STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255109	A. BUILDING _____ B. WING _____	11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF SOUTHAVEN	1730 DORCHESTER DR SOUTHAVEN, MS 38671

(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 and a complaint investigation (CI MS #22673) at the facility from 10/30/23 through 11/2/23. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F558, F580, F656, F688, F689, F812 and F880. The SA found the facility was not in compliance related to (CI MS # 22673) enviroment and Activities of Daily Living and cited F677 and F921. The census at the time of the survey was 125 and the facility was licensed for 140 beds.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review, and facility policy review, the facility failed to ensure a resident's call light was placed within reach as evidenced by the call light laying on the floor not in reach of the resident for (1) one of 26 sampled residents, Resident #102. Findings include: A review of the facility policy titled, "Call Lights: Accessibility and Timely Response," revealed	F 558	F558 1. Resident #102□s Call light was placed within reach of the resident on 10/30/2023 by certified nursing assistant and assisted with toileting. Resident #102 was assessed by the Director of Nursing on 10/30/2023 with no negative outcome was observed. 2. All residents using call lights have the potential to be affected by this deficient practice. All residents were reviewed by	11/27/23

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

Electronically Signed | 11/22/2023

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F 558	Continued From page 1 Policy Explanation and Compliance Guidelines: 6.) "The call system will be accessible to residents while in bed or other sleeping accommodations within the resident's room." ... During initial tour rounds on 10/30/23 at 10:29 AM, the State Survey Agency (SA) heard a resident state loudly, "I have to go to the bathroom right now right now. Hurry before I wet this bed." The SA entered the resident's room and observed Resident #102's call light lying on the floor underneath the bed. Resident #102 stated inablity to call for assistance due to the call light not being reach. On 10/30/23 at 10:31 AM, Certified Nurse Assistant (CNA) #3 entered Resident #102's room and confirmed the call light was under the bed on the floor. CNA #3 stated that Resident #102 was unable to use the call light. CNA #3 handed Resident #102 the call light and Resident #102 immediately pushed the call light. CNA #3 confirmed Resident #102's call light should be in reach at all times to alert alert staff of needing help. An interview with the Administrator on 10/30/23 at 10:45 AM confirmed all call lights should be in reach of residents and call lights not being in place may delay care. Record review of the Admission Record revealed that the facility admitted Resident #102 on 12/06/22 with diagnoses of Adult Failure to Thrive and Cerebral Infarction. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 9/28/23, revealed Resident #102 had a	F 558	the Director of Nursing on 11/03/23 to ensure call lights were within reach of all residents. 3. To ensure the deficient practice does not reoccur, on 11/6/2023 the Director of Clinical Education provided an in-service for staff on ensuring call lights are within reach of all residents. 4. To monitor the performance of our corrective action and to ensure sustainability, the Unit Manager or Charge Nurse will audit all residents 5 days a week for 8 weeks, then weekly for 4 weeks starting 11/6/2023 to ensure their call lights are within reach. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of three months by the Director of Nursing for review and revision as necessary. The Quality Assurance Performance Improvement Committee will review the findings and determine if there is a need to alter our corrective action. Our November 2023 Quality Assurance Performance Improvement meeting will be held on 11/27/2023.	

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F 558	Continued From page 2 Brief Interview of Mental Status (BIMS) score of 06 which indicated that the resident was severely cognitively impaired.	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph	F 580		11/27/23

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F 580	Continued From page 3 (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the resident's physician of an elevated blood sugar of 466 for (1) one of 26 sampled residents reviewed for provider notification of change in condition. Resident # 15 Findings include: A record review of the facility's "Acute Management: Diabetic Resident" protocol, with no onset date, revealed to communicate with resident's provider if resident's blood glucose level was greater than or equal to 300. A record review of Resident #15's "Blood Sugar Summary" and Medication Administration Record (MAR) for October revealed that on 10/26/23 at 5:27 AM the resident's blood sugar was 466. A record review of Resident #15's progress notes for 10/26/23 through 10/27/23 revealed that there was no documentation that the resident's	F 580	1. Resident #15 was assessed upon notification of increased blood sugar on 10/31/2023. Resident did not have any adverse effects from the Blood Sugar level. Nurse Practitioner was notified and assessed resident with no negative findings on 10/31/2023. On 11/21/2023 the licensed practical nurse that failed to notify the physician of the elevated blood sugar for resident #15 was in-serviced on following the center□s Diabetic Management guideline related to notification of change requirements with blood sugar parameters. 2. All residents with diabetes have the potential to be affected by this negative practice. The Director of Clinical Operations reviewed the residents with diabetics and determined there were no other residents affected by this deficient practice on November 13, 2023. 3. To ensure the deficient practice does	

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F 580	Continued From page 4 physician was notified of the 466 blood sugar result. During an interview with Licensed Practical Nurse #1 (LPN) on 10/31/23 at 8:00 AM, LPN #1 stated that the Nurse Practitioner (NP) should be notified for a blood sugar over 400; and there should be documentation in the progress notes that the NP was notified, and any new orders received. She stated the facility has a standing order of blood sugar parameters for NP. She stated that the standing order should be on the MAR. During a record review of the October MAR, LPN #1 verified that there was no standing order on the MAR for NP notification of blood sugars. During an interview with the Director of Nursing (DON), on 10/ 31/23 at 11:15 AM, the DON stated that the resident should have blood sugar notification parameters ordered and the nurse should notify the NP based on the parameters ordered. During an interview with the DON, on 10/ 31/23 at 2:20 PM, the DON verified that in the absence of ordered blood sugar parameters, LPN #3 should have followed the Acute Management: Diabetic Resident protocol for a resident and notified the NP of the resident's blood sugar of 466. During a telephone interview on 10/31/23 at 3:19 PM, with the NP she stated that this particular resident's blood sugars are a little different, as she is usually non-compliant with her diet, but that at the time of the 466 blood sugar the resident was being treated for a urinary tract infection (UTI) and she would expect the nurse to notify her. She stated she was not notified of the blood	F 580	not reoccur, on 11/03/2023, the Senior Director of Clinical Services reviewed the center□s Diabetic Management guideline and verified the parameters and reporting requirements for a hyperglycemic resident listed in this guideline were consistent with the American Diabetic Association recommendations. On 11/1/2023 the Director of Clinical Education provided an in-service for Licensed Nurses regarding the facility□s Diabetic Management protocol and with a focus on the need to notify either the Nurse Practitioners or Physicians if a resident□s blood sugar is outside the guideline parameters. 4. To monitor the performance of our corrective action and to ensure sustainability, the Director of Nursing or Assistant Director of Nursing will audit resident blood sugars 5 days a week for eight (8) weeks and then weekly for 4 weeks starting on 11/6/2023. Any negative findings will be addressed immediately. Findings of audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing Home Administrator for review and interventions as necessary beginning with November Quality Assurance Performance Improvement Committee Meeting on 11/27/2023.	

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F 580	Continued From page 5 sugar results for Resident # 15. During a telephone interview on 11/1/23 at 11:34 AM, with LPN #3 she stated that she did not notify the NP of the Resident # 15's blood sugar of 466. LPN #3 agreed that untreated blood sugar of 466 could delay resolution of the resident's UTI. During an interview with the DON on 11/1/23 at 2:25 PM, the DON agreed that failure to notify the NP of the resident's blood sugar for treatment changes could affect the resident. A record review of Resident #15's Admission Record revealed that she was readmitted to the facility on 9/15/2022. Resident #15's active diagnoses include Type 2 Diabetes Mellitus and Urinary Tract Infection.	F 580		
F 656 SS=G	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 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	F 656		11/27/23

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F 656	Continued From page 6 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. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review, and facility policy review, the facility failed to develop/implement care plans for (2) two residents related to shaving Resident #90 and Resident #173; failed to ensure a call light was in reach of (1) one resident, Resident #102; failed to consult a physician for medication changes for (1) resident, Resident #15; and failed to apply a splint for (1) one of (4) four residents reviewed with assistive devices, Resident #108; for a total of	F 656	1. Resident #90 was shaved by assigned certified nursing assistant on 11/1/2023. On 11/8/2023, resident #90□s care plan was updated to reflect shaving. This resident was assessed by the Director of Nursing on 11/1/2023 and no negative outcome was noted for this resident. Resident #173 was discharged from	

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F 656	Continued From page 7 five (5) residents out of 26 sampled residents. Findings include: A review of the policy titled, "Comprehensive Care Plans," revealed Policy: "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." Resident #90 An observation on 10/30/23 at 11:25 AM revealed Resident #90 in wheelchair with long facial hair. Resident #90 stated he wanted to be shaved. An observation and interview on 10/31/23 at 4:38 PM with Resident #90 and Licensed Practical Nurse (LPN) #4, LPN #4 confirmed the resident stated he wanted to be shaved. Resident #90 stated he tried his best about a week ago to do it himself but just couldn't. An interview, on 11/1/23 at 11:30 AM with CNA #4 revealed that she was assigned to Resident #90 this morning. She stated that residents should be shaved on their shower days or as needed unless they refuse. She stated that when she saw Resident #90 this morning the hair on his face was "ridiculous" and that she shaved him first thing this morning. Review of the Admission Record resident information form revealed Resident #90 was admitted to the facility on 5/26/23 with diagnoses	F 656	facility on 10/31/2023 and we were unable to update his plan of care. Resident #102□s Call light was placed within reach of the resident on 10/30/2023 by certified nursing assistant as addressed in the resident□s care plan. Resident #102 was assessed by the Director of Nursing on 10/30/2023 and no negative outcome was noted for this resident. Resident #15 was assessed upon notification of increased blood sugar on October 31, 2023, by the Nurse Practitioner. Resident #15 did not have any adverse effects from the elevated Blood Sugar level. The Nurse Practitioner reviewed the resident□s treatment plan including the diabetic orders. On October 31, 2023, the Director of Nursing ensured that Diabetic Management protocol parameters were in place in accordance with out Diabetic Management guidelines for Resident #15. Resident #109□s hand was assessed on 11/1/2023 by the Director of Nursing. The resident□s hand was cleaned, and the Carrot (hand roll) was placed in her hand. The Nurse Practitioner was notified and visited 11/1/2023 Resident #109 to assess the affected hand. Resident #109 was referred on 10/31/2023 to Occupational therapy for evaluation and treatment. Resident #109□s care plan was reviewed and updated as needed at this time.	

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F 656	Continued From page 8 that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting left dominate side, Anxiety disorder, Restlessness and Agitation, and Anemia. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/29/23 revealed a Brief Review for Mental Status (BIMS) score of 12 which indicated Resident #90 had moderate cognitive impairment. Resident #173 An observation, on 10/30/23 at 1:20 PM revealed Resident #173 in bed, verbally unresponsive. Resident #173's spouse was at the bedside. She stated he has not been shaved since he was admitted. She stated the staff has not offered to shave him. Resident #173's spouse stated in the past Resident #173 always shaved his face except for a mustache. An interview, on 10/31/23 at 8:15 AM with the Director of Nursing (DON) revealed the staff should offer to shave residents, this was part of the resident's daily care. An interview, on 11/01/23 at 11:29 AM with Certified Nursing Assistant (CNA) #1 revealed when they give the residents a bath or shower, they should shave them if they have hair on their face. An interview, with the Licensed Practical Nurse (LPN) Minimum Data Set (MDS) nurse confirmed Resident #90 nor Resident #173 had an Activities of Daily Living (ADL) care plan for shaving. She stated that she thought everyone should know that shaving should be a part of bathing or	F 656	2. All residents who require shaving have the potential to be affected by this deficient practice. All residents have the potential to be affected by failing to keep the call light within reach. All residents who require a Carrot (hand roll) in their hands have the potential to be affected by this deficient practice. All residents were reviewed by the Director of Nursing on 11/03/2023 to ensure call lights were within reach of all residents. All residents were checked by the Unit Manager on 11/3/2023 to ensure if they needed shaved or assistance with shaving assistance it was provided. The Director of Clinical Operations reviewed all diabetics to assure that no other resident was affected by the negative practice on 11/13/2023. On 10/31/2023 all residents who required the use of a carrot was reviewed to ensure the carrots was in place by the Director Of Nursing. No Negative findings were found. 3. To ensure the deficient practice does not recur, The Director of Nursing or the Director of Clinical Operation will review all the residents care plans that require shaving by 11/21/2023 to ensure that shaving is added to their plan of care. The Administrator starting 11/3/2023 will assure that rounds are made throughout the day to assure that call bells are with in reach of each resident. The Director of Nurses, Assistant Director or Nurse or Unit Manager will round throughout the day to assure that resident who have orders for the use of a Carrot, have the	

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F 656	Continued From page 9 showering. She confirmed it should be part of the care plan. The purpose of the care plan was to let staff know what care the resident should get. An interview on 11/02/23 at 8:57 AM with the DON revealed that care plans should be in place for resident's ADL care and stated the care plan should be in place to make sure appropriate care is provided to the residents and the care plan is the staffs' communication tool for resident care. Review of the Admission Record resident information form revealed the facility admitted Resident #173 on 10/17/23 with diagnoses that included Essential Hypertension, Acute Embolism and Thrombosis of Unspecified Deep Veins of left lower extremity, Cognitive Communication Deficit, and Diabetes Mellitus Type 2. Resident #102 An observation on 10/30/23 at 10:29 AM, revealed Resident #102's call light laying on the floor underneath the bed. A review of the care plan titled, "I am at risk for falls related to New environment, CVA (cerebral vascular accident) needing assist with transfer and bed mobility, impaired cardiovascular, dementia and psychotropic medication use," revised 10/31/23 revealed "Call light or personal items available and in east reach." An interview with the Minimum Data Set Nurse (MDS) on 10/31/23 at 3:19 PM confirmed after review of Resident #102's care plans, staff did not follow the care plan for keeping call light in reach and revealed the purpose of the care plan is direct resident specific care. The MDS nurse stated not following the care plan could lead to	F 656	Carrot in place in accordance with the plan of care. The Director of Clinical Operations provided education on 11/6/2023 to staff regarding the expectation that care plans will be developed and implemented including shaving, availability of call lights, notification of change related to blood sugar parameters and application of assistive devices. 4. To monitor the performance of our corrective action and to ensure sustainability, the Unit Manager or Charge Nurse will conduct audits 5 days a week for four (8) weeks and then weekly for 4 weeks to ensure that the nurses follow Diabetic Management guideline regarding notification of abnormal blood sugars starting 11/6/2023. The Unit Manager or Charge Nurse will audit all residents 5 days a week for 8 weeks, then weekly for 4 weeks starting 11/6/2023 to ensure their call lights are within reach. The Unit Manager or Charge Nurse will conduct Audits 5 days a week for eight (8) weeks and then weekly for 4 weeks starting 11/6/2023 to ensure that the residents who require shaving are shaved. The Director of Nursing or Nurse Assessment Coordinator will conduct audits on all residents with hand splints (carrots) to ensure they are in place and residents hands are clean (if applicable) and free from injury for 8 weeks and then weekly for 4 weeks starting 11/6/2023. Findings of audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing	

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F 656	Continued From page 10 resident specific care needs not being met. Record review of the Admission Record revealed that the facility admitted Resident #102 to the facility on 12/06/22 with diagnoses Adult Failure to Thrive and Cerebral Infarction. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 9/28/23, revealed that Resident #102 had a Brief Interview of Mental Status (BIMS) score of 06 which indicated that she was severely cognitively intact. Resident #15 A record review of Resident #15's care plan, with an onset date of 6/20/23, revealed, Focus: "Resident's proper name" has Diabetes Mellitus with potential for complications...Interventions...If infection is present, consult doctor regarding any changes in diabetic medications... A record review of Resident #15's "Blood Sugar Summary" and Medication Administration Record (MAR) for October revealed that on 10/26/23 at 5:27 AM the resident's blood sugar was 466. A record review of October Physician orders revealed an order, with a start date of 10/25/23, for Macrobid Oral Capsule 100 milligrams (MG) give one (1) capsule by mouth two times a day for Urinary Tract Infection (UTI) for seven (7) days. During an interview on 11/1/23 at 3:00 PM, the Minimum Data Set Nurse (MDS) verified that Resident #15's care plan was not followed when the nurse failed to notify the Nurse Practitioner (NP) of Resident #15's blood sugar of 466. The	F 656	Home Administrator for review and interventions as necessary beginning with November Quality Assurance Performance Improvement Committee Meeting on 11/27/2023.	

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F 656	Continued From page 11	F 656		

MDS nurse stated failure to follow the care plan could lead to a delay in treatment.

A record review of Resident #15's Admission Record revealed that the resident was readmitted to the facility on 9/15/2022. Resident #15's active diagnoses included Type 2 Diabetes Mellitus and Urinary Tract Infection.

Resident #108

An observation/interview on 10/30/23 at 10:30 AM with Resident #108 confirmed that she was unable to open her left hand and that she could not move her left arm. The resident's left hand was contracted with her thumb pressed between the second and ring finger. There was no splint in Resident #108 left hand.

Record review of Care Plans for Resident #108 revealed a care plan initiated on 10/22/23 for a Restorative Splint/Brace program - "Place Carrot (hand roll) in hand as often as able to tolerate."

An interview, with Director of Nursing (DON) on 11/01/23 at 4:11 PM confirmed that the purpose of the care plan was to provide a structured means of providing care and communicating with other staff. The DON confirmed that failure to follow a care plan could result in providing the wrong care to a patient or not providing the care that the resident needs.

A review of the facility face sheet for Resident #108 revealed the facility admitted the resident on 3/08/23 with a diagnosis of Hemiplegia to left side, Contracture of left hand, Hyperlipidemia and Hypertension

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F 656	Continued From page 12 A review of the Minimal Data Set (MDS) with an Assessment Reference Date (ARD) of 8/23/23 revealed a Brief Interview for Mental Status (BIMS) score of nine (9) which indicated Resident #108 was cognitively impaired.	F 656		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, resident/staff interview, record review, and facility policy review the facility failed to apply a hand splint that was recommended by Occupational Therapy to prevent worsening of a contracture for one (1) of three (3) residents with splints resulting in loss of Range of Motion (ROM) for the resident. Resident #108 Findings Include:	F 688	F688 1. Resident #108s hand was assessed on 11/1/2023 by the Director of Nursing. The residents hand was cleaned, and the Carrot (hand roll) was placed in her hand. The Nurse Practitioner was notified and visited 11/1/2023 Resident #108 to assess the affected hand. Resident #108 was referred on 10/31/2023 to Occupational therapy for evaluation and treatment.	11/27/23

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F 688	Continued From page 13 A review of the facility policy titled, "Splinting and orthotics", revealed: "It is the policy of (Proper Name) Rehabilitation that therapists recommend, within their scope of practice, appropriate splinting and orthotics for patients currently receiving therapy services, as the need arises." An observation and interview, on 10/30/23 at 10:30 AM with Resident #108 confirmed that she was unable to open her left hand and that she could not move her left arm. The resident's left hand was contracted with her thumb pressed between the second finger and the ring finger. There is nothing splinting the left hand. An observation, on 10/30/23 at 1:45 PM, confirmed that the resident's left hand is contracted and had a bath cloth rolled up and placed in her hand, however the resident's thumb was not on top or around the cloth and was pressed against the palm of her hand. The resident confirmed she was unable to open her hand or move her left arm. An observation/interview, on 10/31/23 at 9:48 AM revealed Occupational Therapist (OT) was sitting at a table in the day room with Resident #108 and was performing exercises to the residents left hand. There was a Carrot Splint (circular hand splint) inside of Resident #108 left hand. OT confirmed that he was evaluating Resident #108 to possibly be admitted back to therapy for contracture management. OT confirmed that they treated the resident previously and that when they discharged her from therapy to restorative care, therapy could open the resident's left hand halfway, and left thumb was extended out. OT stated that the facility's restorative staff were	F 688	Resident #108s care plan was reviewed and updated as needed at this time. 2. All residents with recommendations for hand splints have the potential to be affected by this deficient practice. All residents with hand splints were reviewed by the Director of Nursing on 11/1/2023 to ensure all devices were in place and residents hands were clean and free from injury. 3. To ensure the deficient practice does not recur, on 11/6/2023 the Director of Clinical Education provided an in-service for staff on ensuring residents with carrots (hand rolls) have them in place as ordered, and the hand is clean and free from injury. 4. To monitor the performance of our corrective action and to ensure sustainability, the Director of Nursing or Nurse Assessment Coordinator will conduct audits on all residents with hand splints to ensure they are in place and residents hands are clean (if applicable) and free from injury5 days a week for eight (8) weeks and then weekly for 4 weeks starting 11/6/2023. Findings of audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing Home Administrator for review and interventions as necessary beginning with November Quality Assurance Performance Improvement Committee Meeting on 11/27/2023.	

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F 688	Continued From page 14	F 688		

supposed to place the Carrot Splint inside her left hand daily. OT confirmed that the Carrot Splint had not been being placed into Resident #108 left hand due to being misplaced. OT confirmed that the hand now has an odor and that there is a reddening between the digits where the thumb is contracted and pressing. OT confirmed that Resident #108 has a decreased range of motion (ROM) to the left hand since being discharged from Occupational therapy.

An interview, on 11/01/23 at 10:45 AM with Certified Nurse Aide (CNA) #2 confirmed she was the CNA assigned to Resident #108 for the day and that she did not put a splint on the resident. CNA #2 confirmed that she was unaware of needing to put a splint on Resident #108.

An interview, on 10/31/23 at 02:00 PM with Director of Nursing (DON) confirmed that Resident #108 has a contracted left hand that OT recommended a splint for the left hand and that it had not been in her hand on 10/30/23. The DON confirmed that not having a splint in the contracted hand could result in a skin integrity issue and worsening of the contracture.

A record review of the OT evaluation revealed Resident #108 was admitted by OT on 8/07/23. Review of the evaluation revealed: "Clinical Impressions on 8/07/23 Patient has increased contractures at L hand/digits specifically. Since the last treatment period, seems from OT opinion that hands have become more contracture to the point where fingers are digging in palm which is causing deficits with skin breakdown and joint integrity and overall hygiene within the hand."

Record review of OT discharge summary

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F 688	Continued From page 15 revealed Resident #108 was discharged from Occupational Therapy on 8/31/23 with Occupational Therapy documentation revealing that the patient is tolerating wearing splint for up to 8 hours without any complaints of pain and skin integrity intact with no redness or swelling. The discharge recommendations were for Restorative Program = Restorative Splint and Brace Program. A review of an OT evaluation dated 10/31/23 revealed OT readmitted the resident back to therapy with the following Clinical Impressions: "Based on clinical assessment and analysis of the documented physical impairments and functional deficits: patient has severe contracture of left hand, due to non-compliance with past splinting schedule." A review of the facility face sheet for Resident #108 revealed that she admitted to the facility on 03/08/23 with a diagnosis of Hemiplegia to left side, Contracture of left hand, Hyperlipidemia and Hypertension A review of the Minimal Data Set (MDS) with an Assessment Reference Date (ARD) of 08/23/23 revealed a Brief Interview for Mental Status (BIMS) score of nine (9) which indicated Resident #108 was cognitively impaired.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		11/27/23

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F 689	Continued From page 16 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and facility policy review, the facility failed to ensure a resident was free from accident hazards as evidenced by an unsecured free standing portable oxygen cylinder for one (1) of 12 residents with portable oxygen cylinders. Resident # 49 Findings include: A review of the facility policy titled, "Oxygen Safety" revealed, Policy: "It is the policy of this facility to provide a safe environment for residents, staff, and the public."...Policy Explanation and Compliance Guidelines: 4.) Oxygen Storage-c. "Cylinders will be properly chained or supported in racks or other fastening (i.e. (example) sturdy portable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full, or empty."... An observation of Resident #49's room on 10/30/23 at 11:20 AM, revealed a free-standing oxygen (O2) cylinder standing upright not secured near Resident #49's closet. A review of Resident #49's physician's orders revealed an order for "O2 @ (at) 3L/min (liters/minuite) via BNC (bi-nasal cannula) continiously." ... An observation on 10/31/23 at 8:33 AM, revealed the Portable oxygen cylinder remained free	F 689	F689 1. Resident #49□s free standing oxygen cylinder was removed from the resident□s room and stored properly by the Director of Nursing 10/31/2023. 2. All residents using oxygen cylinders have the potential to be affected by this deficient practice. All resident rooms were checked by the Director of Nursing on 10/31/2023 to ensure free-standing oxygen cylinders were secure and stored properly. 3. To ensure the deficient practice does not recur, on 11/6/2023 the Director of Clinical Education provided an in-service for staff on ensuring oxygen are secure and stored properly in a stationary device. 4. To monitor the performance of our corrective action and to ensure sustainability, the Unit Manager or Charge Nurse will conduct audits 5 days a week for eight (8) weeks and then weekly for 4 weeks starting on 11/6/2023 to ensure oxygen cylinders are secured and stored properly. Findings of audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing Home Administrator for review and interventions as necessary beginning with November Quality Assurance Performance Improvement Committee Meeting on 11/27/2023.	

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F 689	Continued From page 17 standing near the closet unsecured. An observation and interview with Licensed Practical Nurse (LPN) #2 on 10/31/23 at 8:35 AM, she confirmed the oxygen cylinder was free-standing and not in a secure safe place and she revealed portable O2 cylinders should always be secured because it could fall and injure someone. An observation and interview with The Director of Nursing (DON) on 10/31/23 at 8:40 AM, he confirmed the the portable O2 cylinder was improperly stored and should always be secured and revealed the tank could possibly fall and hurt someone because it was not secured and stable. Record review of the Admission Record revealed that the facility admitted Resident #49 to the facility on 10/22/21 with diagnoses of Chronic Obstructive Pulmonary Disease with acute exacerbation. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 7/29/23, revealed that Resident #49 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated that she was cognitively intact.	F 689		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		11/27/23

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F 812	Continued From page 18 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review, and facility policy review, the facility failed to clean the ice machine for one (1) of two (2) ice machines in the nursing facility, failed to check the water temperature of the dish water in the three-(3) compartment sink prior to use for six (6) days during September and October of 2023, and failed to label, date, clean, and remove expired food for three (3) of 3 resident nourishment refrigerators located on the nursing units. Findings Include: Review of the facility policy titled, "Manuel Warewashing," with a revised date of 9/2017, revealed "Policy Statement: All cookware, dishware, and serviceware that is not processed through the dish machine will be manually washed ... Procedures: 1. The Dining Service staff will be knowledgeable in proper technique including: ... Wash temperature at no less than 110 degrees F (Fahrenheit)." Review of the facility policy titled, "Ice," with a revised date of 9/2017, revealed "Policy	F 812	F812 1. Upon notification on 10/30/2023 the water in the 3-compartment sink was changed to meet the temperature requirements and recorded as required by the policy by the District Dietary Manager. Upon on notification on 10/30/2023 the ice machine was cleaned by the Maintenance Supervisor. Upon on notification on 11/1/2023 the nourishment refrigerator on West wing, East wing and the Rehabilitation Unit were cleaned, and all items were removed that did not belong in the refrigerator by the Unit Managers. All other items were dated and labeled 11/1/2023 by the Unit Managers. 2. All residents have the potential to be affected by this deficient practice. 3. To ensure the deficient practice does not recur, on 11/2/2023 the Director of Clinical Education provided an in-service for staff on ensuring all nourishment refrigerators are cleaned according to policy and that only items for residents are	

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F 812	Continued From page 19 Statement: Ice will be prepared and distributed in a ... sanitary manner ... 2. The Dining Services Director will coordinate with the Maintenance Director to ensure that the ice machine will be disconnected, cleaned and sanitized quarterly and as needed." Review of the facility policy titled, "DMS POLICY AND PROCEDURES: Food Service Manual," with an effective date of August 1, 2012, revealed "POLICY: It is the policy of this facility to assign cleaning schedules on a daily, weekly, and monthly basis. PROCEDURE: All equipment will be identified for cleaning. ... Refrigerators - Weekly." An observation and interview on 10/30/23 at 10:40 AM revealed the 3-compartment sink was just run and steam table pans and cutting boards were being washed by Dietary Aide #1. The District Dietary Manager took the temperature of the wash water, and it was 90 degrees. The Dietary Aide #1 revealed the water was too hot to stick her hands in, so she ran cold water in the sink. She revealed the temp was 135 degrees before she cooled it down. When asked what the water temp should be for dishwashing in the 3-compartment sink, she note the manual dishwashing water temperature should be between 150 degrees to 185 degrees. She then changed and revealed the manual dish washing temperature should be between 135 degrees and 150 degrees. She revealed she did not write the temperature down on the 3-compartment sink temperature log today and revealed that she did not take the temperature of the water every time she washed the dishes in the 3-compartment sink. She confirmed the process of washing the dishes should be followed to avoid residents	F 812	to be kept in the refrigerator and should be dated and labeled appropriately. On 11/10/2023 the Director of Clinical Education provided an in-service for staff on ensuring the ice machines are to remain clean and working properly. On 10/31/23 the Corporate Nursing Home Administrator in serviced the Maintenance Supervisor and the Assistant Maintenance supervisor on the proper cleaning of the ice machine and to follow the cleaning schedule. On 10/30/2023 the District Dietary Manager in-serviced the dietary staff on the proper temperature and charting of temperature on the kitchen 3 compartment sink. 4. To monitor the performance of our corrective action and to ensure sustainability, the Unit Manager or Charge Nurse will audit the nourishment refrigerator to ensure they are clean, do not have items that should not be in there and that other items are dated and labeled properly 5 days a week for eight (8) weeks and then weekly for 4 weeks starting on 11/6/2023. The Nursing Home Administrator or Maintenance Supervisor will monitor the ice machines weekly for 8 weeks and then monthly to ensure they are clean and are cleaned according to the schedule starting week of 11/6/2023. The District Manager or the Dietary Manager or Cook will monitor daily that the temperatures of the three-compartment sink are taken and recorded on the temperature log and are within the acceptable limits starting 10/31/2023 as per their policy. Findings of	

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F 812	Continued From page 20 becoming ill from food served from unclean pots and pans. The District Dietary Manager revealed the dietary staff was in-serviced the first of this month regarding the temperature of the 3-compartment sink and the Dietary Aide should have known the water temperature for the 3-compartment sink. The District Dietary Manager confirmed the water temperature was not high enough to wash dishes and the water temperature should be taken each time before dishes are washed in the 3-compartment sink. An interview on 10/30/23 at 10:46 AM with Dietary Aide #2, revealed she did not know what the temperature of the water should be for the 3-compartment sink because she did not go on that side of the kitchen. She confirmed she had been to an in-service about the 3-compartment sink but did not remember what was said. She noted the temperature of the dish water for the 3-compartment sink should be between 175 degrees and 180 degrees. Record review of the "Three Compartment Sink Log," for September 2023 revealed there was no wash water temperature documented for the "Dinner ... Wash" on 9/5/23 and for "Breakfast ... Wash" on 9/16/23, 9/17/23, and 9/18/23. The "Three Compartment Sink Log" for October 2023 revealed there was no wash water temperature documentation for the "Lunch ... Wash" and "Dinner ... Wash" for 10/31/23. Record review of the in-services for the dietary department, revealed "Topic: Temperatures, Date: 10/11/2023 ... Three compartment sink temps: Wash 110, take the temperature each time you wash pots and pans ... "Date: 10/19 ... All temp logs ... must be filled out daily."	F 812	audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing Home Administrator for review and interventions as necessary beginning with November Quality Assurance Performance Improvement Committee Meeting on 11/27/2023.	

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F 812	Continued From page 21 An observation and interview on 10/30/23 at 11:10 AM with the Maintenance Director, of the ice machine located on the nursing unit revealed the white plastic area of the top, inside, of the ice maker surrounding the ice freezing element, was observed to have pink, yellow and dark coffee colored slim like substance on it where the water drained into the tray under the element. The tray holding the draining water was observed to have a shiny slimy substance around the inside edges of it. The Maintenance Director revealed he had just cleaned the top inside of the ice maker last month, but he did not take the outside panels off to see inside when he cleaned it. He revealed he was able to take the inside panel that covered the element off without removing the outside panel, was able to reach into the top of the ice machine and clean the area and none of this substance came out when he cleaned the machine. He noted he had never removed the side panel of the ice machine and looked inside it. An observation and interview on 10/30/23 at 11:15 AM with the District Dietary Manager confirmed there was pink, yellow, and dark coffee colored slim like substance on the white plastic area in the top, inside of the ice maker surrounding the ice freezing element, and a shiny slimy looking substance around the edges of the tray holding the water that drained into the tray that ran off the ice freezing element. She revealed the ice machine was used by the floor staff and not the kitchen, and she was not aware the ice machine was not clean. An observation and interview on 10/30/23 at 11:30 AM with the Administrator, confirmed there was pink, yellow, and dark coffee colored slime	F 812		

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like substance on the white plastic area in the top, inside of the ice maker surrounding the ice freezing element, and a shiny slimy looking substance around the edges of the tray holding the water that drained into the tray that ran off the ice freezing element. She confirmed there was a possibility for growth of a water borne pathogen in the ice machine that could have possibly caused illness for a resident. The Administrator also confirmed the water temperature to wash dishes in the 3-compartment sink should have been no less than 110 degrees, that the dishes were being washed at an inappropriate temperature, which could present the possibility of illness to a resident being served food from unclean dishes.

Record review of the "LOGBOOK DOCUMENTATION," noting the last date the ice machine on the nursing unit was cleaned, revealed, "Ice Machines ... sanitize interior ... Marked done on-time ... September 26, 2023, ... Sanitize Interior: 1. Sanitize interior of ice machine per manufacturer's instruction."

An observation and interview on 11/01/23 at 08:52 AM with Unit Secretary #1 on the West Wing, revealed the resident nourishment refrigerator to contain:
- 2 bottles of hot sauce (not labeled)
- 4 containers of yogurt (1 was opened in the freezer and were not labeled)
- 4 to go trays from outside the nursing facility (not labeled)
- 2 Sandwiches for resident snacks dated 10/13/23
- 1 opened jar of French Onion Dip (not labeled)
- 1 small pizza box (not labeled)
- 1 zip lock bag of muscadines (not labeled)
- 1 opened bottle of Dr. Pepper soda (not labeled)

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- 1 opened bottle of Faygo soda (not labeled)
- 1 opened jar of Ranch Dip (not labeled)

Unit Secretary #1 confirmed none of the listed items in the resident nourishment refrigerator were properly labeled. She confirmed that every food and drink item placed in the resident nourishment refrigerator should belong to a resident, should have the resident's name on it, and the date it was placed in the refrigerator to ensure items do not remain in the refrigerator past the allowed time for each item. She revealed she was not responsible for the cleaning of this refrigerator because she was only filling in on this unit for the day and she did keep her refrigerator clean on the Rehabilitation Unit.

An observation and interview on 11/01/23 at 9:05 AM with Licensed Practical Nurse (LPN)#1 on the East Wing, revealed the resident nourishment refrigerator had light and dark streaks of residue running down in the outside of the door and had spots of brown residue covering the top of the door. When the resident nourishment refrigerator was opened by the LPN #1, a strong, sour smell came out of the refrigerator. The observation revealed bags filled with containers that were piled into the resident nourishment refrigerator. The observation also revealed brown stains covering the shelf inside the door of the refrigerator. LPN #1 revealed she was not aware of who was responsible to clean the resident nourishment refrigerator, but it appeared to not have been cleaned in a long time.

An observation and interview on 11/01/23 at 9:10 AM with Certified Nurse Aide (CNA) #2 confirmed the resident nourishment refrigerator was not clean, had a strong sour smell coming out of it, and revealed she did not know who was

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responsible for cleaning it. She also revealed she did not know the resident nourishment refrigerator was not clean.

An observation on 11/01/23 at 09:14 AM with the Administrator of items in the resident nourishment refrigerator on the East Wing revealed:
- 1 container of Baskin Robbins Ice Cream (not in the freezer of the refrigerator and not labeled)
- 1 unopened hot pocket - not labeled
- 1 bottle of mayonnaise - not labeled
- pudding for a resident from the supper meal (no name on container, but dated 10/31/23)
- 1 1/2 eaten salad (the salad was noted as the food item with the loud sour smell - not labeled)
- 1 bowl of spaghetti with a puffy grey substance covering the top of the spaghetti in the to go tray from outside the nursing facility (not labeled)
- 1 Kentucky Fried Chicken bag containing a box that was smashed underneath other items in the refrigerator (labeled with resident's name and no date)
- 1 container of yogurt (not labeled)
- 2 containers of Jell-O with expiration the date of 8/30/23
- 2 boxes of white milk with the expiration date of 8/25/23
- 1 store bought container of chicken salad dated 5/16/23 (not labeled with a resident's name)
- 1 sandwich from the resident snack cart (no date of preparation)
- 1 bottle of water frozen in a block of ice in the freezer

The observation also revealed there were plastic bags stuck to the surface of the inside of the resident nourishment refrigerator that could not be pulled out, revealed the brown stains of residue on the shelf in the inside door, revealed the light and dark brown residue spots that were

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located on the top edge of the refrigerator door, and the light and dark brown streaks of residue that ran down the front of the refrigerator door..

An observation and interview on 11/01/23 at 9:18 AM with Unit Secretary #2 on the East Wing, revealed she cleaned the inside of the resident nourishment refrigerator a month ago and all those items removed during the observation were not in the refrigerator at that time. She revealed she was responsible for ensuring the refrigerator was clean.

An observation and interview on 11/01/23 at 9:21 AM with the Administrator of the resident nourishment refrigerator on the Rehabilitation Unit revealed:
- black residue covering the bottom of the freezer door handle and covering the top of the refrigerator door handle
- an unidentifiable food item that had a very loud and foul odor (not labeled)
- 1 jar of a jelly like substance (not labeled)
- 2 boxes of expired white milk
- 1 box of expired chocolate milk
- 1 store bought salad (not labeled)
- 2 yogurts (not labeled)
- 1 2L bottle of Pepsi (not labeled)
- 1 large bottle of coffee creamer (not labeled)

The Administrator confirmed on 11/01/23 at 9:21 AM all expired items should be removed from the resident nourishment refrigerators, that the Unit Secretaries are responsible to check the refrigerators every Friday to ensure items in the refrigerator are properly labeled for the residents and items not labeled or belonged to employees are removed. She confirmed that 3 of 3 of the nursing facility's resident nourishment

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refrigerators were not clean, that they contained spoiled/outdated foods/drinks, and that they contained unlabeled or improperly labeled foods/drinks. She also confirmed that this could have possibly presented an incident where a resident could possibly have become ill from being given improperly labeled food or drink. She confirmed the facility failed to maintain clean resident nourishment refrigerators, failed to prohibit employees from using the resident nourishment refrigerators, failed to properly label food and drink items for the residents, and failed to timely dispose of expired food and drink items from the resident nourishment refrigerators.

An interview on 11/02/23 at 10:57 AM with the Assistant Director of Nursing revealed she was responsible for ensuring the Unit Secretaries cleaned the resident nourishment refrigerators on each nursing unit. She confirmed she rounded and checked all 3 resident nourishment refrigerators earlier this month, saw they were not clean, saw they had expired food/drinks, saw there were food and drink items not labeled, and smelled the odors inside the refrigerators. She revealed she informed the Unit Secretaries of the need to clean the refrigerators and checked the task off as being completed because she trusted they would clean the refrigerators when she told them. She also revealed she did not follow up to see if the resident nourishment refrigerators were cleaned.

Record review of the "Med Room Refrigerator Audit," dated 10/10/2023, revealed "West Med Room: Clean ... Outside Food: No ... East Med Room: Clean ... Outside Food: No ... Rehab Med Room: Clean ... Outside Food: No."

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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 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		11/27/23

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F 880	Continued From page 28 (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, resident and staff interview, and facility policy review the facility failed to prevent the possible spread of infection when a residents oxygen tubing was laying on a resident's floor under her wheelchair and not stored in a plastic bag for (1) of 26 residents on oxygen therapy. Resident # 49 Findings include:	F 880	F880 1. Resident #49□s Oxygen tubing was replaced with new tubing, labeled, and bagged and stored in a clean bag by LPN #2 on 10/31/23. The resident was assessed on 10/31/2023 by the Director of Nursing with no signs and symptoms of infection noted. 2. All residents using Oxygen have the	

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F 880	Continued From page 29 A review of a statement provided by the facility on company letter head dated 11/1/23, revealed "The following respiratory equipment is to be cleaned q (every) week and prn (as needed). Change oxygen tubing and cannula, change prefilled water bottle, wash, and clean filter. Store in plastic bag when not in use."... An observation of Resident # 49's room on 10/30/23 at 11:20 AM, revealed Oxygen (O2) tubing attached to wheelchair portable cylinder tank laying on the floor underneath the wheelchair, an interview with Resident #49, she revealed she had not been up in the wheelchair all morning and revealed the tubing always falls in the floor and confirmed she was unaware of any type of storage bag. An observation 10/31/23 at 8:33 AM O2 tubing attached to wheelchair concentrator laying on the floor underneath the wheelchair. An observation and interview with Licensed Practical Nurse (LPN) #2 on 10/31/23 at 8:35 AM, she confirmed the oxygen tubing was laying on the floor underneath the wheel chair and revealed the oxygen tubing should not be on the floor and stored in a clean area and removed the tubing from the floor and stated she would discard and replace with new tubing and confirmed concerns from the tubing being on the floor is increased risk for infections from bacteria and dust. An observation and interview with The Director of Nursing (DON) on 10/31/23 at 8:40 AM, he confirmed oxygen tubing not in use should be stored in a clean storage bag and never be on the floor and confirmed it is an infection control issue.	F 880	potential to be affected by this deficient practice. All resident□s requiring oxygen tubing were reviewed by the Director of Nursing on 11/03/2023 to ensure oxygen tubing was bagged and stored in a clean area. 3. To ensure the deficient practice does not recur, on 11/6/2023 the Director of Clinical Education provided an in-service for staff on ensuring Oxygen tubing is bagged, labeled, and stored in a clean area. 4. To monitor the performance of our corrective action and to ensure sustainability, the Unit Manager or Charge Nurse will audit to ensure that all oxygen tubing is bagged and stored in a clean area. 5 days a week for eight (8) weeks and then weekly for 4 weeks starting 11/6/2023. Findings of audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing Home Administrator for review and interventions as necessary beginning with November Quality Assurance Performance Improvement Committee Meeting on 11/27/2023.	

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F 880	Continued From page 30 Record review of the Admission Record revealed that the facility admitted Resident #49 to the facility on 10/22/21 with diagnoses of Chronic Obstructive Pulmonary Disease with acute exacerbation. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 7/29/23, revealed that Resident #49 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated that she was cognitively intact.	F 880		