (DON) confirmed the ADL care plan was not followed for Resident #1. Record review of the Admission Record revealed the facility admitted Resident #1 on 4/03/2017 with medical diagnoses that included Major Depressive Disorder and Muscle Weakness. Resident #7 Record review of Resident #7's ADL Care Plan revealed under, Focus: The resident has an ADL self-care performance deficit r/t Rhabdomyolysis. Also revealed under, Intervention/Task: Check nail length and trim and clean on bath day and as necessary. An observation of Resident #7 on 1/14/25 at 9:00 AM, revealed she was lying in bed and had long fingernails approximately one-half (1/2) to three-fourths (3/4) inches in length on both hands. On 1/15/25 at 1:20 PM, an observation and interview with CNA #1 confirmed Resident #7's fingernails were too long. On 1/16/25 at 9:10 AM, an interview with the DON confirmed the ADL care plan was not followed for Resident #7. Record review of the Admission Record revealed the facility admitted Resident #7 on 12/20/24 with a medical diagnosis of Rhabdomyolysis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47874 Resident #2 Record review of Resident #2's ADL Care Plan revealed under, Focus: The resident has an ADL self-care performance deficit r/t weakness, osteoarthritis. Also revealed under, Interventions: Personal hygiene/Oral care: The resident requires x (times) 1 staff participation with personal hygiene and oral care. On 1/14/25 at 8:09 AM, an observation of Resident #2 revealed that she was sitting in her wheelchair in her room. As the resident was trying to communicate, a thick white substance was observed on her upper and lower teeth and on her gums. An observation and interview with the DON on 1/15/25 at 3:22 PM confirmed oral hygiene was not done and described Resident #2's teeth as plaque buildup and food particles. Resident #2 Record review of Resident #2's nutritional Care Plan revealed under, Focus: The resident at risk for potential nutritional problems related to diet restrictions . Also revealed under, Interventions/Task: Resident to have divided plate with meal, date initiated 9/15/22 and Resident to have sippy cup with meals, date initiated 9/22/23 . An observation of Resident #2's lunch meal on 1/14/25 at 11:55 AM revealed that she was served on a regular plate with a glass of tea and water in a goblet style. An observation of the resident's meal ticket at this time revealed, Divided plate, sippy cup. and the resident did not have these available. An interview with the DON on 1/14/25 at 12:01 PM, confirmed Resident #2 did not have the adaptive equipment that was listed on her meal ticket. An interview with the MDS Nurse on 1/16/25 at 8:16 AM revealed the purpose of the care plan was for the staff to know what care to provide for the residents. She confirmed Resident #2's care plan was not followed for oral hygiene and adaptive equipment. Record review of the Admission Record revealed the facility admitted Resident #2 on 10/28/20 with medical diagnoses that included Dysphagia and Left Wrist Drop.

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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. 45598 Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide nail care, oral care and facial hair removal for resident's requiring assistance with activities of daily living (ADLs) for three (3) of 16 sampled residents. Resident #1, #2, and #7 Findings Include: Record review of the facility policy, ADL Care Policy undated, revealed, It is the policy of this facility to provide appropriate treatment and services in relation to ADL care to residents to ensure all ADL needs are met on a daily basis . Resident #1 An observation and interview on 1/14/25 at 9:20 AM revealed, Resident #1 with facial hair on her chin that was approximately three (3) to four (4) inches long. An interview with the resident revealed that she did not like facial hair and stated, I want them gone. An observation and interview on 1/15/25 at 1:27 PM, with Certified Nursing Assistant (CNA) #1 revealed facial hair and fingernails should be taken care of during bath time or anytime it was noticed. She confirmed that Resident #1 had long hair on her chin and admitted it should have already been taken care of. Record review of the Admission Record revealed the facility admitted Resident #1 on 4/03/2017 with medical diagnoses that included Major Depressive Disorder and Muscle Weakness. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/24, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #7 On 1/14/25 at 9:00 AM, an observation and interview with Resident #7 revealed she had fingernails approximately one-half (1/2) to three-fourths (3/4) inches in length past the tips of the fingers. She admitted that she had never had fingernails this long before, and stated, I keep them very short; I feel like they are like claws now. The resident revealed she had been at the facility since December, and no one had offered to clip her nails. An observation and interview on 1/15/25 at 1:20 PM of Resident #7 with CNA #1 revealed that fingernails should be checked every day, cleaned and clipped when needed. She confirmed Resident #7's fingernails were long and Resident #7 stated to CNA #1, I have never had my nails this long before and I want them cut. CNA #1 stated that with the resident's fingernails that long she could scratch herself and cause skin tears or the spread of bacteria. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 8:30 AM, an interview with Registered Nurse (RN) Supervisor revealed that the nurses should be checking behind the aides to make sure the resident needs were taken care of. She revealed she was not aware Resident #7 had long fingernails and confirmed that nail care should be included in their personal hygiene task. On 1/16/25 at 9:10 AM, an interview with the Director of Nursing (DON) confirmed that the nurses and the aide supervisor should be overseeing the completion of ADL care. He revealed that anyone who noticed a need with a resident should take care of the problem or tell someone who could. Record review of the Admission Record revealed the facility admitted Resident #7 on 12/20/24 with a medical diagnosis of Rhabdomyolysis. Record review of Resident #7's MDS with ARD of 11/26/24 revealed under Section C, a BIMS score of 10, which indicated the resident was moderately cognitively impaired. 47874 Resident #2 An observation of Resident #2 on 1/14/25 at 8:09 AM revealed the resident was trying to talk and a thick white substance was observed on her upper and lower teeth and gums. An observation of Resident #2 on 1/15/25 at 8:06 AM revealed no change in the resident's teeth and gums. An observation and interview on 1/15/25 at 3:10 PM, with CNA #2 revealed she was assigned to Resident #2 today on day shift. She confirmed the resident had excess buildup on her teeth and that she did not brush the residents' teeth today. She explained that the resident was on the get up list and that the night shift should have done it. She admitted that she should have checked behind them to ensure it was done. An observation and interview with the DON on 1/15/25 at 3:22 PM described Resident #2's teeth as plaque buildup and food particles. He revealed that the aides and nurses were responsible for oral care and brushing the resident's teeth. The DON stated that the resident could develop decay and cavities from not getting the appropriate oral care. Record review of the Admission Record revealed the facility admitted Resident #2 on 10/28/20 with medical diagnoses that included Dysphagia and Left Wrist Drop.

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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** 45598 Based on observation, staff and resident interviews, and facility policy review, the facility failed to properly store medications, as evidenced by, medications left in a resident's room for one (1) of 16 sampled residents. Resident #41 Findings Include: Record review of the facility policy Medication Storage dated 01/2024, revealed It is the policy of this facility to ensure all medications housed on our premises will be stored in the medication cart and/or medication rooms according to the manufacturer's recommendation An observation on 1/14/25 at 11:00 AM and 2:00 PM revealed a one-ounce bottle of lubricant eye drops and a two-ounce tube of pain relief cream on the overbed table in Resident #41's room. An interview on 1/14/25 at 2:50 PM, with Resident #41 revealed he brought his eye drops and pain cream from home, and he applied them himself. He revealed that he used the eye drops every day and that he hardly ever used the pain cream. The resident explained he kept these items in his room so he could use them as needed. An observation and interview with Licensed Practical Nurse (LPN) #1 on 1/15/25 at 9:58 AM, confirmed Resident #41 had a bottle of lubricant eye drops and a tube of pain cream on his bedside table. She revealed the resident had not been assessed for self-administration and explained medications were not supposed to be in his room. LPN #1 agreed that leaving medications in a resident's rooms was a risk, and another resident could enter his room and take something they were not supposed to have. An interview on 1/15/25 at 10:40 AM, with the Director of Nursing (DON) confirmed that leaving medications in a resident's room should not happen. He revealed that some residents were used to self-administering medications at home before coming into the facility, and it was often hard for them to adjust. The DON stated that if a resident requested to self-administer their medications, then an assessment should have been done to ensure they were competent and knew how to use it. He revealed this one must have slipped through the cracks and explained that someone should have seen the medications in Resident #41's room and removed them. Record review of Resident #41's Admission Record revealed an admitted [DATE], with medical diagnoses that included Unspecified Injury of Left Lower Leg, Muscle Weakness, and Need for Assistance with Personal Care. Record review of Resident #41's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/19/24, revealed, under Section C, a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 47874 Based on observation, staff interview, record review, and facility policy review, the facility failed to provide a resident with adaptive equipment during meals for one (1) of two (2) dining observations. Resident #2 Findings Include: Review of the facility policy titled Assistive Feeding Devices with a revision date of 6/14 revealed under, Policy: Residents shall be provided assistive devices to maintain or improve their ability to eat independently. Also revealed under, Procedure: . 4. The assistive devices are placed on the resident's tray at the time of meal service. An observation on 1/14/25 at 11:55 AM revealed Resident #2's lunch meal was served on a regular plate with a goblet glass of tea and water with a meal ticket that read, Divided plate, sippy cup. An interview with the Director of Nursing (DON) on 1/14/25 at 12:01 PM confirmed that Resident #2 did not have the adaptive equipment that the resident should have had. Record review of the Order Details for Resident #2 revealed an order dated 11/15/21, Patient to have sippy cup at breakfast, lunch, and dinner with meal. A record review of the Order Details for Resident #2 revealed an order dated 11/19/21, . Divided plate with meals. An interview with Dietary Staff #2, on 1/15/25 at 8:10 AM confirmed when adaptive equipment was on a meal ticket, the dietary server should provide it during the tray preparation. She revealed the purpose of ensuring the adaptive equipment was available with the meal was to help the residents be more independent with feeding themselves. An interview with the DON on 1/15/25 at 8:20 AM confirmed that the purpose of the adaptive equipment was to assist the resident with feeding herself and confirmed it should be available with each meal. Record review of the Admission Record revealed the facility admitted Resident #2 on 10/28/20 with medical diagnoses that included Dysphagia and Left Wrist Drop.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observations, staff interviews, and facility policy review the facility failed to ensure items in the walk-in kitchen refrigerator were labeled and dated, discarded by the expiration date, and arranged in a manner to prevent possible cross-contamination for one (1) of three (3) kitchen tours Findings include: Review of the facility policy titled, Labeling and Dating Inservice revised 2/2023, revealed All foods should be dated upon receipt before being stored. Food labels must include: The food item name, the date of preparation/receipt/removal from freezer, and the use by date.Leftovers must be labeled and dated with the date they are prepared and the use by date. Review of the facility policy titled, Food Storage: Cold Foods revealed, 5 .All foods will be stored, wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. An observation and interview on the initial tour of the kitchen with the Dietary Manager (DM) on 1/14/25 at 8:05 AM, revealed in the walk-in refrigerator two white opened containers with a manufacturer label of Yoplait Vanilla Yogurt. The containers were not dated and had a manufacturer best-by date of [DATE]. An observation of a five-pound opened Sysco Tropical Fruit Supreme with no open date nor use-by date. The DM revealed she was unsure when it was opened. An observation of a five-pound white container of Wholesome Farm sour cream dated 12/17/24 with no use-by date, and a large clear plastic container dated 1/11 with no label or use-by date. The DM identified the food item as chicken salad. An unlabeled clear plastic container dated 1/7 with no use-by date, which the DM identified as pimento cheese, a 2-inch-deep rectangular metal pan unlabeled with a date of 1/14, with no use-by date, the DM identified as liquid eggs, a square clear container unlabeled with a date of 1/14, with no use-by date, the DM revealed that is chopped ham, a transparent plastic square container unlabeled with a date of 1/8 on one side and a date of 1/13 on the other side, the DM revealed they had this last night for supper and confirmed the food item was cooked sausage and peppers. She confirmed the date for the meal was last night but wasn't sure why they didn't change the date on the container. Observation revealed a small square pan unlabeled and undated which the DM confirmed the food items were four boiled eggs in a clear liquid and revealed she wasn't sure how long they had been there. An observation of a rectangular metal tray on the bottom shelf of the refrigerator revealed a labeled gallon-sized bag of chicken in a liquid substance; the bag was undated, and in the same pan wrapped in cellophane was an unlabeled and undated food item the DM identified as pork loin . A liquid substance was noted on the bottom of the metal tray where both food items were placed. The DM revealed they were both undated and should not have been in the same container thawing because this could cause bacteria, and the residents could get sick. She confirmed that the food items in the refrigerator were not properly labeled and dated and that all foods should have dates for when they should be discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 1/14/25 at 8:20 AM with the Dietary Aide revealed that when the food items come in, he puts the dates that they arrived, and then when they open them, they are supposed to put that date and then a use by date. He confirmed the items in the walk-in refrigerator were not correctly labeled. In an interview on 1/15/25 at 12:05 PM, the Administrator confirmed that it is the facility policy that all food items be properly labeled, dated when they arrive at the facility, when they are opened and discarded within the proper time to prevent any food-borne illnesses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255276	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Madison Health and Rehab	111 Kelly Blvd Madison, MS 39110

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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** 45598 Based on observation, staff interview, and facility policy review, the facility failed to follow Enhanced Barrier Precautions (EBP) while providing resident care for two (2) of three (3) direct care observations. Resident #28 and Resident #49 Findings Include: Record review of the facility policy Enhanced Barrier Precautions with a revised date of 8/07/24, revealed under, Policy Explanation and Compliance Guidelines: . 2. Initiation of Enhanced Barrier Precautions: . b. An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds . and/or indwelling medical devices (.urinary catheters, feeding tubes .) even if the resident is not known to be infected . Resident #28 An observation on 1/15/25 at 8:55 AM revealed Licensed Practical Nurse (LPN) #2 administered Resident #28's medications through a Percutaneous Endoscopic Gastrostomy (PEG) tube without wearing a gown for EBP. He revealed that EBP were supposed to be utilized when providing care to residents who had Covid-19 or open wounds. He stated that he did not think they had to follow the precautions for residents with PEG tubes. LPN #2 agreed that EBP were put in place to protect the residents and the staff to prevent the spread of germs. Record review of Resident #28's Order Summary Report with active orders as of 1/16/25 revealed an order for EBP related to PEG every shift and medication orders for administration through the PEG Tube. Record review of Resident #28's Admission Record revealed an admitted [DATE] with medical diagnoses that included Ventricular Fibrillation and Dysphagia. Resident #49 An observation on 1/15/25 at 10:50 AM revealed LPN #1 completed Resident #49's catheter care and changed the drainage bag without wearing a gown. LPN #1 revealed they (the staff) had to wear a gown if a resident had open wounds or something contagious like Covid-19. She stated that she was not aware that gowns had to be worn when providing catheter care. An interview on 1/15/25 at 11:25 AM, with the Director of Nursing (DON) revealed EBP were to be used with any residents who had indwelling medical devices to protect the residents from infection. He revealed the staff had been in-serviced and knew they were supposed to wear gloves and gowns when they provided care to these residents. Record review of Resident #49's Admission Record revealed an admitted [DATE] with medical diagnoses that included Malignant Neoplasm of the Prostate and Chronic Kidney Disease. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Record review of Resident #49's Order Summary Report with active orders as of 1/16/25 revealed, Resident to be placed on EBP related to Foley and there was an order for catheter care every day related to Retention of Urine diagnosis.