MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	300S	A. BUILDING: _____ B. WING _____	04/18/2024

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OCEAN SPRINGS HEALTH & REHABILITATION CENTI	1199 OCEAN SPRINGS ROAD OCEAN SPRINGS, MS 39564

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and Compliant Investigations (CIs), at the facility from 4/15/24 through 4/18/24. The SA investigated CI MS #24717 related to abuse, resident's rights, and quality of care, CI MS #24347 related to resident's rights and CI MS #22889 related to resident records and there were no deficiencies cited related to those complaints. CI MS #24211 was a Facility Reported Incident (FRI) related to abuse and there were no deficiencies cited related to the FRI. The SA investigated CI MS #24345 related to pressure sores and cited M615. During the annual recertification survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500, M620, M640, and M1570.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem	M 500		5/16/24

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M 500	Continued From page 1 rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend	M 500		

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changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the

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facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and

16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in

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M 500	Continued From page 4 the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right for a dignified dining experience when the staff did not provide incontinence care for a resident which resulted in odors in the resident's room, causing the meal to be unappetizing, for one (1) of 22 sampled residents. Resident #38 Findings include: A review of the facility's policy "Resident's Rights and Responsibilities", effective 01/07 revealed " ...Each nursing facility resident has a right to a dignified existence ...A facility must protect and promote the rights of each resident ..." On 4/15/24 at 12:17 PM, during an observation in the hallway, Resident #38's call light was lit up above the door. Certified Nurse Aide (CNA) #2 walked into the resident's room, explained to the resident that it would be a minute because she was passing out meal trays, and she exited the room. There were no meal trays being served on the hall at that time. On 4/15/24 at 1:10 PM, during an interview and observation, Resident #38 was lying in bed. There was a strong odor in the room. Resident #38 explained her brief was soiled before lunch and she had asked the staff to change her. She stated the staff told her that she had to wait because the lunch trays were being passed out. She said she had to eat her lunch while wearing a soiled brief and she was uncomfortable with the	M 500	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the State of Deficiencies. This Plan of Correction is prepared solely because of the provisions of State and Federal Laws. 1) On 04/15/2024, Resident #38 was assessed for adverse signs and symptoms resulting form failure to receive incontinent care during dining experience by Director of Nursing, no adverse findings noted. On 04/22/2024 Certified Nursing Assistant (CNA) #1, #2 and #10 were inserviced on residents rights and perineal care, by Director of Nurses. On 04/18/2024 CNA #1 and #10 provided perineal care to Resident #38. 2) Current Residents that receive incontinent care have the potential to be affected by this alleged deficient practice. 3) All Nursing Staff inserviced on 04/22/2024 in regards to residents rights and perineal care during meal times by the Director of Nurses. 4) Unit Managers will observe perineal care for five (5) residents that require incontinent care weekly x 4 weeks, then monthly x 3 months to ensure resident receives timely incontinent care, beginning 04/15/2024. Audits will be given to the Director of Nursing. The Director of Nursing will bring	

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M 500	Continued From page 5 odor. On 4/15/24 at 1:35 PM, in an interview and observation of Resident #38, CNA #10 and CNA #1 came into the resident's room to check on her. The resident reported to both to the CNAs that she had been sitting in a soiled brief for over an hour and had to eat lunch while she was dirty. Both reported they were not aware that the resident needed assistance before lunch trays were served. Resident #38 expressed to both CNAs that she wanted to be changed. During the incontinence care, there was a dark brown ring on the incontinence pad and the resident's brief was heavily soiled. On 4/15/24 at 2:35 PM, during an interview with CNA #2, she explained that she did not tell anyone that Resident #38 had requested and needed to have her brief changed because she had forgotten. On 04/16/24 at 4:00 PM, during an interview with the Director of Nursing (DON), she explained that any staff member, including a CNA or a nurse, could assist with changing a resident and expressed that it was not acceptable for a resident to have to wear a soiled brief while eating lunch or any other time for a long period of time. She explained she expected the staff to assist the residents when they request it and to provide care every two (2) hours and as needed. On 04/18/24 at 3:30 PM, during an interview with the Administrator, he explained he expected all staff to do their job and to treat residents with dignity and respect. He would expect staff to never allow a resident to stay in a soiled brief during lunch.	M 500	audits to the Quality Assurance Performance Improvement Committee Meeting on 05/16/2024, and continue monthly for three (3) months to determine the effectiveness and make necessary changes.	

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M 500	Continued From page 6 A record review of the "Admission Record" revealed the facility admitted Resident #38 on 1/12/21 with current diagnoses including Spinal Stenosis. A record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/13/24, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact.	M 500		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This Statute is not met as evidenced by: Level III Based on observation, interviews, record review, and facility policy review, the facility failed to provide incontinence care in a timely manner for six (6) of 22 sampled residents and resulted in Resident #57 having skin excoriations and Resident #55 free from wearing two (2) incontinence briefs with a current diagnosis of Urinary Tract Infection (UTI). (Residents #57, #55, #1, #8, #14, and #38) Findings include: Resident #57	M 620	1) On 04/15/2024, Resident #1, 8, 38 and 55 were provided incontinent care by Certified Nursing Assistants (CNA)# 3, 4 and 5. The Brief was removed and incontinent care was provided to Resident #57 by CNA# 7, 12 and 13 on 04/16/2024. 2) Residents that require assistance with bowel and bladder care have the potential to be affected by this alleged deficient practice. 3) The Director of Nurses inserviced all Nurses and CNAs on bowel and bladder and perineal care on 04/18/2024.	5/16/24

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M 620	Continued From page 7 On 4/15/24 at 10:00 AM, during an observation, staff were transferring Resident #57 from the bed to an electric wheelchair using a mechanical lift. On 4/15/24 at 4:00 PM, during an observation and interview, Resident #57 was in his electric wheelchair and stated that he had been up in his chair since 10:00 AM and the staff had not changed his brief since then. He explained that he usually wears two (2) incontinence briefs during the day to hold his urine because it takes several staff members to transfer him with the lift and to change him. On 4/15/24 at 4:15 PM, during an observation of incontinence care for Resident #57, Certified Nurse Assistants (CNAs) #3, # 4 and #5 assisted the resident to bed. The CNAs removed two (2) briefs that were saturated with urine and soiled with bowel movement (BM). The resident's perineal area and lower buttocks were red and excoriated. During an interview on 4/15/24 at 4:30 PM, with CNA # 3, CNA #4 and CNA # 5, they explained Resident #57 requested two (2) briefs on dayshift staff did not want to change him and get him back up. The CNAs said they normally assist the resident to bed around 9:00 PM, provide incontinence care, and use a barrier cream on his perineal area and buttocks. An observation on 4/16/24 at 1:00 AM of incontinence care with CNA #7, CNA #12, and CNA #13, revealed Resident #57's brief was saturated with urine. He had redness and excoriations to the perineal area and his lower buttocks had excoriated areas that were bleeding.	M 620	4) The Director of Nurses began monitoring bowel and bladder care on 04/18/2024. Findings of the monitoring will be brought to the Quality Assurance Performance Improvement Committee on 05/16/2024. Director of Nurses will monitor bowel and bladder care for four (4) residents weekly for three (3) weeks, then monthly for three (3) months. Findings will be brought to the Quality Assurance Performance Improvement Committee beginning on 05/16/2024, then monthly for the next three months to determine effectiveness and make necessary changes as indicated.	

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M 620	Continued From page 8 During an interview on 4/16/24 at 1:30 AM with CNA #7, CNA # 12 and CNA #13 confirmed Resident #57 had excoriated areas and that the nurses had advised them to use a barrier cream. On 4/17/24 at 9:00 AM, during an interview with the Medical Director, he confirmed he had been made aware of the excoriations to Resident #57's perineal and buttock areas. The staff were in the process of transferring him to his wheelchair when he went to the resident's room to observe the areas and he was only able to see the redness and excoriations to the perineal area. He asked the wound care nurse to follow up with the excoriated areas. During an interview on 4/18/24 at 10:33 AM with the Director of Nursing (DON), she stated she was unaware Resident #57 had excoriated areas. A record review of the "Admission Record" revealed the facility admitted Resident #57 on 8/2/23 and he had current diagnoses including Quadriplegia. A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/20/24 revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Review of section GG revealed Resident #57 required substantial/maximal assistance with toileting hygiene. Resident #55 On 04/16/24 at 1:10 AM, during an observation and interview, Resident #55 was wearing two incontinence briefs. Licensed Practical Nurse (LPN) #2 confirmed he was wearing two briefs.	M 620		

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Resident #55 reported sometimes the CNAs will put four (4) or five (5) briefs on him so they will not have to change him during the night. LPN #2 explained residents should not wear two briefs unless there is a specific care plan intervention to do so. She explained that wearing two briefs could cause skin breakdown and moisture associated skin damage. The CNAs should round every two hours to check on the residents, but she did not check behind them to be sure they were completing their rounds.

At 1:45 AM on 04/16/24, during an interview with CNA #8, she explained she had not checked on Resident #55 this shift and the 3-11 must have applied two briefs to the resident. She reported she usually started her rounds at 12 AM but had not checked Resident #55 yet.

On 04/17/24 at 11:30 AM, during an interview with Registered Nurse #2/Infection Preventionist Nurse, she explained that being left in a soiled brief for long periods of time increased the risk for UTIs and skin breakdown.

Record review of the "Admission Record" revealed the facility admitted Resident #55 on 9/1/22 and had current diagnoses including Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease.

Record review of the Quarterly MDS with an ARD of 03/29/24 revealed Resident #55 had a BIMS score of 15, which indicated he was cognitively intact. Section GG revealed he required total dependence for toileting hygiene and Section H revealed he was always incontinent of bowel and bladder.

Record review of the "Order Summary Report"

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with active orders as of 04/16/24, revealed Resident #55 had a Physician's Order, dated 4/12/24, for Bactrim DS (an oral antibiotic) for UTI until 4/26/24. Further review revealed a Physician's Order, dated 4/4/24, for Macrobid (an oral antibiotic) for acute cystitis (bladder infection) with hematuria (blood in the urine).

Resident #1

On 04/15/24 at 12:17 PM, during an observation and interview, Resident #1's call light was lit up and sounding. CNA #2 went into the resident's room, explained that it would be a minute because the staff were passing meals trays, and turned the light off. There were two (2) nurses sitting at the nurse's station and there were no meal trays observed on the hall. CNA #2 explained it was the policy of the facility not to change residents while meal trays were being passed out on the floor.

At 12:30 PM on 04/15/24, during an observation and interview, Resident #1 was eating lunch and he stated that he needed to be changed.

At 1:15 PM on 04/15/24, during an observation and interview, Resident #1 was sitting in his wheelchair in his room and reported that he had not been changed.

On 04/15/24 at 01:25 PM, during an observation and interview, Resident #1 left his room and went down the hallway. CNA #10 explained no one had told her that Resident #1 requested to be changed.

A record review of the "Admission Record" revealed the facility admitted Resident #1 on 12/01/2014 and he had current medical

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diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction.

A record review of the Annual MDS with an ARD of 01/16/24 revealed Resident #1 had a BIMS score of 15, which indicated he was cognitively intact. Section GG revealed he required maximal assistance for toileting hygiene and Section H revealed he was frequently incontinent of bowel and bladder.

Resident #8

On 04/16/24 at 1:15 AM, during an observation and interview, Resident #8 was wearing two (2) incontinence briefs that were wet with urine. LPN #2 explained there should be no residents wearing two briefs at any time unless the resident has been care planned to have them. LPN #2 stated that residents wearing two incontinence briefs could cause skin breakdown or infection.

On 04/16/24 at 1:45 AM, during an interview with CNA #8, she explained she had not checked on Resident #1 since the beginning of her shift at 11 PM and the double briefs must have come from the 3-11 shift. She stated she usually started her rounds at 12 AM, but she must have forgotten to check on Resident #1.

Record review of the "Admission Record" revealed the facility admitted Resident #8 on 1/15/20 and had current diagnoses including Acute on Chronic Systolic (Congestive) Heart Failure.

Record review of the Quarterly MDS with an ARD of 3/6/24 revealed Resident #8 had a BIMS score of 00, which indicated his cognition was severely impaired. Section GG revealed he required

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maximal assistance with toileting hygiene and Section H revealed he was always incontinent of bowel and bladder.

Resident #14

On 04/16/24 at 1:05 AM, during an observation and interview, Resident #14's brief was torn off and there was BM noted on the resident. The incontinence pad underneath the resident had a brown ring. CNA #8 reported it was not unusual for the resident to tear off the brief and explained that she completed rounds on the residents at 12 AM, 2AM, 4 AM, and 6 AM. CNA #8 stated that she did not think she had checked Resident #14's brief earlier because the resident was asleep. She confirmed there was a brown ring noted to the incontinence pad and that Resident #14 had not been changed for a long period of time.

On 04/16/24 at 1:23 AM, during an interview with LPN #2, she explained that when there was a brown ring on a resident's incontinent pad, then the resident had not been changed for a long period of time. She said the CNAs should complete rounds on the residents every two (2) hours, but she did not check behind the CNAs.

A record review of the "Admission Record" revealed the facility admitted Resident #14 on 9/3/13 with current medical diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction.

A record review of the Quarterly MDS with an ARD of 3/18/24 revealed Resident #14 had a BIMS score of 00, which indicated her cognition was severely impaired. Section GG revealed she required maximal assistance for toileting hygiene and Section H revealed she was always

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incontinent of bowel and bladder.

Resident #38

During an observation on 4/15/24 at 12:17 PM, Resident #38's call light was on and Certified Nurse Aide (CNA) #2 walked into the resident's room, explained to the resident that it would be a minute because she was passing out meal trays, and exited the room. There were no meal trays being served on the hall.

During an observation and interview on 4/15/24 at 1:10 PM, Resident #38 was lying in bed and there was a strong odor in the room. Resident #38 explained her brief was soiled before lunch and she had asked the staff to change her. She stated the staff told her that she had to wait because the lunch trays were being passed out.

During an observation and interview on 4/15/24 at 1:35 PM, Resident #38 reported to CNA #10 and CNA #1 that she had been sitting in a soiled brief for over an hour. Both reported they were not aware she needed assistance before lunch trays were served. During incontinence care, there was a dark brown ring on the incontinence pad and the resident's brief was heavily soiled.

During an interview on 4/15/24 at 2:35 PM, CNA #2 explained she did not tell anyone that Resident #38 had requested to have her brief changed because she had forgotten.

On 04/16/24 at 1:20 AM, during an interview and observation, Resident #38 reported that she had not been changed all night. LPN #2 confirmed Resident #38's brief was wet and soiled.

A record review of the "Admission Record"

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M 620	Continued From page 14 revealed the facility admitted Resident #38 on 1/12/21 with current diagnoses including Spinal Stenosis. A record review of the Quarterly MDS with an ARD of 3/13/24, revealed Resident #38 had a BIMS score of 14, which indicated she was cognitively intact. During an interview with the Director of Nursing (DON), on 04/16/24 at 4:00 PM, she explained she was unaware that staff were applying two incontinence briefs on the residents. She reported that no residents should wear two briefs and she expected the staff to follow the standards of care for all residents. She explained there were enough staff on the units to assist with resident care if the CNAs were busy. She expected staff to keep residents from having to wait for long periods of time to receive assistance with incontinence care.	M 620		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on interviews and record review the facility failed to ensure a resident's safety by not assessing for the risk of substance use and not developing interventions for a resident with known	M 640	1) On 05/07/2024, Resident #57 was offered to attend Alcoholics Anonymous (AA) by RN Supervisor. 2) Current Residents with substance abuse disorders have the potential to be	5/16/24

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M 640	Continued From page 15 substance use disorder (SUD) for one (1) of 22 sampled residents. (Resident # 57) Findings include: During an interview on 4/15/24 at 1:00 PM, Resident #57 stated that he frequently signed himself out of the facility to visit a friend that lived down the street. He confirmed he used his electric wheelchair to travel beside the road to his friend's home. He commented that the facility was trying to discharge him from the facility because he enjoyed visiting his friends outside of the facility. The resident confirmed he would drink a couple of beers while visiting his friends sometimes but denied bringing alcohol or tobacco back into the facility. During an interview on 4/16/24 at 9:00 AM, Resident #57's family member revealed Resident #57 had a history of alcohol abuse since he had an accident which caused him to become paralyzed from the waist down. The family member commented that the resident has been drinking more lately and felt as if he needed some help with substance abuse. The family member stated the facility had not recommended any programs or behavioral health services related to SUD. On 4/16/24 at 10:00 AM, during an interview with License Practical Nurse (LPN) #2 states, she explained that she was the care plan nurse. She confirmed Resident #57 had an alcohol abuse problem and the facility had not developed a care plan or had thought about putting interventions into place to assist the resident with SUD. During an interview on 4/16/24 at 11:00 AM with the Director of Nursing (DON), she stated	M 640	affected by this alleged deficient practice. 3) 6 other Residents were identified that had alcohol dependent and other psychoactive substance abuse on 04/22/2024. The monitoring will make sure that they do not want to participate in Alcoholics Anonymous. All Nurses were inserviced on "How to recognize Residents that suffer from substance abuse", on 04/22/2024. 4) On 04/22/2024, the Director of Nurses will begin to audit Residents identified with Alcohol and Substance Abuse daily for two (2) weeks, then three (3) times a week for two (2) weeks, then weekly for three (3) months. These Audits will ensure they do not want to participate in Alcoholics Anonymous. Results of the Audits will be presented to the Quality Assurance Performance Improvement Committee by the Director of Nurses monthly for three months starting 05/16/2024 to determine effectiveness and make necessary changes as indicated.	

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Resident #57 enjoyed leaving the facility two or three times a week on his electric scooter. The DON confirmed that he signed himself out and traveled along the side of the highway and visited his friends. During these visits, he would drink alcohol and returned to the facility impaired. The DON explained that because the resident was cognitively intact, he could make his own decisions. The DON stated Resident #57 brought alcohol and tobacco products back into the facility when he returned and would give tobacco products to the other residents. The DON confirmed the facility has not assessed or developed interventions related to the resident's alcohol abuse. The DON also stated the resident has been seen by behavioral health services previously, but those visits were not related to substance use disorder.

In an interview on 4/17/24 at 2:00 PM with the Medical Director (MD), he confirmed Resident #57 should be referred to a program because he needed help dealing with alcohol abuse. The MD stated the facility did not have interventions in place to assist the resident with his behavior.

A record review of the "Admission Record" revealed the facility admitted Resident #57 on 8/2/23 with current diagnoses including Quadriplegia and Unspecified Injury at C1 Level of Cervical Spinal Cord.

A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/20/24 revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively Intact.

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M1570	Continued From page 17	M1570		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observation, staff interview and facility policy review, the facility failed to prevent the possible spread of infection as evidenced by a nurse touching medications with her bare hand and Certified Nursing Assistants (CNAs) discarding soiled linens and briefs on the floor for three (3) of nine (9) medication and incontinence care observations.	M1570	1) Registered Nurse (RN)# 3 was inserviced by the Director of Nurses on facility policy "Medication - Oral Administration". CNA# 8 was inserviced by the Director of Nurses on facility policy "Perineal Care" and "Infection Control" with an emphasis on discarding soiled linen and briefs in proper receptacle on 04/22/2024. Resident# 14's room was cleaned by Housekeeping Personnel on	5/16/24

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M1570	Continued From page 18 Findings include: Medication Administration Review of the facility's policy "Medication- Oral Administration Of", revised 8/15/2019, revealed, "Procedure ...Refrain from touching powders, capsules, or pills with hands ..." On 04/16/24 at 8:59 AM, during a medication administration observation, Registered Nurse (RN) #3 placed a resident's pill into her ungloved hand and placed it in a medication cup. On 04/16/24 at 10:59 AM, during an interview with RN #3, she confirmed she had placed a resident's pill in her ungloved hand and then put it in a medication cup because it was easier that way. She said she knew that it was not right, and it was not the way she was trained to administer medications. She stated it was a break in infection control. On 04/17/24 at 9:45 AM during an interview with RN #2/Infection Preventionist, she revealed the facility policy on medication administration specifically speaks to not touching medications with your hands. Incontinence Care Review of the facility's policy "Perineal Care", revised 9/5/17 revealed " ... Procedure ... dispose of linen ..." On 4/16/24 at 1:05 AM, in an observation of incontinence care for Resident #14, CNA #8 removed a soiled brief, incontinence pad, and linens and placed them directly on the floor,	M1570	04/16/2024. 2) All Residents have the potential to be affected by this alleged deficient practice. 3) The Director of Nurses inserviced all nurses on facility policy, "Medication - Oral Administration" regarding not physically touching pills during medication administration on 04/22/2024. The Director of Nurses inserviced all clinical staff on "perineal Care" regarding disposal of soiled linen and brief on 04/22/2024. 4) Registered Nurse/Unit Manager will monitor medication administration and infection control practices weekly two (2) times a week for three (3) weeks then monthly for two (2) months, beginning 04/22/2024. Register Nurses/Unit Manager will monitor bowel and bladder care to include proper disposal of soiled linen and briefs for 4 residents weekly for three (3) weeks then monthly for three (3) months, beginning 04/22/2024. All Findings will be brought to the Quality Assurance Committee Improvement Committee on 05/16/2024 and monthly for three (3) months to determine effectiveness and make necessary changes as indicated.	

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M1570	Continued From page 19	M1570		

without placing them in a bag. After CNA #8 completed the care, she went to retrieve a bag, and then placed all the soiled items from the floor into a bag and placed them in the dirty linen room.

At 1:25 AM on 4/16/24, in an observation of incontinence care for Resident #38, CNA #8 was assisted by CNA #9. CNA #8 removed a soiled brief and discarded it directly onto the floor and not in a bag. After she completed the care, CNA #8 retrieved a bag and placed the dirty brief in a bag and placed it in the trash.

At 1:35 AM on 4/16/24, during an interview with Licensed Practical Nurse (LPN) #2, she explained that dirty or soiled linens and briefs should not be placed directly onto the floor and should be contained in a garbage bag to maintain proper infection control.

On 04/16/24 at 1:40 AM, during an interview with CNA #8, she confirmed she discarded dirty linens and briefs on the floor when providing care for Resident #14 and Resident #38. She explained she should have placed all the dirty linen in a bag while, but she got nervous and tried to hurry up and clean the residents.

On 04/16/24 at 4:00 PM, during an interview with the Director of Nursing (DON), she explained she was informed of the dirty linen being placed on the floor during care and the CNA received disciplinary action. She reported that CNA #8 had been trained and had competency skills check off related to incontinence care and infection control. The DON stated that she expected the staff to follow standard practices related to infection control.

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M1570	Continued From page 20 On 04/17/24 at 11:30 AM, during an interview with Registered Nurse #2/Infection Preventionist Nurse, she explained that discarding soiled briefs and linens directly onto the floor was an infection control issue and even though the CNA and picked up the soiled items from the floor, the concerns were still present on the floor.	M1570		