STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255171	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINONA MANOR HEALTH CARE AND REHABILITATION CENTER	627 MIDDLETON ROAD WINONA, MS 38967

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey in the facility from 9/25/23 through 9/28/23. The SA determined the facility was not in compliance with Medicare and Medicaid regulations for participation. During the survey, the SA cited deficiencies at F550, F565, F576, F584, F645, F656, F677, F761, and F880. The facility had a census of 97 at the time of the survey and held a license for 119 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		11/3/23

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

Electronically Signed | 10/19/2023

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review and facility policy review the facility failed to honor a resident's dignity as evidence by posting a sign on a resident's door concerning care for one (1) of 96 residents residing in the facility. Resident # 81 Findings include: Record review of the facility policy titled "Notice Of Privacy Practices" undated, revealed under, "Our Responsibilities: Our nursing facility is required to: Maintain the privacy of your health information ... " An observation, of Resident #81's room door on 09/25/23 at 10:48 AM, revealed a sign posted that read, "Patient to wear helmet at all times." The resident was observed sitting in a wheelchair in her room and was unable to communicate verbally.	F 550	1. Root Cause Analysis was conducted by the Quality Assurance Performance Improvement (QAPI) Committee on 9/29/23 and based on findings, a sign was posted on resident #81 door concerning care, compromising resident's dignity/rights. On 9/26/23, sign was removed from resident #81 door by Director of Clinical Services. Quality review of current residents was conducted on 9/26/23 by Director of Clinical Services to ensure no signs were posted on the doors of residents to compromise their dignity/rights. 2. All residents have the potential to be affected by this alleged practice. 3. Education initiated on 9/29/23 by Director of Clinical Services with current staff to ensure resident's rights/dignity are honored. New hires will receive education	

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F 550	Continued From page 2 An observation, of Resident #81's room door on 9/26/23 at 9:15 AM confirmed a sign posted that read, "Patient to wear helmet at all times" and three (3) identical signs posted on the walls in the resident's room that read, "Patient to wear helmet at all times." An interview on 9/26/23 at 11:08 AM, with Licensed Practical Nurse (LPN) # 2 confirmed a sign posted on Resident #81's door that read, "Patient to wear helmet at all times" and LPN confirmed that it should not be posted visible to the public. She revealed posting clinical information on the door was a privacy issue. An interview with Registered Nurse (RN) #2 on 9/26/23 at 11:12 AM, confirmed the sign posted on Resident #81's door. She revealed that the sign was private care information that should not be visible to the public due to honoring residents' privacy. An interview with the Director of Nursing (DON) on 9/26/23 at 11:40 AM, revealed Resident #81's care information should not be posted on the door and she confirmed it was a privacy concern. Record review of the Admission Record revealed that Resident #81 was admitted to the facility on 1/19/23 with medical diagnoses that included Metabolic Encephalopathy, Major Depressive Disorder, Generalized Anxiety Disorder, Pseudobulbar Affect and Alcohol Abuse with Alcohol-Induced Psychotic Disorder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/12/23 revealed under section C, a Brief Interview for Mental Status (BIMS) score was not	F 550	upon hire. 4. Beginning on 10/2/23 Quality Monitoring of 25 residents to be conducted by Executive Director (ED) or Director of Clinical Services (DCS) weekly x 4 weeks, then monthly x 4 months. Findings will be reported by the Executive Director monthly X 6 months to Quality Assurance Performance Improvement (QAPI) Committee. On 10/31/23 will conduct a QAPI to review findings from Quality Monitoring on the first Friday of each month during the QAPI meeting by the QAPI Committee for 6 months to ensure our solutions are sustained. Quality monitoring schedule modified based on findings. 5. AOC: November 3, 2023	

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F 550	Continued From page 3 conducted due to Resident #81 is rarely/never understood.	F 550		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other	F 565		11/3/23

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F 565	Continued From page 4 residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review, and facility policy review, the facility failed to follow up on a grievance from Resident Council meetings related to answering call lights in a timely manner for two (2) of 10 residents in the Resident Council Meeting. Resident #39 and #66 Findings include: Record review of facility policy titled "Policies and Procedure - Subject: Complaint/Grievance", dated 11/30/14, revealed, "The Center will support each resident's right to voice a complaint/grievance without fear of discrimination or reprisal. The center will make prompt efforts to resolve the complaint/grievance and informed the resident of progress towards resolution" Resident Council meeting was held with State Agency on 9/26/23 at 3:00 PM with 10 residents present. An interview on 9/26/23 at 3:00 PM, at the Resident Council meeting revealed Resident #39 (Resident Council President) and Resident #66 had concerns that the call lights were not always answered timely. They both stated that this concern had been mentioned in previous Resident Council meetings and they did not receive a resolution or follow-up for this grievance. They also stated that it had improved in the past, but they were now having concerns again. The other eight residents attending the meeting revealed they had no concerns with their call lights being answered timely.	F 565	1. Root Cause Analysis was conduced by the Quality Assurance Performance Improvement (QAPI) Committee on 9/29/23 and based on findings, concerns were voiced during Resident Council meetings related to answering call lights in a timely manner. The facility must make efforts to resolve the concerns in a timely manner. Quality Review of current residents was conducted on 9/26/23 by Executive Director and Director of Clinical Services to ensure call lights are answered in a timely manner. 2. All residents have the potential to be affected by the alleged practice. 3. Education initiated on 9/29/23 by Director of Clinical Services with current Certified Nurses' Assistant and Licensed Nurses to ensure call lights are answered in a timely manner. Call light drill was performed on 9/29/2023 by Director of Clinical Services and Executive Director by pressing random resident's call lights and clocking the time it takes staff to respond. This drill included 3 resident's call lights. The Executive Director and Multi-Disciplinary team will make compliance surveillance rounds within the facility on 5 residents per week to ensure call lights are answered timely. In addition, the Executive Director and Director of Clinical Services will interview 5 residents per month regarding call light response time. New hires will be educated upon hire	

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F 565	Continued From page 5 An interview with the Activity Director on 9/26/23 at 3:40 PM, revealed the residents had mentioned the call lights not being answered timely several times in Resident Council meetings and the department head was notified. During an interview on 9/27/23 at 3:00 PM, the Director of Nursing (DON) confirmed she was aware of the ongoing concern of the call lights not being answered timely. She confirmed it is the facility's responsibility to follow up on all grievances and the facility failed to discuss a resolution and follow-up with the council members concerning the grievance. Record review of Resident Council minutes dated 7/26/23, revealed, several concerns related to call lights. Record review of Resident Council minutes dated 8/24/23, revealed a concern with call lights was mentioned. Record review of the Admission Record for Resident #39 revealed she was admitted to the facility on 7/14/22. Record review of Resident #39's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/17/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Record review of the Admission Record for Resident #66 revealed she was admitted to the facility on 12/17/21. Record review of Resident #66's MDS with ARD of 8/22/23 revealed a BIMS score of 15 which	F 565	during orientation by Director of Clinical Services. 4. Beginning on 10/2/23 Quality Monitoring of staff answering 10 residents call lights in a timely manner to be conducted by Director of Clinical Services and Assistant Director of Clinical Services 3x/ weekly x 4 weeks, then 2x/ weekly x 3 weeks, then weekly x 1 week, then monthly x 3 months. Findings will be reported by Director of Clinical Services monthly x 6 months to Quality Assurance Performance Improvement (QAPI) Committee meeting. On 10/31/23 we will conduct a QAPI to review findings from Quality Monitoring on the first Friday of each month during the QAPI meeting by the QAPI Committee for 6 months to ensure our solutions are sustained. Quality Monitoring schedule modified based on findings. 5. November 3, 2023	

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F 565	Continued From page 6 indicated the resident was cognitively intact.	F 565		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional	F 576		11/3/23

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F 576	Continued From page 7 expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and facility policy review, the facility failed to deliver mail to the residents on Saturday for 10 of 10 residents in Resident Council, with the potential to affect all residents. Findings include: Record review of "Information Handbook" dated 1/22, revealed, "Mail: We deliver mail to your room daily with the exception of Sunday. All mail is delivered to you unopened unless otherwise authorized." The handbook also revealed, "You have the right to: privacy in written and spoken communication; send and promptly receive unopened mail". Interviews during the Resident Council meeting on 9/26/23 at 3:00 PM, with 10 residents present revealed they received their mail unopened, but did not receive it on Saturdays, because the mail was not delivered to the facility on Saturday. They stated during the week, the front office Receptionist or the Activity Director delivered the mail and packages to the residents. An interview with the front office Receptionist on 9/26/23 at 3:35 PM, revealed on Monday through Friday, the mail was delivered from the Post Office to the facility. She stated the facility had informed the Post Office to not deliver mail on Saturdays since there was no one in the office to deliver it to the residents.	F 576	1. Root Cause Analysis was conducted by the Quality Assurance Performance Improvement (QAPI) Committee on 9/29/23 and based on findings, mail was not delivered to residents on Saturday. On 9/25/23, US Postal Service in Winona, MS was contacted by Activity Director to resume mail delivery on Saturdays to facility. Quality review of current residents was conducted on 10/2/23 by Activity Director to ensure residents received mail delivery on Saturday. 2. All residents have to potential to be affected by this alleged practice. 3. Education initiated on 9/29/23 by Executive Director with Activity Director on the rights of residents to send and receive mail, packages, through the postal services and by other means. 4. Beginning on 10/2/23 Quality Monitoring of current residents to be conducted by Activity Director or Executive Director (ED) weekly x 4 weeks, then monthly x 4 months. Findings will be reported by the Executive Director monthly x 6 months to Quality Assurance Performance Improvement (QAPI) Committee. On 10/31/23 will conduct a QAPI to review findings from Quality Monitoring on the first Friday of	

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F 576	Continued From page 8 An interview, with the Activity Director on 9/26/23 at 3:40 PM, revealed the mail was delivered to the facility on Monday through Friday, but not on the weekends. She stated the Post Office does not deliver mail to the facility on Saturday. During an interview on 9/26/23 at 3:45 PM, the Director of Nursing (DON) confirmed the facility had a Saturday mail delivery hold with the Post Office and the mail was not delivered to the facility on that day. She confirmed the facility failed to honor the residents' right to receive their mail and packages on Saturday.	F 576	each month during the QAPI meeting by the QAPI Committee for 6 months to ensure our solutions are sustained. Quality Monitoring schedule modified based on findings. 5. AOC: November 3, 2023	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		11/3/23

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F 584	Continued From page 9 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, and staff and resident interview the facility failed to provide a safe clean environment as evidenced by a dirty wheelchair with a torn arm rest for Resident #249 and dirty floors throughout the facility, scuffed painted areas, gouged sheetrock, broken drawers, broken window and sharp areas on resident doors for four (4) of 4 survey days. Findings include: An interview with the Administrator on 9/28/23 at 9:00 AM revealed the facility did not have a policy addressing a safe and clean environment. An observation on 9/25/23 at 1030 AM, revealed blackish build up along the edges of all of the hallways at the baseboards and around the door frames of resident's room entry and bathroom	F 584	1. On 9/26/23, resident #249 dirty wheelchair was cleaned by CNA, on 9/27/23, torn arm rest was replaced by Maintenance Director. On 9/26/2023, resident room #210 closet drawers were repaired. On 9/26/2023, resident room #208 scuffed paint was re-painted, closet cabinet was painted and edges were repaired, gouged sheetrock was repaired . On 9/26/2023, resident room #212 chair rail was repaired, window was repaired, paint was touched up and sharp edge on door was repaired, 9/26/23 additional housekeeping was brought in to assist with cleaning of the floors, as well as, to assist with the scrapping of the hallways along the baseboards and door frames. 2. Quality Review of housekeeping and	

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F 584	Continued From page 10 doors. There are several brownish stain spots scattered along the floor of the east hall between Room 101 to Room 114. Observations on 09/25/23 at 11:25 AM and 9/26/23 at 9:03 AM, revealed Resident #249 sitting in a wheelchair that had a thick brown and gray substance on the frame and the spokes of the wheels. The right vinyl armrest was tattered and torn with jagged edges exposed. An observation on 9/25/23 at 3:30 PM, revealed the drawers under the closet in Room 210 are broken, hanging down and unable to be closed. An observation on 9/25/23 at 3:33 PM, in Room 208 revealed the paint scuffed off and the wall had areas gouged out of the sheet rock behind the bed. The clothes closet cabinet had scuffed areas with missing paint and broken edges. An observation and interview on 09/25/23 at 03:36 PM, with Resident #52 revealed the drawer under the clothes closet was broken and hanging and will not close properly. The top of the counter space on the right side of the room has paint scuffed and peeled off the top. Resident #52 stated that she would not want this in her house if she wasn't in the nursing home. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/17/23 revealed a Brief Interview for Mental Status (BIMS) score of nine (9)which indicated Resident #52 had moderate cognitive impairment. An observation on 9/25/23 at 4:00 PM, revealed the wall behind the A and B bed in Room 212	F 584	maintenance practices was conducted by the Executive Director and Maintenance Director on 9/26/23. All residents have the potential to be affected by this alleged deficient practice. 3. Education of housekeeping staff conducted on 9/28/23 by District Manager on routine cleaning schedule. Maintenance Director education conducted on 9/26/23 by Executive Director on ensuring broken items are repaired. Weekly wheelchair cleaning log implemented 9/27/2023 by Director of Clinical services to include that wheelchairs are cleaned every Friday night on 11pm-7pm shift. Staff was educated and in serviced on 9/27/2023 on proper cleaning of wheelchairs and completion of cleaning log. Education and in services implemented in order to ensure individuals are provided a safe, homelike environment. 4. Beginning on 10/2/23 the Executive Director, Housekeeping Supervisor, and Maintenance Director will conduct a quality review of 6 resident rooms and 2 common areas 4x/weekly x 4 weeks, then 3x/ weekly x 4 weeks, then 2x/ weekly x 4 weeks, then weekly x 4 weeks. The wheelchair cleaning log is viewed weekly by Executive Director to ensure wheel chairs are clean. Findings will be reported by the Executive Director monthly x 6 months to Quality Assurance Performance Improvement (QAPI) Committee. On 10/31/23 we will conduct a QAPI to review findings from Quality Monitoring on the	

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F 584	Continued From page 11 below the chair rail had approximately 75% of the paint off. The chair rail was broken behind the bed with a sharp edge on it and was pulled away from the wall. An observation and interview on 09/26/23 at 02:10 PM, with the housekeeping District Manager confirmed the dark areas on the tile in the hallways, the build up of brownish-black material against the walls and noted the build up was worse near the hand sanitizer dispensers. He stated that some of the stuff on the floor was where they put down new baseboards and left strips of adhesive. He stated that they would try to get it up. He confirmed the black colored build up in the corners at the doors should not be there. He confirmed that the building is the resident's home and the floors should not have all the spots and build up on the tiles. If the tiles could not be cleaned the only thing to do would be to replace them. An observation and interview on 9/26/23 at 3:30 PM, the Maintenance Director confirmed the broken drawers, scuffed paint , gouged walls and loose broken chair rail should not be like that. He confirmed he would not want to live in a house with these issues. He stated that they make daily rounds, if possible, to check on things like this, but the staff should also report anything they find that needs repair. An observation and interview on 09/26/23 at 03:35 PM, the Director of Nurses (DON) confirmed that Resident #249's wheelchair was dirty and needed to be cleaned. She stated the wheelchair was "disgusting." The DON revealed that it should have been cleaned last weekend and she wasn't sure when the last time it was	F 584	first Friday of each month during the QAPI meeting by the QAPI Committee for 6 months to ensure our solutions are sustained. Quality Monitoring schedule will be modified based on findings. 5. AOC: November 3, 2023	

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	255171	A. BUILDING _____ B. WING _____	09/28/2023

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F 584	Continued From page 12	F 584		

cleaned. She revealed she had assigned one Certified Nurses Assistant (CNA) every weekend to clean the wheelchairs and had just put that in place about a month ago because the wheelchairs were not getting cleaned. She revealed we don't have a checklist in place at this time but that is something we are working on. The DON confirmed the right armrest was torn and jagged and could cause the resident to get a skin tear and she would get that taken care of.

An observation on 9/27/23 at 8:55 AM, on the west hall of all the room doors revealed where the door frame meets the floor had a blackish build up on the floor approximately one half (1/2) to one (1) inch wide.

An interview on 9/28/23 at 8:42 AM, with the Floor Technician revealed they stripped the floors last month and he buffed the floors yesterday. He stated he thinks the stains are rust left from a few years ago when the sewer overflowed and will not come up.

During an observation and interview on 9/28/23 at 8:45 AM, with the Administrator (ADM) she revealed the floors were stained and dirty in the halls and the resident's rooms and that they needed new floors. She confirmed Room 133 had paint scuffed off the closet door, Room 209 clothes closet and drawers needed repair and the shelf needed to be repainted. She confirmed the gouged walls behind the beds and the broken, loose chair rail behind the bed needed fixing. She confirmed the metal plate on the door of Room 212 had rough gouged areas and the metal plate corner was bent outward approximately two (2) inches. The ADM stated that the bent metal plate could possibly cut somebody. She confirmed the

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F 584	Continued From page 13 hole in the window in Room 212 should have been fixed instead of putting tape over it and the tape no longer covered the actual hole. She stated that the building was dirty and in need of attention and updating. The ADM stated that her house did not look like this and confirmed the residents home should not look like it does.	F 584		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of	F 645		11/3/23

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F 645	Continued From page 14 services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and	F 645	1. Root Cause Analysis was conducted	

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F 645	Continued From page 15 facility policy review, the facility failed to complete a level one (1) Preadmission Screen (PAS) for a resident admitted to the facility for 1 of three (3) residents reviewed for Preadmission Screening and Resident Review (PASARR). Resident #81. Findings include: Record review of the facility policy titled "Preadmission Screening and Resident Review (PASARR)" with a revision date of 11/08/21 revealed, "Policy: The center will assure that all Serious Mentally Ill (SMI) and Intellectually Disabled (ID) residents receive appropriate pre-admission screenings according to Federal/State guidelines. The purpose is to ensure that the residents with SMI or are ID receive the care and services they need in the most appropriate setting." Also revealed under, "Procedure: 1. It is the responsibility of the center to assess and assure that the appropriate preadmission screenings, either Level I or Level II, are conducted and results obtained prior to admission and placed in the appropriate section of the resident's medical record..." Record review of the Admission Record revealed that Resident #81 was admitted to the facility on 1/19/23 with medical diagnoses that included Metabolic Encephalopathy, Major Depressive Disorder, Generalized Anxiety Disorder, Pseudobulbar Affect, and Alcohol Abuse with Alcohol-Induced Psychotic Disorder. An interview, with the Nursing Consultant on 9/26/23 at 11:00 AM revealed the facility did not complete a Level 1 Preadmission Screen for Resident # 81, and therefore a Level II had not been done.	F 645	by the Quality Assurance Performance Improvement (QAPI) Committee on and based on findings a Preadmission Screening and Resident Review for resident #81 was not completed. Preadmission Screening and Resident Review (PASARR) was completed on 9/26/23 for resident # 81. 2. All new admissions will be reviewed within 24 hours of admission by the Executive Director to validate a Preadmission Screening and Resident Review has been conducted and is present within the electronic medical record in order to ensure 100% of PASARR's are completed. All new admissions could be affected by this. 3. Education initiated on 9/26/23 with Admissions by Executive Director ensuring Preadmission Screening and Resident Review (PASAAR) is completed on new admits ensuring they are appropriate for nursing home placement. 4. Beginning on 10/2/23, the Executive Director will conduct a quality review of new admits 2 times per week for 90 days to ensure that a Preadmission Screening and Resident Review is completed and is included within the electronic medical record. All negative findings will be corrected immediately and reported to the Quality Assurance and Performance (QAPI) Committee for further review and recommendations. On 10/31/23, we will conduct a QAPI to review findings from the Quality Monitoring on the first Friday	

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F 645	Continued From page 16 An interview with the Admission's Coordinator on 9/26/23 at 11:02 AM, revealed she was responsible for the PASARRs. She confirmed that a Level I was not done when Resident #81 was admitted to the facility. She revealed that the purpose of the PASARR was to identify if the resident was appropriate for nursing home placement. An interview with the Administrator (ADM) on 9/26/23 at 2:20 PM, revealed that all residents admitted to the facility should have a PAS to ensure that they are appropriate for nursing home placement and ensure they receive the care and services needed. She confirmed that Resident #81 should have had a PAS completed on admission. An interview with the Director of Nursing (DON) on 9/28/23 at 8:40 AM revealed that Resident #81 did have some anxiety/agitation at times. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/12/23 revealed under section C, a Brief Interview for Mental Status (BIMS) score was not obtained due to Resident #81 is rarely/never understood.	F 645	of each month X 3 months during the QAPI meeting to ensure our solution are sustained. Quality Monitoring schedule will be modified based on findings. 5. AOC: November 3, 2023	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		11/3/23

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objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.

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F 656	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to implement comprehensive care plans for four (4) of the twenty-eight resident care plans reviewed. Resident #32, Resident #33, Resident #57 and Resident #248. Findings include: Review of the facility policy titled, "Policies and Procedures" Subject: Plans of Care with a revision date of 09/25/2017 revealed, An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements ...Procedure: Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Resident #33 Record review of Resident #33's Activities of Daily Living (ADL) care plan revealed, "Focus: I have an ADL self-care performance deficit r/t (related to) Cardiac Dx (Diagnosis), HX (History) of CVA (Cerebral Vascular Accident), Aphasia, Cognitive Communication deficit, and Muscle Weakness ... Interventions ...Personal Hygiene ...I require extensive assistance x 1-2 staff for personal hygiene ...shaving. An observation, on 09/25/23 at 11:35 AM,	F 656	1. Root Cause Analysis was conducted by the Quality Assurance Performance Improvement (QAPI) Committee on 9/29/2023 and based on findings comprehensive care plans were not implemented for residents #32, #33, #57, and #248. On 9/26/2023, resident #32 fingernails were cut and cleaned by Certified Nurse Assistant. On 9/26/2023, residents #33, #57, and #248 were shaved by Certified Nurse Assistant. A review of Residents #21, #33, #57, and #248 was conducted by the multi-disciplinary team to ensure that all plans of care adequately addressed each resident's current needs. All negative findings were corrected immediately. 2. All residents have the potential to be affected by this deficient practice. 3. Education was initiated on 9/26/2023 with current Certified Nurses' Assistants and Licensed Nurses to ensure resident's nails are cleaned, and cut on a routine schedule, resident's requiring grooming to include shaving be included in each resident's plan of care. New hires will be educated during orientation by Director of Clinical Services. 4. Beginning on 10/2/2023, Director of Clinical Services and Assistant Director of Clinical Services will audit the care delivery and conduct Quality Monitoring on 10 residents 4x/weekly, then 3x/weekly X 4 weeks, then 2x/weekly X 4 weeks, then weekly x 4 weeks to ensure resident's nails are cut and clean and residents are appropriately groomed and	

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F 656	Continued From page 19 revealed Resident #33 lying in bed. This observation revealed the resident is non-verbal but acknowledged when he was spoken to and was able to respond by shaking his head to yes or no questions. Resident #33's facial hair was approximately one-half (1/2) inch long on his chin, above his mouth, and on the sides of both cheeks. The resident shook his head no when asked if he liked the facial hair to be that long. Resident #33 shook his head, yes when he was asked if he would like to be shaved. An observation, on 09/26/23 at 08:10 AM, revealed Resident #33 remains unshaven. Resident #33 nodded his head yes; acknowledging that he would like to be cleaned up and shaven. An interview and observation, on 09/26/23 at 11:25 AM, with Certified Nurse Aide (CNA) #2 revealed she is assigned to the resident, and he got a bed bath today. Observation of Resident #33 lying in bed revealed the resident remained unshaven. CNA #2 revealed "well I didn't give him a full bed bath I just did his peri-care." CNA #2 revealed she wasn't sure if she was supposed to shave him or not, but that shaving was part of grooming. CNA #2 confirmed that the resident's facial hair was long, and he needed to be shaved. When the resident was asked if he would like to be shaved, the resident shook his head yes. An interview and observation on 09/26/23 at 11:30 AM, CNA #1 revealed a shower or bed bath consisted of haircare and shaving the men. CNA #1 asked the resident if he would like to be shaved, and he shook his head yes while touching his face. CNA #1 confirmed that it "looked like it had been a long time since he was	F 656	shaven. Findings will be reported by Director of Clinical Services monthly X 6 months to Quality Assurance Performance Improvement (QAPI) Committee during the QAPI meeting to ensure our solutions are sustained. Quality monitoring schedule will be 10/31/2023, we will conduct a QAPI to review findings from the Quality Monitoring on the first Friday of each month during the QAPI meeting by the QAPI COmmittee for 6 months to ensure our solutions are sustained. Quality Monitoring modified based on findings. 5. AOC: November 3, 2023	

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shaved" and she "wasn't sure" when the last time was.

An observation and interview on 09/26/23 at 11:45 AM, the Director of Nurses (DON) asked Resident #33 if he would like to be shaved and the resident shook his head yes. The DON confirmed that the resident looked like he hadn't been properly groomed in a while and stated, "We are having a grooming problem in the facility." The DON revealed when the CNAs are giving him a bed bath they should be asking if he wants to be shaved too.

A record review of Resident #33's Admission Record revealed the resident was admitted on 10/14/2016 with diagnoses that included Specified Sequelae of Cerebral Infarction, Aphasia following Nontraumatic Subarachnoid Hemorrhage, and Hemiplegia and Hemiparesis following other Cerebrovascular Disease affecting right dominant side.

Resident #57

Record review of Resident #57's ADL care plan revealed, "Focus: I have an ADL Self-care performance deficit r/t (related to) Dementia, Schizoaffective Disorder-Bipolar type, DM (Diabetes Mellitus) with Neuropathy, and Anxiety. Interventions ... Bathing/Showering: I am dependent on 1-2 staff for bathing/showering ...Personal hygiene ...I require extensive assistance and sometimes total assistance from 1 staff for personal hygiene.

An interview and observation on 09/25/23 at 11:30 AM, revealed Resident #57's facial hair was approximately ½ inch to his chin and on the sides

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of his face. Hair was approximately one (1) inch on his neck area. Resident #57 revealed he likes to be shaven and has mentioned it before to the staff, "but it doesn't do any good." He revealed he couldn't remember the last time he was shaven.

An observation and interview on 09/26/23 at 08:30 AM, revealed Resident #57 lying in bed, he remained unshaven. He revealed they said they were going to get to me today and stated " I sure hope they do."

An observation and interview on 09/26/23 at 10:50 AM, revealed Resident #57 remains unshaven. The resident revealed "they told me a while ago that they were going to come back and shave me. I'm still waiting though."

An interview and observation on 09/26/23 at 10:55 AM, with CNA #2 revealed she was assigned to the resident today and confirmed that the resident had long facial hair on his chin, cheeks, and neck, and she was supposed to do personal care which included shaving. She revealed she wasn't sure when he was last shaved since she is only part-time.

An observation and interview on 09/26/23 at 11:35 AM, the DON confirmed that Resident #57's facial hair was long, and he needed to be shaved. The DON stated that "he refuses sometimes" The Resident stated, "I don't refuse at all to be shaved they just don't offer to shave me."

A record review of Resident #57's Admission Record revealed the resident was admitted to the facility on 08/12/2021 with diagnoses that included Schizoaffective Disorder, Bipolar type,

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Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified Protein-Calorie Malnutrition, Major Depressive Disorder, and Vascular Dementia.

A record review of Resident #57's MDS revealed an ARD of 6/28/23 and in Section C a BIMS score of 10 which indicates the resident has a moderate cognitive impairment.

Resident #248

Record review of Resident #248's ADL care plan revealed, "Focus: I have an ADL self-care performance deficit r/t impaired balance, Limited mobility, Limited ROM (range of motion) due to humerus fracture, multiple pubis fractures, and hx of multiple healing rib fractures ...Interventions ...Personal Hygiene routine: I required extensive assistance x 1 staff with my personal hygiene and oral care daily and PRN ...Bathing/Showering: I am dependent on 1-2 staff assistance with my bed baths and or showers 3x week and PRN due to weakness and tremors.

An observation and interview on 09/25/23 at 03:25 PM, with Resident #248 revealed him lying in bed with facial hair approx. 1/2 inch (in) long to his chin and sides of his face. He revealed "several weeks ago a girl in therapy shaved me, I haven't been shaved since then." He revealed he hasn't "had a shower since he has been here" and he thinks if he got a shower, "it would make him feel a lot better."

Record review of Resident #248's Admission Record revealed the resident was admitted to the facility on 09/11/2023 with diagnoses that included, Parkinson's Disease, Unspecified

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WINONA MANOR HEALTH CARE AND REHABILITATION CENTER	627 MIDDLETON ROAD WINONA, MS 38967

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F 656	Continued From page 23	F 656		

Nondisplaced Fracture of Surgical Neck of Right Humerus, Muscle Weakness, and Need for assistance with personal care.

An observation and interview on 09/26/23 at 08:20 AM Resident #248 facial hair approx. 1/2 in. long to his chin and sides of his face. The resident revealed he hasn't received a shower but would like one.

An observation on 09/26/23 at 11:15 AM, revealed Resident #248 remains unshaven.

On 09/26/23 at 11:55 AM, an observation and interview of Resident #248 with the DON present revealed the resident with facial hair approximately ½ inch long to his chin, and sides of his face. He revealed he doesn't remember how long it's been since he was shaved but it was in therapy. He revealed he has not had a shower since he has been here but has only had a bed bath. The DON confirmed that the resident had long facial hair and stated, it looks like it's been a while since he was shaven. Resident #248 revealed he would like to be shaved at least every other day.

An interview on 09/26/23 at 01:18 PM, the DON revealed she believed the resident 100%, if he says he hasn't had a shower then she can guarantee he is being truthful. The DON revealed "we are having a grooming problem here in the facility. I will make sure this gets taken care of today."

A record review of Resident #248's MDS with an ARD of 09/18/23 revealed in Section C a BIMS score of 12, which indicates the resident has a moderate cognitive impairment.

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An interview on 09/27/23 at 09:16 AM, the MDS Nurse revealed she is responsible for developing the comprehensive care plan. She revealed the care plan is developed so that each resident gets the appropriate individualized care they need. She confirmed that Resident #57 and Resident #248 ADL care plans don't specify shaving, but it is part of grooming and personal hygiene. She revealed the plan of care for Resident #33, Resident #57, and Resident #248 were not being followed.

An interview on 09/27/23 at 04:54 PM, the DON revealed the purpose of a care plan is to establish a plan of care for each individual resident. She confirmed the care plans for Resident #33, Resident #57, and Resident #248 were not being followed.

Resident #32

Record review of Resident #32's Care Plan revealed the Focus: Nail Care:check nails weekly on Tuesday and PRN (as needed) and trim when necessary.

An observation on 09/25/23 at 2:05 PM, of Resident #32 revealed long fingernails that measured three-eights (3/8) inch (in.) in length with a brown substance underneath. The resident's right hand was contracted, with the fingers turned inward toward the palm.

An interview on 9/26/23 at 11:35 AM with the DON confirmed that Resident # 32's nails were long and needed cleaning and cutting.

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F 656	Continued From page 25 An interview with the MDS Nurse on 9/27/23 at 8:30 AM, confirmed that staff did not follow Resident #32's care plan for nail care. An interview with the DON on 9/27/23 at 4:55 PM, revealed that the purpose of the care plan was to establish a plan of care to provide the needed care for the resident. She confirmed that staff did not follow the care plan for Resident #32 related to nail care. Record review of the Admission Record revealed Resident #32 was admitted to the facility on 5/24/23 with medical diagnoses that included Chronic Obstructive Pulmonary Disease, Vascular Dementia, Contracture, Unspecified Joint and Personal History of Transient Ischemic Attack. Record review of the MDS with an ARD of 8/23/23 revealed, under section G, that Resident # 32 requires one-person physical assistance with personal hygiene. Section C revealed a BIMS score of 07, which indicates the resident is severely cognitively impaired.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review the facility failed to provide Activities of Daily Living (ADL) care for four (4) of 97 residents	F 677	1. Root Cause Analysis was conducted on 9/29/2023 by Quality Assurance Performance Improvement (QAPI) Committee and based on findings,	11/3/23

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F 677	Continued From page 26 observed during the initial tour related to nail care for Resident #32, and failure to shave Residents #33, #57 and #248 and provide a shower for Resident #248. Findings include: Review of the facility policy titled, "Policies and Procedures Subject: Grooming Activities", with a revision date of 3/19/19, revealed Grooming activities are provided to assist the residents in meeting their physical needs as well as self-esteem needs. 2 ...Grooming Activities shall include but are not limited to: Shaving, Applying Makeup, Combing hair, and Nail care. Resident #33 An observation, on 09/25/23 at 11:35 AM, revealed Resident #33 lying in bed. This observation revealed the resident is non-verbal but acknowledged when he was spoken to and was able to respond by shaking his head to yes or no questions. Resident #33's facial hair was approximately one-half (1/2) inch long on his chin, above his mouth, and on the sides of both cheeks. When asked if he liked the facial hair to be that long Resident #33 shook his head no. Resident #33 shook his head, yes acknowledging that he would like to be shaved. An observation, on 09/26/23 at 08:10 AM, revealed Resident #33 remained unshaven. Resident #33 nodded his head yes, acknowledging that he would like to be cleaned up and shaven. An interview and observation, on 09/26/23 at 11:25 AM with Certified Nurse Aide (CNA) #2	F 677	Activities of Daily Living (ADL) care to include nail care for resident #32, shaving for residents #33, #57, and #248 and showering for resident #248. On 9/26/2023 nail care was provided for resident @32, shaving was provided for residents #33, #57, and #248, and shower was provided for resident #248 on 9/26/2023. Quality review of current residents on 9/26/2023 by Director of Clinical Services and Assistant Director of Clinical Services to ensure residents are provided Activities of Daily Living (ADL) care to include shaving, nail care, and showers. 2. All residents have the potential to be affected by this deficient practice. 3. Education with CNAs and Licensed Nurses initiated on 9/26/2023 by Director of Clinical Services on this regulation to ensure all dependent residents are provided Activities of Daily Living (ADL) care. 4. Beginning on 10/2/2023, Quality Monitoring of Activities of Daily Living (ADL) to include nail care, shaving, showers and grooming for 5 dependent residents to be conducted by Director of Clinical Services and Assistant Director of Clinical Services 3x/weekly X 4 weeks, then 2x weekly X 4 weeks, then monthly X 3 months. Findings will be reported monthly by the Director of Clinical Services X 6 months to Quality Assurance Improvement (QAPI) Committee. On 10/31/2023, we will conduct a QAPI to review findings from the Quality Monitoring. The QAPI Committee will meet on the first Friday of each month X 6	

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F 677	Continued From page 27 revealed she was assigned to Resident #33 and he got a bed bath today. An observation of Resident #33 lying in bed revealed the resident remained unshaven. CNA #2 revealed she didn't give him a full bed bath, she only did peri-care. CNA #2 revealed she wasn't sure if she was supposed to shave him or not, but that shaving was part of grooming. CNA #2 confirmed that the resident's facial hair was long, and he needed to be shaved. When Resident #33 was asked if he would like to be shaved, the resident shook his head yes. An interview and observation, on 09/26/23 at 11:30 AM, with CNA #1 revealed a shower or bed bath consist of haircare and shaving the men. CNA #1 asked Resident #33 if he would like to be shaved, and he shook his head yes while touching his face. CNA #1 confirmed that it "looked like it had been a long time" since he was shaved, and she wasn't sure when the last time was. An observation and interview, on 09/26/23 at 11:45 AM, with the Director of Nurses (DON) confirmed Resident #33 would like to be shaved. The DON confirmed that the resident looked like he hadn't been properly groomed in a while and stated, "We are having a grooming problem in the facility." The DON revealed when the CNAs are giving him a bed bath they should be asking if he wants to be shaved too. A record review of Resident #33's Admission Record revealed the resident was admitted on 10/14/2016 with diagnoses that included Specified Sequelae of Cerebral Infarction, Aphasia following nontraumatic subarachnoid hemorrhage, and Hemiplegia and Hemiparesis	F 677	months to ensure solutions are sustained. 5. AOC: November 3, 2023	

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following other Cerebrovascular Disease affecting right dominant side.

Resident #57

An observation and interview, on 09/25/23 at 11:30 AM, revealed Resident #57's facial hair was approximately ½ inch long on his chin and sides of his face and approximately one (1) inch long on his neck area. Resident #57 revealed he likes to be shaven and has mentioned it before to the staff, "but it doesn't do any good." He revealed he couldn't remember the last time he was shaved.

An observation and interview, on 09/26/23 at 08:30 AM, revealed Resident #57 remained unshaven. He stated they (the staff) said they were going to get to him today. He stated, "I sure hope they do."

An observation and interview, on 09/26/23 at 10:50 AM, revealed Resident #57 remained unshaven. The resident stated, "They told me a while ago that they were going to come back and shave me. I'm still waiting though."

An interview and observation, on 09/26/23 at 10:55 AM, with CNA #2 revealed she was assigned to Resident #57 today and confirmed that the resident had long facial hair on his chin, cheeks, and neck, and she was supposed to do personal care which included shaving. CNA #2 revealed she wasn't sure when he was last shaved because she was only part time.

An observation and interview, on 09/26/23 at 11:35 AM, the DON confirmed that Resident #57's facial hair was long, and he needed to be shaved. The DON stated that "he refuses

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sometimes." Resident #57 stated, "I don't refuse at all to be shaved they just don't offer to shave me."

A record review of Resident #57's Admission Record revealed the resident was admitted to the facility on 08/12/2021 with diagnoses that included Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified Protein-Calorie malnutrition and Vascular Dementia.

A record review of the MDS with an ARD of 6/28/23 revealed, in Section C, a BIMS score of 10 which indicated Resident #57 had moderate cognitive impairment.

Resident #248

An observation and interview, on 09/25/23 at 03:25 PM, revealed Resident #248 lying in bed with facial hair approximately 1/2 inch long on his chin and the sides of his face. He revealed several weeks ago a girl in therapy shaved him, but he has not been shaved since then. He revealed he hasn't "had a shower since he has been here" and he thinks if he got a shower, it would make him "feel a lot better."

Record review of Resident #248's Admission Record revealed the resident was admitted to the facility on 09/11/2023 with diagnoses that included, Parkinson's disease, unspecified Nondisplaced Fracture of surgical neck of right humerus, Muscle weakness, and need for assistance with personal care.

An observation and interview, on 09/26/23 at 08:20 AM, with Resident #248 revealed facial hair that was approximately 1/2 in. long on his chin

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and on the sides of his face. The resident revealed he
"still haven't received a shower, but would like one."

An observation, on 09/26/23 at 11:15 AM,revealed Resident #248 remains unshaven.

On 09/26/23 at 11:55 AM, an observation and interview with the DON confirmed Resident #248 had facial hair approximately ½ inch long on his chin, and on the side of his face. He revealed he doesn't remember how long it's been since he was shaved, "but it was in therapy." He revealed he has not had a shower since he has been here but has only had a bed bath. The DON confirmed that the resident had long facial hair and stated, "It looks like it's been a while since he was shaven." Resident #248 revealed he would like to be shaved at least every other day.

An interview, on 09/26/23 at 01:18 PM, with the DON revealed she believed the resident 100%. She stated, "If he says he hasn't had a shower, then I can guarantee he is being truthful." The DON revealed they were having a grooming problem in the facility and would make sure this gets taken care of today.

A record review of Resident #248's MDS with an ARD of 09/18/23 revealed in Section C a BIMS score of 12, which indicated the resident had moderate cognitive impairment.

Resident #32

An observation, on 09/25/23 at 2:05 PM, of Resident #32 revealed long fingernails that

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F 677	Continued From page 31 measured three-eights (3/8) inch in length with a brown substance underneath. The resident revealed he would like to have his nails cut. An interview and observation on 9/26/23 at 11:30 AM, with Certified Nurse Aide (CNA) #3 confirmed that Resident #32's nails were long and needed cleaning and clipping. She revealed that the long nails could cause skin concerns. She revealed that the aides were responsible for cleaning the nails when needed. Furthermore, she revealed they could also trim the nails if the resident was not a diabetic. An interview, on 9/26/23 at 11:35 AM, with the DON confirmed that Resident #32's nails were long and needed cleaning and cutting. She confirmed that the long nails could result in skin concerns. She revealed the aides were responsible for cleaning and trimming the residents' nails, since he was not a diabetic. Record review of the Admission Record revealed Resident #32 was admitted to the facility on 5/24/23 with medical diagnoses that included Chronic Obstructive Pulmonary Disease, Vascular Dementia and Personal History of Transient Ischemic Attack. Record review of the MDS with an ARD of 8/23/23 revealed, under section G, that Resident #32 requires one-person physical assistance with personal hygiene. Section C revealed , a BIMS score of 07, which indicates the resident is severely cognitively impaired.	F 677		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		11/3/23

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F 761	Continued From page 32 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, resident/staff interview, record review, and facility policy review the facility failed to ensure medications were not left in the resident's room for one (1) of 28 sampled residents. Resident #4. Findings include: A review of the facility policy, titled "5.3 Storage and Expiration Dating of Medications Biologicals" with a revision date of 08/07/23 revealed. Applicability: This Policy 5.3 sets forth the	F 761	1. Root Cause Analysis was conducted on 9/29/2023 by Quality Assurance Performance Improvement (QAPI) Committee and based on findings medication was left in resident #4 room on his bedside table in a cup. On 9/25/2023, medicaitn was removed from resident #4 room. 2. All residents have the potential to be affected by this alleged deficient practice. 3. Education was initiated on 9/26/2023 with Licensed Nurses on this regulation to	

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F 761	Continued From page 33 procedures relating to the storage and expiration dates of medications, biologicals. syringes and needles.... Procedure:... 3.3; Facility should ensure that all medications and biologicals, including treatment items are securely stored in a locked cabinet/cart or locked medication room that is inaccessible to residents and visitors... #13 Bedside Medication Storage:13.1 - Facility should not administer/provide bedside medications or biologicals without a Physician/Prescriber order and approval by the Interdisciplinary Care Team and Facility administration.13.2 Facility should store bedside medications or biologicals in a locked compartment within the resident's room..." An observation and interview, on 09/25/23 at 01:58 PM, revealed a Ventolin Inhaler and a Trelegy Ellipta inhaler sitting on the overbed table inside a styrofoam cup. The Resident confirmed that he uses the inhalers himself. Resident #4 confirmed that he uses the Trelegy Ellipta Inhaler one time a day and that he uses the Ventolin Inhaler sometimes two times a day and sometimes he doesn't use it at all. A record review, for Resident #4 revealed there was no self administration medication assessment, physician orders, or care plan for self-administration of medication. An interview, on 09/26/23 at 01:40 PM, with Licensed Practical Nurse (LPN)#1 confirmed that there was a Trelegy Ellipta Inhaler and a Ventolin Inhaler inside of a styrofoam cup sitting on Resident #4 overbed table and that "it's not supposed to be there." An interview, on 09/26/23 at 02:00 PM, with Registered Nurse (RN)#1 confirmed there was a	F 761	ensure medication is not left at the bedside unless the resident is deemed appropriate to self administer their medication and if so, a locked box must be provided to the resident. 4. Beginning on 10/2/2023, Director of Clinical Services and Assistant Director of Clinical Services will conduct Quality Monitoring on 10 residents 4x/weekly X 4 weeks, then 3x/weekly X 4 weeks, then 2x/weekly X 4 weeks, then weekly X 4 weeks to ensure medication is not left in resident's room unless they have been deemed safe to self administer their medications. Findings will be reported by Director of Clinical Services monthly X 6 months to Quality Assurance Performance Improvement (QAPI) Committee. On 10/31/2023, we will conduct QAPI to review findings from the Quality Monitoring by the QAPI Committee for 6 months to ensure our solutions are sustained. Quality Monitoring schedule will be modified based on findings. 5. AOC: November 3, 2023	

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Trelegy Ellipta inhaler and a Ventolin inhaler inside of a styrofoam cup sitting on Resident #4's overbed table and that it's not supposed to be there. RN #1 confirmed that Resident #4 "had not been assessed for self-administration of medication." RN#1 confirmed that the Trelegy Ellipta inhaler is scheduled to be given at 09:00 AM daily. RN #1 confirmed that the Trelegy Ellipta Inhaler has only been signed off as given five times this month on the Medication Administration Record (MAR), and if it isn't documented as being given that it was not done. RN #1 confirmed that inhaler is being given after 03:00 PM when the Respiratory Therapist comes in. RN#1 confirmed that the order for the Trelegy Ellipta inhaler order that is scheduled for 09:00 AM should have been changed to reflect a new time, to be given after 03:00 PM but has not been changed, and that the inhalers should be locked in medication cart until medication is given. RN#1 confirmed that if a resident wandered into Resident #4's room they could get the medication and cause harm to themselves, and that Resident #4 could possibly "take too much medication."

An interview, on 09/26/23 at 03:00 PM, with the Director of Nursing (DON) confirmed that the inhalers should be locked inside medication carts and that nurse should be administering them and that the "nurses should have noticed the medication Resident #4 room."

A review of the Admission Record for Resident #4 revealed that he was admitted to the facility on 03/09/20 with a diagnosis of Cerebral Infarction, Chronic Obstructive Pulmonary Disease, Hypertension, and Type Two Diabetes.

A review of the Minimum Data Set (MDS) with an

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F 761	Continued From page 35 Assessment Reference Date (ARD) of 09/12/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #4 was cognitively intact.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		11/3/23

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F 880	Continued From page 36 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility policy review, the facility failed to prevent the possibility of the spread of infection as evidenced by, missing biohazard containers in one (1) of nine (9) transmission based precaution rooms,	F 880	1. Root Cause Analysis was conducted on 9/29/2023 by Quality Assurance Improvement (QAPI) Committee and based on findings, biohazard container was not placed in resident #54 room,	

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F 880	Continued From page 37 failure to disinfect rooms that required specialized cleaning and appropriate chemicals related to a specific organism for three (3) of nine (9) resident rooms, allowing a urinary catheter bag to lie on the floor, attempting to use contaminated oxygen tubing from the floor on a tracheostomy humidifier and attempting to use a soiled washcloth during catheter care for one (1) of six (6) care observations. Resident #8, #54, #75 and #81. Findings include: Review of the facility policy titled, "Isolation-Initiating Transmission-Based Precautions" with a revised date of August 2019, revealed 3 ...When Transmission-Based Precautions are implemented, the Infection Preventionist (or designee): f. Ensures that protective equipment and supplies needed to maintain precautions during care are in the resident's room; and g. Ensures that an appropriate linen barrel/hamper and waste container, with appropriate liner, are placed in or near the resident's room. Record review of facility's "Policies and Procedures Subject: Catheter Care, Urinary", dated 9/5/17, revealed, "Wash perineal area with soap and water from front to back. Rinse well and dry." Record review of the facility policy titled "Contaminated Isolation Room Cleaning" with a revision date of 10/25/16 revealed, under, "B. Enter the Isolation Room - To protect the facility from the patient, every effort is made to keep the bacteria in the room and isolated in the double bag procedure along with using the EPA	F 880	residents #54, #75, and #81, room not disinfected with specialized cleaning and appropriate chemicals related to a specific organism, resident #8, catheter touching the floor, using soiled washcloth, and attempting to replace contaminated oxygen tubing on tracheostomy humidifier. On 9/26/2023, catheter was secured to bed to prevent touching the floor, soiled washcloth was discarded, Respiratory Therapist replaced oxygen tubing on tracheostomy humidifier. On 9/25/2023, red barrels were placed in resident #54 room by Unit Manager. On 9/27/2023, Director of Clinical Services at local hospital supplied facility with cleanser appropriate for a specific organism. 2. All residents have the potential to be affected by this alleged deficient practice. 3. Education initiated on 9/27/2023 by the Director of Clinical Services with Certified Nurse Assistant and Licensed Nurses on this regulation to ensure infection control is maintained in the facility to prevent the possibility of the spread of infection. CNA's were educated on 9/27/2023 catheter bags not touching the floor, proper cleaning techniques concerning the disposal of soiled wash cloths, education on notifying Licensed nurses when O2 tubing needs placed on residents. 4. Beginning on 10/2/2023, Director of Clinical Services and Assistant Director of Nursing will conduct Quality Monitoring of residents with catheters to ensure bags are not touching the floor, residents on isolation with appropriate supplies. Beginning 10/2/2023, Catheter care	

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F 880	Continued From page 38 approved solution... Record review of facility's letterhead revealed, "This facility does not have a policy on positioning and placement of catheter bags." An interview, with Licensed Practical Nurse (LPN) #3 on 9/25/23 at 11:04 AM, revealed Resident #8 was in contact isolation due to testing positive for Candida Auris. During an observation and interview with Certified Nursing Assistant (CNA) #7 and LPN #3, on 9/26/23 at 9:08 AM, revealed Resident #8's catheter bag was attached to the side of the bed, but the bottom third of the bag was touching the floor. CNA) #7 confirmed the catheter bag for Resident #8 was on the floor and stated "that just happens when the bed is low". LPN #3 revealed the urinary catheter bag was not to touch the floor even if the bed was in low position. She confirmed this was an infection control concern that could lead to an infection to the resident. During an interview on 9/26/23 at 2:55 PM, the Director of Nursing stated Resident #8 was admitted to the facility on 8/14/23, and was diagnosed with Candida Auris prior to admission and was placed in contact isolation on admission. During an observation and interview on 9/27/23 at 10:00 AM, with CNA #4, revealed her gathering her linen and other supplies and donned her Personal Protective Equipment (PPE) since Resident #8 was in contact isolation. She obtained her soapy cleansing solution in one basin and water in another basin for her perineal/catheter care and preceded with the resident's care. She cleaned the groin area and	F 880	competency of 5 Certified Nurse Assistants 3 times weekly X 4 weeks, then 2 times weekly X 3 weeks, then once weekly X 2 weeks. Findings will be reported by the Director of Clinical Services monthly X 6 months to Quality Assurance Improvement (QAPI) Committee. On 10/31/2023, we will conduct a QAPI to review findings from the Quality Monitoring on the first Friday of each month during the QAPI meeting by the QAPI Committee to ensure our solutions are sustained. Quality Monitoring schedule will be modified based on findings. 5. AOC: November 3, 2023	

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stool was still noted to be on the washcloth. She proceeded to rinse, even though stool was still being obtained on the cloth. During the care, she noted that the resident's oxygen tubing was disconnected from the tracheostomy (trach) humidifier tubing/collar and the oxygen tubing was on the floor, so she picked the tubing up off of the floor (with dirty gloves still in place) and began to reach for trach humidifier collar tubing to reattach. The SA stopped her at this point and requested she get Respiratory Therapy to change the tubing and not place a tubing that was on the floor onto the resident's trach humidifier mist/trach collar. She then acknowledged that this could lead to an infection for the resident. Respiratory Therapy came into room and replaced oxygen tubing and repositioned the resident's head into a comfortable position. CNA #4 resumed catheter care. While providing care, she reached into the soiled linen red bag and removed a previously used wash cloth and placed it in the soapy water basin and approached the resident. SA once again stopped her and told her that cloth was from the dirty linen bag. She stated "Oh no, I grabbed the wrong one". She confirmed this was a major infection control risk. She emptied the basin and got a clean basin and proceeded to make the warm soapy solution. Then once again she proceeded with care and completed care without other incident. After the catheter care, CNA #4 confirmed she "messed up" with infection control concerns. She stated she knows what to do, but she was nervous and was not thinking it through. She stated good infection control is needed to protect the residents and to keep germs from spreading to others.

During an interview on 9/27/23 at 10:40 AM, the Director of Nursing (DON) confirmed the facility

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failed to prevent the likelihood of the spread of infection by not using appropriate infection control measures during a resident's catheter care.

During an interview on 9/27/23 at 2:50 PM, the DON confirmed the cleanser for room disinfectant used by the facility did not cover the Candida Auris organism, therefore, there was a risk of spreading the infection to others.

Record review of Resident #8's Laboratory Services document dated 6/27/23 revealed the results of the axilla and groin swab for resident detected Canada Auris Deoxyribonucleic acid (DNA) detected.

Record review of Order Summary Report Physician's Order for Resident #8 dated 8/28/23, revealed with indwelling catheter and assess for catheter care every shift and as needed by Certified Nursing Assistant.

Record review of Order Summary Report for Resident #8 revealed an order dated 8/14/23 for contact isolation due to Candida Auris.

Record review of letter from the Director of Nursing, undated, revealed, "(Proper name of Resident #8) was admitted on 7/3/23 to our facility. She admitted with a diagnosis of Candida Auris. She was immediately placed on Transmission Based Precautions with all measures put in place. However, the isolation order was not entered/transcribed until 8/14/23. Staff has implemented all TBP (Transmission Based Precautions) since admission".

Record review of Admission Record for Resident #8 revealed the resident was admitted to the

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facility on 7/28/23 with diagnoses which included Nontraumatic Intracerebral Hemorrhage, Tracheostomy, Type 2 Diabetes Mellitus, Stage 3 Pressure Ulcer to Sacral Region, Gastrostomy Status.

Record review of Resident #8's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/31/23 revealed in Section C, Resident #8 was rarely or never understood which indicated the resident was severely cognitively impaired.

Resident #54

An observation on 09/25/23 at 10:40 AM, revealed an isolation cart outside of room Resident #54's room. There were no red barrels for disposal of linen and trash in the resident's room.

An interview with LPN #3 on 9/25/23 at 10:40 AM, revealed Resident #54 was ordered to be in contact isolation for Carbapenem Resistant Acinetobacter Baumannii (CRAB). She confirmed this resident needed red barrels in the room for disposal of used linen and trash and this resident did not have these available in his room. She stated the proper disposal of trash and proper handling of linen was needed to prevent the spread of infections. She stated she had not noticed the barrels were missing from this room and she was unsure how the staff were disposing of these items.

During an interview on 9/27/23 at 2:55 PM, the DON confirmed the facility failed to ensure the proper handling of the used linen and trash of a resident in contact isolation. She confirmed for

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effective infection control, it is necessary to have the proper supplies available to decrease the likelihood of the spread of infection and the facility failed to do this. She stated red barrels in the rooms were required for residents in contact isolation and she was unsure why these were not in this resident's room, but that they could have been removed for a newly diagnosed Covid-19 positive resident.

Record review of Resident #54's Order Summary Report Physician's Order dated 1/12/23 revealed an order for "Isolation: Contact - CRAB - All care/medications provided in room every shift for Carbapenem Resistant Acinetobacter Baumannii".

Record review of Interdisciplinary Progress Notes, undated, revealed, "Received CRAB results 11/22/22 on (proper name of Resident #54) results positive and resident was immediately placed on transmission based precautions".

Record review of Resident #54's Admission Record revealed the resident was originally admitted to the facility on 12/4/20 with diagnoses that included Nontraumatic Subarachnoid Hemorrhage from Unspecified Intracranial Artery.

Record review of the MDS with an ARD of 8/14/23 revealed in Section C, Resident #54 was "rarely or never understood" which indicated the resident was severely cognitively impaired.

An observation on 09/26/23 at 09:15 AM, outside Resident #81's room, revealed an isolation cart with personal protective equipment (PPE) inside.

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A small magnetic sign was attached to the outer casing of the doorway that read, "Contact Precautions."

An interview on 9/26/23 at 9:30 AM with LPN #2 revealed that Resident #81 was in contact isolation for Candida Auris. She revealed that staff must dress out in a gown and gloves to provide care and perform handwashing or hand sanitizer before and after care.

An interview on 9/26/23 at 10:55 AM with Housekeeping #1 revealed that she used the cleaning solution "Virex Plus" to clean the surfaces and room of Resident #81 that was on contact isolation. She revealed she sprayed down the surfaces of the room including knobs, tables, side rails, bed (all surfaces) with the cleaning solution and allowed it to sit five (5) minutes before wiping it down with a clean cloth.

An interview, with the DON on 9/26/23 at 3:30 PM revealed all residents currently with a diagnosis of Candida Auris were admitted into the facility with the organism Candida Auris (C. Auris). She revealed that none of the residents have had any symptoms, and they have not had any other cases spread inside the facility. She revealed the residents were placed on contact isolation when admitted from the hospital.

An interview, with the DON on 9/26/23 at 4:45 PM, revealed that she had reached out to the Environmental Regional Manager and the Virex Plus solution was not effective against the organism, Candida Auris. She revealed that they had Sani-Cloth Germicidal Wipes at the facility that could be used for now. She confirmed that the facility had not been using the Sani-Cloth

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wipes and that cleaning with a disinfectant (Virex Plus) that was not effective against the organism could lead to the spread of the infection. She revealed the facility had not had any in-house outbreaks of C.Auris.

An interview, with Housekeeping #2 on 9/27/23 at 8:45 AM revealed she used the Virex Plus for disinfecting the isolation rooms and allowed a 5-minute wait time for room surfaces and then wiped it down.

An interview, with Housekeeping #3 on 9/27/23 at 9:05 AM revealed she sprayed the Virex Plus solution onto a cloth and wiped down all the surfaces of the room.

An interview with the Environmental District Manager on 9/27/23 at 9:25 AM, confirmed that the Virex Plus solution was not effective against the organism Candida Auris (C. Auris). He revealed that he was not made aware that the facility had C. Auris in the building until yesterday, when this State Agent (SA) requested the Safety Data Sheet on Virex Plus. He revealed he was not sure who at the facility was responsible for reaching out to him to ensure the effective disinfectant was in the facility and being used. He revealed the facility could use the Sani-Hands and use bleach to mop. He confirmed that not cleaning with an ineffective disinfectant could lead to the spread of infection inside the facility.

An interview with the Administrator (ADM) on 9/27/23 at 9:40 AM, revealed that she had been working at the facility for three (3) weeks and was not aware of the residents residing at the facility with C. Auris until yesterday. She acknowledged that using an ineffective disinfecting cleaner could

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lead to the spread of infection.

An interview with the DON on 9/27/23 at 4:50 PM, revealed that she would have been the person responsible for contacting the Environmental District Manager to ensure that the facility cleaning/disinfecting products used were effective against C. Auris. She confirmed that ineffective cleaning products could lead to the spread of infection.

An interview with the Mississippi State Department of Health (MSDH) Epidemiology Division on 9/28/23 at 8:15 AM, with Pharmacist #1 regarding the facility use of Virex Plus for the organism Candida Auris revealed that Virex Plus does not kill the Candida Auris organism.

Record review of the "Education In-service Attendance Record" revealed a training session was conducted on 8/10/23 regarding "C. Auris -isolation" and revealed under, "Candida auris Positive ... All disinfection should be completed with an Environmental Protection Agency (EPA) registered disinfectant effective against Candida auris (List P). ..."

Record review of the "Infection Control Log" from the dates of 1/01/23 through 9/27/23 revealed that Resident #81 was admitted to the facility with Candida Auris on 1/19/23.

Record review of the Admission Record revealed that Resident #81 was admitted to the facility on 1/19/23 with medical diagnoses that included Metabolic Encephalopathy, Type 1 Diabetes Mellitus with Hyperglycemia and Generalized Anxiety Disorder.

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F 880	Continued From page 46 Record review of the MDS an ARD of 7/12/23 revealed under section C, a Brief Interview for Mental Status (BIMS) score was not conducted due to Resident #81 is rarely/never understood.	F 880		