STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255137	A. BUILDING _____ B. WING _____	12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NESHOBA COUNTY NURSING HOME	1001 HOLLAND AVENUE PHILADELPHIA, MS 39350

(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 #23354 at the facility from 12/12/23 through 12/15/23. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F550, F558, F565, F625, F656, F658, F688, F692, F693, F810, and F812 . The SA found the facility to be in compliance related to CI MS #23354 and no deficiencies were cited. The census at the time of the survey was 118 and the facility was licensed for 145 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	F 550		1/24/24

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

Electronically Signed | 01/04/2024

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. 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 observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide dignity to residents as evidenced by leaving urinary catheter bags uncovered for two (2) of five (5) residents with a catheter. Resident #24 and Resident #89. Findings Include: Review of facility policy titled, "Resident Rights," revealed, "The resident has the right to a dignified existence ...8. Privacy and confidentiality: The resident has a right to personal privacy ..." Review of a statement on facility letterhead dated 12/14/23 and signed by the Director of Nursing (DON) revealed, "We do not currently have	F 550	F550 1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #24 catheter bag was covered by Charge Nurse on 12/13/23. Resident #89 catheter bag was covered by charge Nurse on 12/13/23. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The facility acknowledges that all residents with a urinary catheter bag have the potential to be affected by the deficient	

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F 550	Continued From page 2 included in our policy that catheter bags have to be covered in dignity bag." Resident #24 An observation and interview on 12/12/23 at 12:01 PM, revealed Resident #24 sitting in her wheelchair. A urinary catheter bag with no privacy cover was observed hanging on the bottom of the back of the wheelchair. Observation and interview on 12/13/23 at 2:55 PM, observed Resident #24 lying in bed with the catheter bag placed in front of the privacy bag and not in the privacy covering. On 12/13/23 at 3:05 PM an observation and interview with the Director of Nursing (DON) confirmed the catheter bag is always to be in a privacy bag, if we are out of privacy bags, we use a pillowcase. She revealed this makes no sense for the catheter to be placed in front of the privacy bag instead of in it. Record review of the form LTC Physician Order Review/Renewal revealed Urinary Catheter Care with original order date of 08/28/23 ensure catheter bag is covered for dignity. Record review of Resident #24's LTC Physician Order Review/Renewal revealed she was admitted to the facility on 04/08/21 with diagnoses that included Bladder retention, Acquired hydronephrosis and Chronic renal failure. Record review of Resident #24's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/23/23, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated	F 550	practice. 3. What measures will be put into place or systemic changes made to ensure practice will not recur? On 12/29/23-1/3/24 the Administrator in training performed staff in-services on requirement that catheter bags be covered. Staff not present will be in-serviced on their return to work. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program. Beginning 1/3/24 Charge Nurse will monitor all residents with urinary catheter bags daily for 2 weeks, then 4 days a week for 2 weeks, then weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring.	

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F 550	Continued From page 3 the resident was cognitively intact. Resident #89 An observation on 12/12/23 at 10:45 AM, revealed Resident #89 lying in bed with a urinary catheter bag with no privacy covering hanging from the left side of the bottom of the bed visible from the hallway. Record review of the LTC Physician Order Review/Renewal physician orders physician order's dated 11/26/23 revealed, twice a day (BID), ensure catheter bag is covered for dignity. During an interview on 12/13/23 at 3:22 PM with the Director of Nursing (DON) confirmed that the urinary catheter bag is always to be covered in a privacy bag because that is a dignity and privacy issue for the resident. She revealed all nursing staff know that the catheter bags are supposed to be kept covered. She confirmed when the unit managers make their rounds, they are continually reminding the aides to make sure the bags are covered for privacy. Record review of Resident #89's LTC Physician Order Review/Renewal revealed she was admitted to the facility on 4/21/22 with diagnoses that included Indwelling Foley Catheter present and Congestive Heart failure. Record review of Resident #89's MDS with ARD of 10/3/23, revealed a BIMS score of 12 which indicates the resident had moderate cognitive impairment.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F 558		1/24/24

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F 558	Continued From page 4 §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 observation, resident and staff interview, record review and facility policy review the facility failed to accommodate a resident's mobility needs for (2) two of (3) three sampled residents reviewed for mobility needs. (Resident #82, and #83) Findings include: Review of the facility policy titled, "Use of Assistive Device," revealed Policy: "The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and/or dignity." ... Policy Explanation and Compliance Guidelines: 1.) "Assistive devices are tool, products, types of equipment, or technology that may help individuals perform tasks and activities..." Resident #82 An interview and observation on 12/12/23 at 11:10 AM, revealed the resident has a bariatric bed with no side rails. The resident stated, "I used to have half rails on my bed, and I could use them to pull myself up and around in the bed, but the facility took my rails off of my bed and I want them back". The resident confirmed that the	F 558	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Side rail assessment was completed on resident #82 and side rails were approved by interdisciplinary team 12/18/23. Side rails were installed 12/18/23. Side rail assessment was completed on resident #83 and side rails were approved by interdisciplinary team 12/18/23. Side rails were installed 12/18/23. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The facility acknowledges that all residents that are able to use the side rails for mobility purposes have the potential to be affected. 3. All residents will have a side-rail assessment completed by 1/12/24. Interdisciplinary team will review all side-rail assessments and approve side rails for all residents if indicated.	

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F 558	Continued From page 5 facility said they were taking all rails off the beds because they have to. The resident confirmed that she is mobile and active and liked having the rails to help turn herself and reposition while in the bed. An interview, on 12/15/23 at 8:00 AM, with the Director of Nursing (DON), regarding removal of the side rails for Resident #82, the DON stated, " The resident has a bariatric bed and can move around". The DON confirmed that she was not aware the resident wanted her rails back or needed them back on. The DON confirmed that the facility was told by the Administrator to remove all the side rails from the beds. Record review of Bed Rail Use Assessment Form dated 07/06/2023 revealed that Resident # 82 benefits from the use of bed rails to assist resident with turning side to side and provides the resident with a feeling of comfort and security for fear of falling out of bed. The bed rail assessment also revealed that there was no potential risk of using the bed rails. A record review of the facility form LTC Physician Order Review/Renewal for Resident #82 revealed that she was admitted to the facility on 09/12/2022 with a diagnoses including Depression, Endogenous obesity, Weakness, and Osteoporosis. Record review of the Minimal Data Set (MDS) with an Assessment Reference Date (ARD) of 11/10/2023 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.	F 558	Staff in-service was performed on 12/29/23-1/3/24 by Administrator in Training regarding residents' needs for accommodations and side rail use according to the side rail assessments. All staff not present will be in-serviced on their return to work. Side Rail Policy revision to reflect reasonable accommodations and resident needs and preferences regarding side rails was approved by the Medical Director on 1/3/24. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program. Beginning 1/3/24 Charge nurse will monitor for side rail placement matching recommendations of interdisciplinary team on side rail assessment. Charge nurse will monitor 5 residents per day x 2 weeks, then 5 residents 3 days a week for 2 weeks, then 5 residents weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring.	

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F 558	Continued From page 6	F 558		

Resident #83

An interview on 12/12/23 at 10:30 AM, with Resident #83 revealed "They took my side rails and now I don't have anything to hold on to when I get up. It's hard for me to hold on to my table and the arm of the bedside commode when I'm trying to transfer to the commode." She revealed she had complained about this and was told it was because of the "State" that the side rail was removed. She revealed I've even tried to hold on to the bedside table, but it moves around and isn't safe.

An interview on 12/13/23 at 2:30 PM, Resident #83 revealed that maintenance came in one day and just removed them. She revealed Registered Nurse (RN) #4 came in and said that the "State" said it was a new rule and we had to take them off. She revealed I told her and anyone who would listen to me that I needed the bar to hold onto. She stated I used it to hold onto when I got up out of bed to use the bedside commode and to position myself in the bed. The resident revealed nobody came back in to see what I needed to help me with positioning since they took them away.

An interview on 12/13/23 at 3:50 PM, with the Director of Nurses (DON) revealed Resident #83 was assessed for side rails on 6/28/23 but the side rail wasn't removed until 8/30/23. The DON confirmed that Resident #83 had been positioning herself using the rail and using it to get to her bedside commode but since she could get up on her own, we removed the side rails because that's what we thought we were supposed to do. She stated we didn't give the resident the option

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F 558	Continued From page 7 of signing a consent form to keep the side rails because she could get in and out of bed. The DON confirmed that according to the Bed Rail Use Assessment that was completed on 8/30/23, the resident had requested to keep her side rails and confirmed it was for mobility/transferring assistance. She confirmed that nothing was put in place for mobility or transferring assistance when the side rails were removed. An interview on 12/13/23 at 4:00 PM, with Licensed Practical Nurse (LPN) #1 confirmed that the resident had requested to keep the rails and that she was using them for mobility and transferring. Record review of Bed Rail Use Assessment Form with date of assessment 6/28/23 revealed, that the Resident #83 requested to keep rails for Mobility/transferring assistance. Under Benefit(s) to using the bed rails(s) Assists resident with turning side to side, provides resident with a feeling of comfort and security for fear of falling out of bed, and assists with balance while attempting to stand/standing was marked "Yes." Record review of the Physician Order Review/Renewal revealed Resident #83 was admitted to the facility on 06/24/20 with diagnoses that included Risk for falls, Primary osteoarthritis of left knee, Osteoporosis, and Osteoarthritis. Record review of Resident #83's MDS with ARD of 10/19/23, revealed a BIMS score of 14 which indicates the resident is cognitively intact.	F 558		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)	F 565		1/24/24

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F 565	Continued From page 8 §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 residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, record review and facility policy review, the facility failed to address a grievance	F 565	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient	

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F 565	Continued From page 9 discussed in resident council for the use of bed rails for five (5) of 12 residents that attended resident council. Resident #15, Resident #27, Resident #37, Resident #61, and Resident #66. Findings Include: Record review of the facility policy titled "Resident and Family Grievances" undated revealed under, "Policy Explanation and Compliance Guidelines: ... 8. Grievances may be voiced in the following forums: ... d. Verbal complaint during resident or family council meetings..." An interview with the Resident Council President (Res #27) on 12/12/23 at 12:25 PM, revealed that the residents had discussed the facility's removal of the bed rails during a previous meeting. She revealed that most of the residents want them back so that it would make it easier for them to move from side to side and turn themselves in the bed. Record review of the Resident Council meeting minutes dated 11/01/23 revealed 12 residents discussed being upset about rails being taken off their beds and a desire to have them back. Record review of the 2023 Grievance Log revealed no grievances were documented related to bed rails. The Resident Council meeting was held on 12/13/23 at 3:00 PM with 12 active resident council members present. Residents #15, Resident #27, Resident #37, Resident #61 and Resident #66 revealed their biggest concern was the facility removed all the bed rails. Resident #66 revealed she relied on her bed rails for safety,	F 565	practice: Resident #15 grievance was placed into the electronic reporting system. On 12/15/23 side rail assessment was completed and reviewed by the interdisciplinary team. Resident #15 side rails were installed 12/15/23. Resident #66 grievance was placed into the electronic reporting system. On 12/15/23 side rail assessment was completed and reviewed by the interdisciplinary team. Resident #66 side rails were installed 12/15/23. Resident #37 grievance was placed into the electronic reporting system. On 12/15/23 side rail assessment was completed and reviewed by the interdisciplinary team. Resident #37 side rails were installed 12/15/23. Resident #27 grievance was placed into the electronic reporting system. On 12/15/23 side rail assessment was completed and reviewed by the interdisciplinary team. Resident #27 side rails were installed 12/15/23. Resident #61 grievance was placed into the electronic reporting system. On 12/15/23 side rail assessment was completed and reviewed by the interdisciplinary team. Resident #61 side rails were installed 12/15/23. 2. How the facility will identify other residents having the potential to be	

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F 565	Continued From page 10 turning over in bed and pulling herself up. She revealed that now she must lie one way once she's in the bed and was unable to turn over. She revealed she had to grab onto the mattress for repositioning in bed and the entire mattress moved, which she stated was unsafe. Resident #61 revealed he wanted his side rails for turning over in bed and to assist him with getting out of bed. Resident #15, Resident #27 and Resident #37 revealed they also depended on their side rails to turn over in bed and to stay pulled up in the bed. All residents agreed they had discussed the bed rail issue with multiple staff members during a previous resident council meeting. Resident # 37 revealed she was told by staff that they had to remove them by law because they could not have anything that confined them. Resident #100 that was in attendance revealed they were told it was a state guideline that the facility was unable to allow bed rails. The residents all voiced that the facility went throughout the entire building, removing all the bed rails except for a few and they wanted them back. An interview with Social Services (SS) #1 on 12/14/23 at 9:10 AM revealed she did not attend any recent resident council meetings and no concerns had been brought to her attention out of the meetings. She revealed the residents come to her with any problems and she will initiate a grievance report. She revealed the facility held meetings where they discussed the status of the grievances and how it was handled. She stated that Resident #27 had come to her after the bed rails were removed and requested an explanation. The resident revealed to her that she needed the bed rails to turn herself in bed and to assist with getting out of bed. SS #1 revealed that	F 565	affected by the same deficient practice: The facility acknowledges that all residents who report a grievance have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure practice will not recur? Policy entitled Resident and Family Grievances was revised with final approval by Social Services Director/Grievance officer on 1/3/24. In-service on revised policy was given to all staff by Administrator in Training on 12/29/23-1/3/24. All staff not present will be in-serviced on their return to work. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program. Beginning 1/3/24 Social Services Director will monitor grievance log for unresolved grievances 3 times a week for 2 weeks, then 2 times a week for 2 weeks, then weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring..	

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F 565	Continued From page 11	F 565		

the nursing department explained to the resident why the bed rails had been removed, and the resident never returned to her to voice a complaint. She stated that a grievance had not been entered for any of the residents that voiced their concerns with the removal of the bed rails in the resident council meeting dated 11/01/23. She confirmed that issues or concerns discussed in resident council that had not been addressed and resolved should be considered an unresolved grievance.

An interview with Activity Director #1 on 12/14/23 at 9:05 AM, revealed that she was aware of the residents' concerns regarding removal of bed rails. She confirmed that she was present in the meeting on 11/01/23 when the residents discussed that they needed the rails for getting up, pulling themselves up and rolling over in bed. She revealed that a list was made of the residents that requested to have their rails back, and it was given to the Director of Nursing (DON). She confirmed that the residents' voiced concerns should have been written up as a grievance and acted upon.

An interview with the Administrator in Training (AIT) on 12/14/23 at 10:03 AM, confirmed that the residents' concerns related to the removal of bed rails discussed in a previous resident council meeting should have been written up as a grievance. She acknowledged that issues and concerns that are mentioned in resident council that have not been addressed by the facility should be considered an unresolved grievance. She revealed that the facility misinterpreted the information that was provided to the facility related to bed rail usage and removed the residents' bed rails thinking they were doing the

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F 565	Continued From page 12 right thing and now realize they were not. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/23 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 13, which indicates that Resident #15 is cognitively intact. Record review of the MDS with an ARD of 11/15/23 revealed under section C, a BIMS summary score of 14, which indicates Resident #27 is cognitively intact. Record review of the MDS with an ARD of 11/28/23 revealed under section C, a BIMS summary score of 15, which indicates Resident #37 is cognitively intact. Record review of the MDS with an ARD of 9/26/23 revealed under section C, a BIMS summary score of 14, which indicates Resident #61 is cognitively intact. Record review of the MDS with an ARD of 10/09/23 revealed, under section C, a BIMS summary score of 15, which indicates Resident # 66 is cognitively intact. Record review of the MDS with an ARD of 12/12/23 revealed under section C, a BIMS summary score of 15, which indicates Resident #100 is cognitively intact.	F 565		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		1/24/24

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F 625	Continued From page 13 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review and facility policy review the facility failed to provide written notification to the resident/representative regarding bed hold when the resident was sent to the hospital for four (4) of 4 residents reviewed for hospitalization. Resident #24, Resident #54, Resident #87, and Resident #94 Findings include:	F 625	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On 12/29/23 resident #24 was provided a written copy of the bed hold policy. Policy was given and explained to resident #24 by the Social Services Director. Social Services Director explained reason for transfer that occurred on 9/14/23 to	

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F 625	Continued From page 14 A record review of a statement on facility letterhead written by the Director of Nursing and dated 12/15/23, revealed, "Our bed hold policy doesn't include to mail a copy to Responsible Party (RP) for transfer/discharge." Resident #24 Record review of Resident #24's Nursing Narrative Note dated 09/14/23 revealed Nurse Practitioner (NP) ordered to direct admit Resident #24 to local hospital with dx(diagnosis) of Chronic Renal Failure. An interview on 12/15/23 at 8:05 AM, the Social Services Director revealed she mailed the transfer/discharge form to the resident but did not mail out the bed-hold notice with the amount to hold the bed. She confirmed Resident #24 did not have a bedhold notice given because she wasn't aware that she needed to mail those out. An interview on 12/15/23 at 8:15 AM, the Administrator confirmed that anytime a resident is discharged or transferred they are supposed to have a written transfer/discharge and a notification of bed-hold which includes the amount so the resident or resident representative will know how much they will need to pay to hold their bed. Record review of the "Physician Order Review/Renewal" revealed Resident #24 was admitted to the facility on 04/08/21 with diagnoses that include, Chronic renal failure, Bladder retention, Acquired hydronephrosis, and Foley catheter in place. Record review of Resident #24's Minimum Data	F 625	resident. On 12/29/23 Social Services Director notified Resident #54's son by phone explaining the bed hold policy and the reason for transfer that occurred 9/22/23. Social Services Director mailed copy of Bed hold policy to son on 12/29/23. On 12/29/23 Social Services Director notified Resident #87's son by phone explaining the bed hold policy and the reason for transfer that occurred 11/7/23. Social Services Director mailed copy of Bed hold policy to son on 12/29/23. On 12/29/23 Social Services Director notified Resident #94's brother by phone explaining the bed hold policy and the reason for transfer that occurred 8/15/23. Social Services Director mailed copy of Bed hold policy to Resident #94's brother on 12/29/23. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The facility acknowledges that all residents who are transferred or go out on therapeutic leave have potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure practice will not recur? On 12/29/23 Bed Hold Policy was revised to include mailing to resident or their	

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F 625	Continued From page 15 Set (MDS) with Assessment Reference Date (ARD) of 10/23/23, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Resident #54 Record review of Resident # 54 revealed that the resident was hypotensive and was transferred out to the Emergency room (ER) for evaluation on 09/29/23 and returned to the facility on 10/03/23. The facility notified the residents Responsible Party of the transfer to the ER and the bed hold policy by telephone. An interview on 12/15/23 at 8:30 AM, with the Social Service Director revealed that she completed the transfer/discharge notification and reviewed it over the phone with the Responsible Party. The Social Service Director confirmed that she reviews the bed hold policy with the Responsible Party as well, but that she does not mail the bed hold policy. Social Service Director confirmed that she did not know she was supposed to mail the bed hold policy. An interview on 12/15/23 at 8:30 AM, with the Administrator confirmed that the facility is supposed to mail both the transfer/discharge notice and the bed hold policy when a resident is transferred to the hospital. Record review revealed Resident #54 was admitted to the facility on 03/23/23 with a diagnosis of Deep Vein Thrombosis (DVT) of lower extremity, benign hypertension, chronic	F 625	responsible party if not given in writing prior to transfer. Revised Bed Hold Policy was approved by Nursing Home Administrator on 12/29/23. Social Services staff will notify resident/responsible party of bed hold policy on transfer or prior to therapeutic leave. Charge nurse will notify resident/responsible party in absence of Social Services. Social Services Director will mail copy of bed hold policy on next business day if not provided or if explained by phone prior to emergency transfer. In-service on revision of Bed Hold Policy was given by Social Services Director to Social Service Staff and Charge Nurse on 1/4/24. Social Services staff and Charge Nurses not present will be in-serviced on their return to work. 4. How corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program. Beginning 1/3/24 Social Services Director will review daily census for any transfer/therapeutic leave and monitor for whether a copy of Bed Hold Policy was provided to resident/responsible party 3 times a week for 2 weeks, then 2 times a week for 2 weeks, then weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at	

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F 625	Continued From page 16 obstructive pulmonary disease, difficulty in walking, history of alcohol abuse, constipation, and vascular dementia. Record review of the MDS with an ARD of 10/26/23 revealed a BIMS score of 04 which indicated Resident #54 was moderately impaired. Resident #87 Review of the nurse's notes revealed Resident #87 was transferred to the Emergency Room (ER) on 11/7/23 for Altered Mental Status. Review of the Acknowledgement of Receipt of Bed-Hold Policy dated 11/07/23 for Resident #87 revealed, the Responsible Party (RP) was notified of the of the Bed-Hold via phone call by the Social Service staff . Review of the "LTC (Long-Term Care) Order Review /Renewal Form" Resident #87 was admitted by the facility on 10/23/20 with diagnoses of Communication Impairment, Cognitive Function finding, and Dementia with Disturbance. Review of the MDS for Resident #87 with ARD of 11/7/23 revealed Section A0200-F: Entry /discharge reporting coded: "Discharge assessment -return anticipated." ... Section A2105: Discharge Status coded "Short-Term General Hospital."... Resident #94	F 625	subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring..	

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F 625	Continued From page 17	F 625		

Record review of the MDS for Resident # 94 revealed a Discharge assessment -return anticipated was completed on 8/14/23.

Record review of the "Nursing Home Transfer and Discharge Notice" revealed that Resident #94 was transferred to the hospital on 8/14/23.

An interview with Social Services #1 on 12/14/23 at 3:32 PM, revealed that she does not mail a copy of the bed hold policy to the Resident Representative (RR) when a resident transfers out or discharges from the facility. She revealed that she calls the RR and discusses it with them. She revealed there was no need to mail a copy of the bed hold policy because no changes have been made since admission, so she reiterates with the RP that Medicaid will cover bed hold for 15 days.

An interview with the Administrator in Training (AIT) on 12/14/23 at 4:30 PM, confirmed that the bed hold policy should be mailed to the Resident Representative (RP) anytime a resident was transferred out or discharged from the facility. She revealed that she wasn't aware that bed hold policies were not being mailed out with transfers/discharges.

Record review for Resident #94 revealed the resident was admitted to the facility on 11/29/21 with medical diagnoses that included Vascular Dementia and Cerebrovascular Accident.

Record review of the MDS with an ARD of 8/11/23 revealed under section C, a BIMS summary score was not conducted because Resident #94 is rarely/never understood.

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F 656	Continued From page 18	F 656		
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 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	F 656		1/24/24

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F 656	Continued From page 19 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 interviews, record review, and facility policy review, the facility failed to implement a care plan for a trapeze bar for (Resident #81), a side rail use care plan for (Resident #1), and a care plan for two handle adaptive cups for (Resident #41 and Resident #60) for four (4) of 29 resident care plans reviewed. Findings include: Review of the facility policy titled, "Comprehensive Care Plans," revealed Policy: "It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that identified in the resident's assessment..." Resident #1 Review of the care plan titled, "LTC (Long-Term Care) Falls IPOC (Individual Pan of Care)," last updated 9/28/23, revealed Interventions: "upper side rails ½ x (time) (2) two activated 9/28/23..."	F 656	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #81 had side rail assessment completed and interdisciplinary team recommended side rails on 12/14/23. Care plan was updated to reflect side rails. Side rails were installed 12/14/23. Resident # 81's care plan was updated to remove the trapeze bar on 12/14/23. On 12/12/23 resident #1's care plan was verified to be correct, and the lower side rails were removed 12/12/23. This left only upper side rails as indicated on care plan. On 12/12/23 Resident #41 was provided 2 handled cup during meal as indicated on care plan. On 12/12/23 resident #60 was provided 2 handled cup during meal as indicated on care plan. 2. How the facility will identify other	

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F 656	Continued From page 20 On 12/12/23 at 10:30 AM an observation revealed Resident #1 lying in bed with side rails up times four (4). A review of the care plans for Resident #1 with Registered Nurse (RN)/ Charge Nurse #2 on 12/13/23 at 2:35 PM, she revealed Resident #1 was to have the bilateral upper side rails up only and confirmed staff were not following his care plan. An interview with Certified Nurse Assistant (CNA) #3 on 12/13/23 at 2:55 PM, she revealed after review of Resident #1's Kardex profile report, he should only have two side rails up on his bed. CNA #3 confirmed she did put all four side rails up because she felt that is what the sister would want to keep him safe. CNA # 3 confirmed she did not follow the plan of care for Resident #1. Review of the Profile History report for Resident #1 revealed, ADLS-upper side rails ½ x (2) two. An interview with the Director of Nursing (DON) on 12/13/23 at 3:00 PM, she confirmed staff were not following the care plan for Resident #1 regarding side rails and revealed the purpose of the care plan is to direct resident specific care and failing to follow the plan of care may result in the incorrect care of a resident. Record review of the LTC (Long-Term Care) Order Review /Renewal Form Resident #1 was admitted by the facility on 1/25/19 with diagnoses of Epilepsy and recurrent seizures, Cerebral palsy, and other abnormal involuntary movements.	F 656	residents having the potential to be affected by the same deficient practice. The facility acknowledges that all residents have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure practice will not recur? Staff in-services were performed 12/29/23-1/3/24 by Administrator in Training on necessity to develop plan of care and to implement the plan of care as written. Any employee not present will be in-serviced on their return to work. The Dietary Director performed in-services 12/18/23-12/21/23 on importance of adaptive equipment being on trays as ordered. Any dietary employee not present will be in-serviced on their return to work. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program. Beginning 1/3/24 Station manager will utilize electronic health record reports query to identify all new orders and verify implementation and care plan update. Station manager will monitor this 4 days a week for 2 weeks, then 3 days a week for 2 weeks, then weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance	

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F 656	Continued From page 21 Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 11/02/23, revealed that Resident #1 had a Brief Interview of Mental Status (BIMS) score of 5 which indicated that he was severely cognitively impaired. Resident #81 Review of the care plan titled, "LTC ADL Rehab (Rehabilitation) IPOC," last updated 11/07/23, revealed Interventions: "Trapeze bar to increase mobility in bed." ... A review of the Activities of Daily Living (ADL) care plan with Registered Nurse (RN)/Charge Nurse # 2 on 12/13/23 at 2:46 PM, she revealed Resident #81 had a Trapeze bar to increase mobility in bed added to his plan of care as starting 11/7/23 and confirmed there was not a trapeze bar on Resident #81's bed. An interview with the Director of Nursing on 12/13/23 at 3:40 PM, she confirmed staff were not following the care plan related to the trapeze bar for Resident #81. Review of the LTC (Long-Term Care) Order Review /Renewal Form Resident #81 was admitted by the facility on 5/28/20 with diagnoses of Hemiplegia of left nondominant side and Cerebrovascular accident. Record review of the MDS Section C with an ARD of 11/02/23, revealed that Resident # 81 had a BIMS score of 12 which indicated that he was moderately cognitively impaired. Resident #41 Record review of Resident #41's Nutritional Care	F 656	Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring. Beginning 1/3/24 Dietary Director will monitor trays with adaptive equipment 5 times a week for 2 weeks, then 3 times a week for 2 weeks, then weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring.	

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Plan revealed, "ADAP (adaptive) equip (equipment):2 handled cup" ...

An observation of Resident # 41 during lunch meal on 12/12/23 at 11:57 AM revealed the resident being fed by staff. 8 ounces of iced tea and water provided in a clear plastic cup along with a bottled Ensure. Observation did not reveal a 2-handled cup for the lunch meal.

Record review of Resident #41's Physician Order Review/Renewal revealed the resident was admitted to the facility on 1/29/19 with medical diagnoses that included Anxiety, Alzheimer's Disease, Cerebrovascular Disease, Major Depressive Disorder and Self-Care Deficit.

Record review of the MDS with an ARD of 11/9/23 revealed under section C, a BIMS summary score of 3, indicating Resident #41 is severely cognitively impaired.

Resident #60

Record review of Resident #60's Nutritional Care Plan revealed, "Handled cup with lid per occupational therapy (OT) rec (recommendations)..."

An observation of Resident # 60 during a lunch meal on 12/12/23 at 11:52 AM, revealed the resident feeding herself ice cream. 8 ounces of iced tea and water provided in a clear plastic cup, along with a 12 ounce can of sprite and a bottled Ensure. Observation did not reveal a handled cup for the lunch meal.

An interview with the Registered Dietician (RD)

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F 656	Continued From page 23 on 12/12/23 at 12:05 PM, confirmed that the handled cup for Resident #41 and #60 should have been sent out by the Dietary Department with the lunch meal. An interview with the Director of Nursing (DON) on 12/15/23 at 8:36 AM confirmed that the facility did not follow the care plan for Resident #41 and #60's 2-handled cup with meals. An interview with the MDS Nurse on 12/15/23 at 9:10 AM revealed the purpose of the care plan was to provide the staff with guidelines for resident care. She revealed that if it's on the care plan, it should be done. She confirmed that Resident #41 and Resident #60's care plan was not followed for the 2 handled cup with meals. Record review of Resident #60 LTC Physician Order Review/Renewal revealed the resident was admitted to the facility on 08/18/23 with diagnosis that included Dementia, Rheumatoid Arthrirtis and Pressure ulcer stage 1. Record review of the MDS with an ARD of 10/13/23 revealed a BIMS score of 07, indicating Resident #60 had severe cognitive impairment.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and	F 658	1. How corrective action(s) will be	1/24/24

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F 658	Continued From page 24 facility policy review the facility failed to follow physician orders for a resident with side rails for one (1) of 27 sampled residents (Resident # 1). Findings include: A statement provided on facility letter head revealed, "We do not currently have a policy on Following Physician Orders." Review of the Job Summary for Registered Nurses (RN) and Licensed Practical Nurse (LPN) provided by the Administrator in Training revealed, Duties and Responsibilities: "Follows physician's orders in giving nursing care." An observation on 12/12/23 at 10:30 AM revealed Resident #1 lying in bed with side rails up times four (4). A review of the LTC (Long-Term Care) Order Review /Renewal Form revealed a physician's order for Resident #1 dated 9/28/23, "upper side rails 1/2 x 2 (two) due to DX (diagnosis) of seizures and cerebral palsy with spastic involuntary movements." Review of the Bed Rail Use Assessment Form dated 9/8/23 and 12/5/23 for Resident #1 revealed, Recommended type: ½ length rail -left, right upper. A review of the physician's orders for Resident #1 with Registered Nurse (RN)/Charge Nurse #2 on 12/13/23 at 2:35 PM, she revealed Resident #1 was to have the bilateral upper side rails up only. An observation at the same time of Resident #1 with RN /Charge Nurse #2 she confirmed that Resident #1 had all 4 side rails up on his bed and	F 658	accomplished for those residents found to have been affected by the deficient practice: On 12/12/23 resident #1's Order for side rails was verified. Lower side rails were removed on 12/12/23 to reflect the order. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: Facility acknowledges that all residents have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure practice will not recur? Staff in-services on following physician orders were performed by Administrator in Training on 12/29/23-1/3/24. Policy revision was made by Director of Nursing on 1/5/24 to reflect the necessity of following physician orders. Policy was approved on 1/3/24 by Medical Director. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program. Beginning 1/3/24 Station manager will utilize electronic health record reports query to identify all new orders and verify implementation. Station manager will monitor this 4 days a week for 2 weeks,	

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F 658	Continued From page 25 stated he should not have all four rails up. She then revealed staff were not following the physicians order plan placed the resident at increased risk of injury with the use of the four rails. An interview with the Director of Nursing (DON) on 12/13/23 at 3:00 PM, she revealed Resident #1 should only have his top two side rails up and confirmed staff were not following the physician's orders placing the resident at increased risk for injury. Review of the LTC Order Review /Renewal Form Resident #1 was admitted by the facility on 1/25/19 with diagnoses of Epilepsy and recurrent seizures, Cerebral palsy, and other abnormal involuntary movements. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 11/02/23, revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 5 which indicated that he was severely cognitively impaired.	F 658	then 3 days a week for 2 weeks, then weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring.	
F 688 SS=D	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	F 688		1/24/24

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F 688	Continued From page 26 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 resident and staff interview, record review and facility policy review the facility failed to accommodate a residents mobility needs for (1) one of (3) three sampled residents reviewed for mobility needs. Resident #81 Findings include: Review of the facility policy titled, "Use of Assistive Device," revealed, "Policy: The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and/or dignity ... Policy Explanation and Compliance Guidelines: 1.) "Assistive devices are tool, products, types of equipment, or technology that may help individuals perform tasks and activities..." An interview with Resident #81 on 12/12/23 at 11:28 AM, he revealed the first part of November someone came and took his side rails off and stated he used the rails to help the staff with turning and positioning him and the staff said they can't use bed rails anymore. An observation at that same time revealed no side rails on Resident #81's bed. An interview with Resident #81 on 12/13/23 at	F 688	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #81 had side rail assessment completed and interdisciplinary team recommended side rails on 12/14/23. Side rails were installed on 12/14/23. Resident # 81's care plan was updated to remove the trapeze bar on 12/14/23. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: Facility acknowledges that all residents have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure practice will not recur? On 12/29/23-1/3/24 Administrator in training performed staff in-services on assessing resident's need for side rails to prevent a decrease in bed mobility/range	

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F 688	Continued From page 27 3:15 PM, revealed that a staff member he did not know came in earlier and asked about his trapeze bar for his bed and said she would make sure he got one put on the bed. Resident #81 then stated, "I forgot the staff told me back in November when my side rails were taken off that they were going to put a trapeze bar on my bed and that was over a month ago." The resident confirmed he did tell staff he would try the trapeze bar to help with moving in bed. An interview with Registered Nurse/Charge Nurse (RN) #2 on 12/13/23 at 2:46 PM revealed Resident #81 should have a Trapeze bar to increase mobility in bed as of 11/7/23. An observation of Resident #81's bed RN/Charge Nurse #1 confirmed there was not a trapeze bar to the bed. An interview with the Maintenance Supervisor at 3:10 PM, he revealed had not received a requisition to apply a trapeze bar to Resident #81's bed. A record review of the requisitions submitted for November 2023 revealed no requisition for a trapeze bar. An interview with the Director of Nursing on 12/13/23 at 3:40 PM, she confirmed that Resident #81 should have had a trapeze bar applied to his bed on 11/7/23 when the side rails were removed to aide in his bed mobility and somehow it got missed and revealed a concern from not applying the trapeze bar is Resident #81 may have a decline in bed mobility status and would not be able to assist in his care. An interview with the Administrator on 12/14/23 at	F 688	of motion. Staff not present will be in-serviced on their return to work. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program. Beginning 1/3/24 Charge nurse will monitor for side rail placement matching recommendations of interdisciplinary team on side rail assessment. Charge nurse will monitor 5 residents per day x 2 weeks, then 5 residents 3 days a week for 2 weeks, then 5 residents weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring.	

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F 688	Continued From page 28 9:20 AM, he revealed nursing staff was instructed to assess all residents using side rails to determine their needs. He confirmed Resident #81 should have had a trapeze bar placed on his bed to assist in his bed mobility and a physicians order should have been added for tracking instead of just adding the trapeze as an intervention. The Administrator confirmed the facility did not provide the equipment to accommodate the resident's bed mobility needs. An interview with RN #3 on 12/15/23 at 8:33 AM, she revealed she initiated the trapeze order for Resident # 81 because she thought the resident would benefit from the trapeze bar and confirmed she should have followed up to ensure the resident got the trapeze bar but did not. Review of the LTC (Long-Term Care) Order Review /Renewal Form revealed the resident was admitted to the facility on 5/28/20 with diagnoses of Hemiplegia of left nondominant side and Cerebrovascular accident. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 11/02/23, revealed that Resident # 81 had a Brief Interview of Mental Status (BIMS) score of 12 which indicated that he was moderately cognitively impaired.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 692		1/24/24

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F 692	Continued From page 29 comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review and facility policy review the facility failed to accommodate hydration needs for a resident when a water pitcher was not in accessible reach of the resident for (1) one of 109 residents with water pitchers. (Resident # 50) Findings include: Review of the facility policy titled, "Hydration," revealed Policy: Water will be placed where it is easily accessible to the resident." ... During an observation down Hallway 1 on 12/12/23 at 10:25 AM, Resident #50 was overheard hollering out for help from his room. Upon entering the room Resident #50 was observed sitting in a reclining wheelchair. When asked if he needed help, the resident stated, "I need some water." The water pitcher was located on a bedside table that was across the room from	F 692	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident # 50 had water pitcher placed within reach on 12/12/23. On 12/12/23 RN assessed resident. Resident had no apparent ill effects from deficient practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The facility acknowledges that all residents that are receiving hydration/nutrition by mouth have the potential to be affected by the deficient practice.	

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F 692	Continued From page 30	F 692		

where the resident was sitting in his chair. The State Agency went directly to the nurse station and notified a staff member that Resident #50 requested a drink of water. She replied, "We'll get him some."

During the continued initial survey rounds on 12/12/23 at 10:45 AM, Resident #50 was heard from the hallway stating, "I'm so thirsty so thirsty somebody please get me some water." Upon entrance to the room Resident #50 revealed again he could not reach his water pitcher and needed someone to get it for him because he is unable to get it. An observation revealed the water pitcher was sitting on the bedside table across the room from the resident.

An observation and interview with Registered Nurse (RN) #3 on 12/12/23 at 10:48 AM, she confirmed Resident #50 was unable to reach his water pitcher and was unable to propel his wheelchair and get to the water pitcher. RN #3 also confirmed Resident #50 is capable of of drinking from the water pitcher independently and the water pitcher should have been placed in residents reach at all times and the revealed concerns from the resident not having his water in reach is that it placed the resident at risk for increased thirst and possibly dehydration.

An interview with the Director of Nursing on 12/13/23 at 2:45 PM, she revealed Resident #50 should have had his water pitcher always placed in his reach. She confirmed by not having the water pitcher in reach staff were not meeting the residents needs and placed the resident at increased risk for dehydration.

Review of the LTC (Long-Term Care) Order

3. What measures will be put into place or systemic changes made to ensure practice will not recur?

Staff in-services were performed by the Administrator in Training on 12/29/23-1/3/24 on importance of making sure that all resident's water pitchers are within reach. Any employee not present will be in-serviced on their return to work.

4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program.

Charge nurse will monitor for water pitcher being within reach. Charge nurse will monitor 5 residents per day for 2 weeks, then 5 residents 3 days a week for 2 weeks, then 5 residents weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring.

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F 692	Continued From page 31 Review /Renewal Form Resident #87 was admitted by the facility on 11/07/19 with diagnoses of Self- Care deficit and at risk for deficient fluid volume. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 11/08/23, revealed that Resident # 50 had a Brief Interview for Mental Status (BIMS) score of 11 which indicated that he was moderately cognitively impaired.	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 693		1/24/24

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F 693	Continued From page 32 Based on observation, staff interview, record review, and facility policy review the facility failed to provide a PEG (percutaneous endoscopic gastrostomy) tube feeding as ordered for one (1) of five (5) residents with PEG tubes observed during survey. Resident #54. Findings include: A review of the facility policy titled " Standard Guidelines for Enteral Nutrition", revealed, "...Provide the enteral feedings as ordered." An observation, on 12/13/23 at 7:30 AM of Resident #54's feeding pump at bedside, is observed as being turned off at that time. No feeding was infusing at the current time and the bag was empty. The feeding bag hanging had the date of 12/12/23 and 1700 written on it. An interview, on 12/13/23 at 7:35 AM with Licensed Practical Nurse (LPN) #1 confirmed that the bag hanging had 12/12/23 1700 written on it and that it is empty and that the pump is cut off. LPN #1 confirmed that the resident not having his feeding could cause him to be dehydrated or have weight loss. A record review of Resident #54's Physician Order revealed "...Jevity 1.5 at 60ml(milliliters)/hour continuous via PEG." An interview, on 12/13/23 at 8:15 AM, with LPN #1 confirmed that she had just hung the Jevity 1.5 at 60cc/hour. LPN stated, "There wasn't any feeding at the nurse's station, we had to get it from the kitchen, and they just brought it to the nursing station". LPN #1 stated, "I called the night nurse, LPN #2 to see when the feeding ran	F 693	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #54 had feeding pump resumed as ordered on 12/13/23. Registered Nurse assessed resident 12/13/23. Resident showed no ill effects from deficient practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: Facility acknowledges that all residents that received tube feedings by feeding pump have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure practice will not recur? On 12/29/23-1/3/24 the Administrator in training performed staff in-services for Registered Nurses (RN) and License Practical Nurses (LPN) on assuring that each resident with a feeding pump has the pump running at the rate ordered by physician. RNs and LPNs not present will be in-serviced on their return to work. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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F 693	Continued From page 33 out and she said it ran out at 6:00 AM on 12/13/23 and that she didn't have any more to put in the bag because the kitchen had not brought the feeding to the nurse's station". An interview, on 12/13/23 at 3:30 PM with the Administrator in Training (AIT), confirmed that Resident #54 should receive Jevity 1.5, 60cc/hour continuous. AIT stated " They should have ordered the Jevity 1.5 from the kitchen on 12/12/23 so that they would not run out. AIT confirmed that the nurses also have a key to the kitchen so they could have gone and got it themselves from the kitchen". An interview on 12/14/23 at 3:15 PM with Registered Dietician (RD), regarding the weight loss for the resident and she stated that the resident had a 180-day weight loss of 15 percent. The RD stated that the weight loss occurred before the resident received his peg tube on 09/29/23 and the resident has not had any weight loss in the last month. An interview, on 12/14/23 at 6:00 PM with LPN #3 confirmed that she had placed 3 cans of Jevity 1.5 (711 milliliters) in his bag for his peg feeding at approximately 5:00 PM on 12/12/23 and that it should have lasted approximately 12 hours. An interview on 12/14/23 at 6:30 PM with LPN #2 confirmed that Resident #54's feeding pump ran out of feeding at approximately 6:00 AM on 12/13/23 and that the feeding that was ordered from the kitchen had not come to the nursing station to refill the bag. A review of the LTC (Long-Term Care) Order Review /Renewal form for Resident #54 revealed	F 693	program. Beginning 1/3/24 Charge Nurse will monitor all residents with feeding pumps daily for 2 weeks, then 4 days a week for 2 weeks, then weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring.	

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F 693	Continued From page 34 that he was admitted to the facility on 03/23/23 with diagnoses chronic obstructive pulmonary disease, constipation, and vascular dementia. Record review of the Minimal Data Set (MDS) with an Assessment Reference Date (ARD) of 10/26/23 revealed a Brief Interview for Mental Status (BIMS) score of 04 which indicated Resident #54 was severely cognitively impaired.	F 693		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review and facility policy review, the facility failed to provide a resident with a handled cup for drinking during mealtime for two (2) of eight (8) residents observed with adaptive equipment for dining. Resident #41 and Resident #60 Findings Include: Record review of the facility policy titled "Adaptive Eating Devices" undated revealed, "Policy: Adaptive eating equipment devices are available for those residents needing them ... Adaptive devices in use are sanitized and provided for each meal. Adaptive devices are noted on each resident Tray Ticket and in the medical record..." Resident #60	F 810	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On 12/12/23 Resident #41 was provided 2 handled cup during meal as indicated on care plan. ON 12/12/23 resident #60 was provided 2 handled cup during meal as indicated on care plan. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice:	1/24/24

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F 810	Continued From page 35 Record review of Resident #60's lunch meal ticket provided with the meal dated 12/12/23 revealed, "Handled cup with lid." An observation of Resident # 60 during a lunch meal on 12/12/23 at 11:52 AM, revealed the resident feeding herself ice cream. 8 ounces of iced tea and water provided in a clear plastic cup, along with a 12 ounce can of sprite and a bottled Ensure. The observation did not reveal that the resident had a handled cup for the lunch meal. An interview on 12/12/23 at 11:53 AM, with Registered Nurse (RN) #5, confirmed that Resident # 60 did not have a handled cup with the lunch meal. She revealed that the Dietary Department was responsible for sending out the adaptive equipment with the meal tray. She revealed the purpose of the resident having a handled cup was to make it easier for the resident to hold the cup independently. Record review of the Occupational Therapy (OT) Evaluation and Plan of Care for Resident # 60 dated 9/28/23 revealed, "Patient will safely utilize and 2- handled mug and standard straw with Set-up and occasional Verbal Cues in order to increase (I) independence with self feeding tasks." Record review of Resident #60's Physician Order Review/Renewal revealed, an order dated 8/18/23, " ...handled cup with lid per OT (Occupational Therapy) rec (recommendation) ..." Record review of Resident #60's Physician Order Review/Renewal revealed the resident was admitted to the facility on 8/18/23 with medical diagnoses that included Dementia, Rheumatoid	F 810	The facility acknowledges that all residents requiring adaptive equipment have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure practice will not recur? 12/18/23 Dietary Director performed in-services on meal tray accuracy and adaptive equipment. Dietary staff not present will be in-serviced on their return to work. 12/20/23 Dietary supervisor will check tray for accuracy of food and adaptive equipment and initial tray card prior to tray being placed on cart. 12/29/23-1/3/24 Administrator in Training performed in-services to all nursing staff on ensuring adaptive equipment was on trays as ordered. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program. Beginning 1/3/24 Dietary Director will monitor trays with adaptive equipment 5 times a week for 2 weeks, then 3 times a week for 2 weeks, then weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance	

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F 810	Continued From page 36 Arthritis and Chronic Obstructive Pulmonary Disease. Record review of the MDS with an ARD of 10/13/23 revealed under section C, a BIMS summary score of 7, indicating Resident #60 is severely cognitively impaired. Resident #41 Record review of Resident #41's lunch meal ticket provided with the meal dated 12/12/23 revealed, "2-handled cup with lid..." An observation of Resident # 41 during lunch meal on 12/12/23 at 11:57 AM revealed the resident being fed by staff. 8 ounces of iced tea and water provided in a clear plastic cup along with a bottled Ensure. The observation did not reveal that the resident had a 2-handled cup for the lunch meal. An interview with Certified Nurse Aide (CNA) #4 on 12/12/23 at 11:59 AM, confirmed that Resident # 41 did not get a 2-handled cup with the lunch meal. Record review of Resident #41's Physician Order Review revealed, an order dated 1/22/21, " ... ADAP (adaptive) equip (equipment); 2 handled cup with meals per resident request ..." Record review of Resident #41's Physician Order Review/Renewal revealed the resident was admitted to the facility on 1/29/19 with medical diagnoses that included Anxiety, Alzheimer's Disease, Cerebrovascular Disease, Major Depressive Disorder and Self-Care Deficit.	F 810	Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent Quality Assurance Performance Improvement committee meetings for 3 months. QAPI committee will then determine need for further monitoring. Beginning 1/3/24 Dietitians will monitor weekly for 3 months for adaptive equipment on trays in dining room and on units. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring.	

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F 810	Continued From page 37	F 810		

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/9/23 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 3, indicating Resident #41 is severely cognitively impaired.

An interview with the Registered Dietician (RD) on 12/12/23 at 12:05 PM, confirmed that the handled cup for Resident # 41 and Resident #60 should have been sent out by the Dietary Department with the lunch meal. She revealed if it's ordered on the meal ticket, the resident should have it during meals. She revealed that the Occupational Therapy (OT) Department recommends adaptive equipment for the residents to be able to feed themselves as much as possible.

An interview with Dietary Department #3 on 12/14/23 at 9:05 AM, revealed the purpose of Resident #41 and Resident #60 having a handled cup was to allow the residents the ability to hold the cup and drink themselves. She revealed that the cups were ordered by the Occupational Therapist (OT) and should be sent with every meal. She confirmed that it was the Dietary Department's responsibility to provide the adaptive equipment as ordered.

An interview with the Director of Nursing (DON) on 12/15/23 at 8:36 AM revealed the facility did not have any special monitoring to ensure the residents were getting adaptive equipment with meals. She revealed the Certified Nurse Aides (CNA's) were to look to see if it was provided with the meal and if not, will alert the kitchen that it was not provided.

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F 812	Continued From page 38	F 812		
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 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 observation, staff interviews, and facility policy review, the facility failed to ensure food items in the kitchen refrigerators were dated and labeled and failed to ensure kitchen equipment was clean for two (2) of three (3) kitchen tours. Findings Include: Record review of the facility policy titled, "Food Storage" undated, revealed Food is stored, prepared and transported at appropriate temperatures and by methods designed to prevent contamination or cross contamination ...13. Leftover food is stored in covered	F 812	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No specific resident was identified to be affected by the deficient practice. 12/12/23 Dietary staff members discarded all unlabeled and undated food items from all refrigerators. 12/12/23 dietary staff cleaned the 2 compartment and 3 compartment refrigerators.	1/24/24

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F 812	Continued From page 39 containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 3 days or discarded. f ...Meat, fish, and poultry should be stored on lower shelves..." Record review of the facility policy titled, "Ice" undated, revealed, "Ice will be produced and handled in a manner to keep it free from contamination ...2. Ice machines will be maintained in a clean and sanitary condition to prevent ice contamination. Record review of the Weekly Cleaning Schedule, undated, revealed under Task to be completed, 3 compartment Refrigerator, 2 compartment Refrigerator. No Date/initials were recorded on the schedule. An observation and interview during the initial tour of the kitchen on 12/12/23 at 10:00 AM, with Dietary worker #1 revealed a 2-compartment refrigerator with two (2) opened, undated 5-pound (lb) containers with a manufacturing label of Tuna Salad. An undated 5 lb clear container with a manufacturer label of Chicken Salad. A 5 lb opened and undated clear container with a manufacturer label of Pimento cheese. A bag of rolls identified by Dietary Worker #1, that was unlabeled and undated. Dietary Worker #1 confirmed these food items are always supposed to be dated and labeled. She revealed foods out of date could make a resident sick. The inside of the refrigerator was noted with food substances on the bottom of the refrigerator. Dietary Worker #1 confirmed the inside of the refrigerator needed to be cleaned. She revealed no cleaning schedule is being used but revealed we need to use one to make sure things are getting done. An	F 812	12/13/23 maintenance staff cleaned the ice machine, defrosted and cleaned the ice bin, and cleaned the filters on the ice machine. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The facility acknowledges that all residents that receive food/beverages from the dietary department have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure practice will not recur? 12/13/23 a new ice bin was ordered for the ice machine. 12/27/23 new ice bin installed. On 12/18/23 Dietary Director performed in-service on the cleaning schedule and the importance of keeping the schedule correct and up to date. Staff not present will be in-serviced on their return to work. On 12/18/23 Dietary Director performed in-service on labeling and dating food items. Staff not present will be in-serviced on their return to work. On 12/18/23 Dietary Director performed in-service on cleaning ice machine to	

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F 812	Continued From page 40 observation of the three (3) compartment refrigerator revealed a half tomato identified by Dietary Worker #1 wrapped in clear plastic wrap was unlabeled and undated. She revealed this needs to go into the trash. A large clear bag was identified by Dietary Worker #1 as cheddar cheese with no label or date. A brown shipping box with no label or date was observed sitting on the third shelf of the refrigerator, Dietary Worker #1 identified the food as a thawing turkey. She revealed this shouldn't be on this shelf but should be on the bottom shelf and should be labeled and dated. A rectangular metal pan unlabeled and undated, Dietary Worker #1 identified the food as chopped turkey. She confirmed this should be labeled and dated so we know how long it's been here. An observation of the bottom of the refrigerator was noted with dried and liquid substances throughout. The outside of the refrigerator was noted with dried substances and smudges. Dietary Worker #1 confirmed this refrigerator needs a good cleaning also. An observation inside the ice maker revealed the white plastic covering was noted with black and brown speckled substances. Dietary Worker #2 revealed maintenance is supposed to clean the inside of the ice makers. We wipe down the outside. She confirmed there was a black and brown substance inside of the icemaker and revealed that it shouldn't be there, and she wasn't sure when it was last cleaned. During an interview and observation on 12/13/23 at 9:50 AM, the Dietary Manager (DM) revealed I was out yesterday, but they told me of the stuff that was found. The DM revealed there is a cleaning schedule, but we don't use it. The staff know they are supposed to keep the equipment clean and the food items are always to be labeled	F 812	maintenance employee responsible for cleaning ice machine. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program. Beginning 1/3/24 Dietary Director will monitor labeling and dating on all opened food items in refrigerators daily for 3 weeks, then weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring. The Dietary Supervisor will monitor in the absence of the Dietary Director. Beginning 1/3/24 Dietary Director will monitor the completion of the cleaning schedule daily for 3 weeks, then weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring. The Dietary Supervisor will monitor in the absence of the Dietary Director. Beginning 1/3/24 the Infection Preventionist will monitor cleanliness of	

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F 812	Continued From page 41 and dated. During an observation of the ice maker, the DM confirmed there were black and brown specks of substance. He revealed I'm not sure when it was last cleaned but it needs to be cleaned. He revealed he is ultimately responsible for ensuring the kitchen equipment is kept clean and that includes the ice maker. He revealed maintenance is responsible for cleaning it monthly. During an interview and observation on 12/13/23 at 10:00 AM, the Maintenance Supervisor revealed it is the responsibility of the maintenance department to clean and sanitize the ice maker monthly. He confirmed that the ice maker had a lot of black substances inside and revealed it looked like mold. He confirmed it doesn't look like it has been cleaned in a while. During an interview and observation on 12/13/23 at 10:10 AM, Maintenance Worker #2 confirmed that we are responsible for cleaning the inside of the ice maker monthly. He confirmed that the ice maker doesn't look clean and that the black substance throughout the top looks like mildew. He confirmed, "I guess I didn't clean it and it could potentially cause sickness to a patient." An interview and record review of the cleaning schedule on 12/14/23 at 11:00 AM, the DM confirmed all kitchen equipment is on the cleaning schedule form, but we haven't been using the form. He revealed it's the responsibility of all the dietary workers to clean the equipment but ultimately, it's my responsibility to make sure that everything is in place to ensure the tasks are completed.	F 812	ice machines at Station 1, Station 2, Station 3/4 and in kitchen, 2 times a week for 3wks, then weekly for 3 weeks, then monthly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring.	