STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Driftwood Nursing Center	1500 Broad Avenue Gulfport, MS 39501

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 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. 43283 Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure an indwelling urinary catheter was clinically indicated for one (1) of four (4) residents observed with catheters. (Resident #87) Findings Include: A review of the facility's Appropriate Use of Indwelling Catheters Policy, dated 03/01/17, revealed: .An indwelling urinary catheter will be utilized only when a resident's clinical condition demonstrates that catheterization is necessary. Policy Explanation and Compliance Guidelines .4. The use of an indwelling urinary catheter will be in accordance with physician orders, which will include the diagnosis or clinical condition making the use of the catheter necessary .6. Documentation to support decision-making will be included in the medical record, including but not limited to: a. Clinical or medical conditions demonstrating the need for an indwelling catheter. b. Assessment of incontinence .d. Services provided to restore normal bladder function to the extent possible .7. Indwelling urinary catheters will be used on a short-term basis . During an observation on 10/29/24 at 11:00 AM, Resident #87 was observed lying in bed and had an indwelling catheter drainage bag on the side of the bed. A record review of the Admission Record revealed the facility admitted Resident #87 on 09/14/24 with diagnoses including Cerebral Infarction. A record review of the Order Summary Report with active orders as of 10/30/24, revealed Resident # 87 had a physician order, dated 9/23/24 for a urinary catheter. A record review of the Progress Notes, dated 09/20/24 at 11:46 AM, revealed Resident #87 had a Nurse's Note indicating .Foley (type of indwelling catheter) cath (catheter) patent and draining clear yellow urine into drainage bag . This was the first documentation in the medical record which indicated Resident #87 had an indwelling catheter. Further review of the medical record revealed there was no documentation to explain when or why an indwelling catheter was placed for Resident #87. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 10:30 AM, during an interview with Licensed Practical Nurse (LPN) #2, she stated that she updated physician orders daily and recalled putting in the catheter orders for Resident #87 on 09/23/24 based on a charge nurse's request. However, she did not recall the diagnosis used for the catheter and suggested that the charge nurse may have provided the reason, though she was not certain. At 10:50 AM on 10/31/24, during an interview with LPN #1, she confirmed Resident #87 did not have an indwelling catheter when he was admitted by the facility. She explained that she had been off and when she returned to work, she noted Resident #87 had a catheter, and asked LPN #2 to enter the orders, though no diagnosis was given for the catheter. Upon reviewing the progress notes, she found documentation indicating a Urinalysis was collected on 09/20/24, suggesting the catheter placement occurred around that time, but confirmed there was no documentation specifying the reason for insertion. During an interview on 10/31/24 at 11:20 AM, the Director of Nursing (DON) confirmed Resident #87 did not have a sufficient diagnosis for an indwelling catheter. She had investigated the catheter's origin, suspecting an agency nurse placed it. The DON noted the lack of documentation regarding when or why the catheter was inserted and emphasized her expectation that staff document any changes in resident care and adhere to facility policies. At 11:45 AM on 10/31/24, during an interview with the facility's Nurse Practitioner (NP), she acknowledged awareness of the catheter issue with Resident #87. She explained that the nurse had contacted an on-call doctor, not her, about the catheter placement. She confirmed that urinary retention does not justify the use of an indwelling catheter.

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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 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. 37415 Based on observation and staff interview, the facility failed to ensure food temperatures were tested under sanitary conditions for one (1) of four (4) kitchen observations. Findings Include: During an observation of food temperature readings for the lunch meal on 10/30/24 at 11:45 AM in the kitchen area, the cook was observed using a thermometer to check the temperature of the macaroni and cheese. After testing the temperature, the cook wiped the thermometer on a clean towel. The same thermometer was then used to test the baked chicken, green peas, pureed chicken, and mashed potatoes, with the cook wiping the thermometer on the same towel after each test without sanitizing it. During an interview on 10/31/24 at 09:00 AM, the cook stated she had been cooking at the facility for six (6) months and had been cleaning the thermometer with a clean, dry towel during that time. She was uncertain if she had been specifically trained on sanitizing the thermometer, mentioning that numerous in-services were conducted, but she could not recall specific sanitation training. The cook further stated that she was informed by the Dietary Manager (DM) that failing to sanitize the thermometer could lead to cross-contamination and risk residents becoming ill. During an interview on 10/31/24 at 09:30 AM, the DM confirmed that the cook failed to sanitize the thermometer between food items. She stated that the cook was trained to dip the thermometer in a sanitation solution and dry it after each test. However, she acknowledged that no official in-service documentation was available, as training was often conducted informally through verbal instructions. During an interview on 10/31/24 at 10:00 AM, the Registered Dietitian stated that staff are instructed to sanitize thermometers by dipping them in a sanitizing solution and drying them between each food item. She confirmed that the cook should have sanitized the thermometer after testing each item. During an interview on 10/31/24 at 2:30 PM, the Administrator expressed an expectation that kitchen staff sanitize thermometers between food items to prevent cross-contamination.

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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. 43283 Based on observations, interviews, record reviews, and facility policy review, the facility failed to use enhanced barrier precautions (EBP) by not wearing the appropriate personal protective equipment (PPE) during catheter care for one (1) of four (4) residents reviewed for catheter care. (Resident #87) Findings Include: A review of the facility's policy titled Enhanced Barrier Precautions, dated 05/01/24, revealed, .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions: 'Enhanced Barrier Precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high-contact resident care activities . 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 .i .indwelling medical devices (e.g .urinary catheters . During an observation on 10/28/24 at 3:11 PM, Resident #87 was observed lying in bed and had an indwelling catheter drainage bag attached to the bed. There was a yellow dot present near the name of the resident on the outside of the resident's room. During an interview on 10/29/24 at 8:45 AM, Registered Nurse (RN) #1 explained that a yellow dot next to a resident's name in the hallway signifies that the resident is on EBP and explained that residents with openings such as wounds and catheters are on EBP and all staff have been in-serviced accordingly. At 1:50 PM on 10/30/24, Certified Nurse Aide (CNA) #1 and CNA #2 were observed providing catheter care to Resident #87, and did not wear a gown during the care. During an interview on 10/31/24 at 9:10 AM, RN #1 explained that all staff are expected to follow EBP by wearing a gown and gloves while providing care. She noted that PPE supplies are stored in a closet on each hall and are readily available to staff. During an interview on 10/31/24 at 9:50 AM, CNA #1 confirmed that a yellow dot next to a resident's name indicates EBP and that PPE, including gowns, must be worn while providing care. She admitted that she did not wear a gown during catheter care on 10/30/24 and stated that she just got nervous. She confirmed that PPE is available in the closet on the hall. During an interview on 10/31/24 at 11:20 AM, the Director of Nursing (DON) confirmed that enhanced barrier policies are in place and that all staff have been educated on these precautions. She emphasized her expectation that staff always adhere to EBP. At 12:10 PM on 10/31/24, during an interview with CNA #2, he admitted that he did not wear a gown while assisting with catheter care for Resident #87 on 10/30/24. He acknowledged being aware of EBP but stated he was focused on care and forgot to apply PPE. (continued on next page)

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