

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/08/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255268		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/07/2023	
NAME OF PROVIDER OR SUPPLIER NEW ALBANY HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 118 SOUTH GLENFIELD ROAD NEW ALBANY, MS 38652			
(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			F 000			
F 550 SS=D	The State Agency (SA) conducted an annual re-certification survey at the facility from 12/4/23-12/7/23. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F550 F565, F610, F623, F656, F658, F757, F759 and F806. The census at the time of the survey was 89 and the facility is licensed for 114. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.			F 550			1/26/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/20/2023

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

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review and facility policy review the facility failed to provide privacy for a resident with a urinary catheter as evidence by no privacy bag covering the urine drainage bag for one (1) of four (4) residents with catheters reviewed. Resident # 79 Findings Include: Record review of facility policy titled "Resident Rights" dated 2020, revealed, "The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. ... 7. Privacy and confidentiality. a. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. a. Personal privacy includes accommodations, medical treatment ...personal care ..."	F 550	On 12/5/2023, resident #79 catheter bag was covered with a privacy bag. The facility has determined that all residents with catheters have the potential to be affected. A 100% audit of all residents with catheters was conducted by the Quality Assurance (QA) nurse on 12/5/2023 to ensure all catheters have a privacy bag in place. The staff educator began an in-service on 12/6/2023 with nurses and aides on using privacy bags with all catheters. The QA nurse will conduct catheter audits 2 times per week for 4 weeks beginning on 12/5/2023 and then weekly for 3 months. This plan of correction will be monitored at the monthly Quality Assurance meeting		

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F 550	Continued From page 2 Record review of facility note on letterhead revealed "Our catheter policy does not use the verbiage 'privacy bag'. It is added to include this verbiage as of 12/6/23, staff are being in serviced on the use of privacy bags." This was signed by the Administrator and dated 12/6/23. An observation and interview on 12/5/23 at 2:50 PM, of Certified Nursing Assistant (CNA) #1 during catheter care for Resident #79 revealed a catheter bag attached to the left side of the bed with yellow urine noted in the tubing and bag. The catheter bag was not covered with a privacy bag. CNA #1 revealed she was unsure why this resident had a catheter bag without the privacy flap attached since the privacy catheter bag is the type used in the facility. She revealed an uncovered bag was a dignity concern for the resident. During an interview on 12/5/23 at 2:53 PM, Resident #79 revealed she was unaware her bag was uncovered. She stated she preferred it to be covered. During an interview and observation with the Assistant Director of Nursing (ADON)/Wound Manager on 12/5/23 at 2:55 PM, the ADON observed the catheter bag without a privacy bag, and she revealed it was the facility's policy for a urinary catheter bag to have a privacy bag. She stated she was unsure why this bag without a privacy flap was being used. She confirmed the use of a privacy bag was for dignity and privacy for each resident with a urinary catheter and should be in use. During an interview on 12/5/23 at 2:59 PM, the Director of Nursing (DON) revealed a urinary	F 550	beginning January 8, 2024 until such time consistent substantial compliance has been met. This plan of correction will be discussed at the monthly Quality Assurance meetings for the next 6 months.		

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F 550	Continued From page 3 catheter bag should be in a privacy bag or a bag with a privacy flap to protect the resident's privacy. She confirmed that by not using a privacy bag for this resident, the facility failed to honor the resident's right for privacy. During an interview on 12/5/23 at 3:10 PM, the Administrator confirmed the facility failed to protect the resident's right for privacy and dignity by not ensuring the urinary catheter bag was covered. Record review of Order Summary Report revealed a physician's order dated 11/20/23 for a Foley catheter to bedside drainage bag. Record review of Resident #79's "Admission Record" revealed she was admitted to the facility on 10/18/22 with diagnoses that included Obstructive and Reflux Uropathy. Record review of Resident #79's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/16/23, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.	F 550			
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at	F 565		1/26/24	

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F 565	Continued From page 4 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 staff and resident interviews, record review and facility policy review, the facility failed to resolve a grievance of missing clothing for six (6) of 11 residents reviewed for grievances. Resident #9, Resident #28, Resident #39, Resident #47, Resident #54, and Resident #66. Findings Include: Record review of the facility policy titled "Conflict Resolution and Resident Complaint and Grievance Process" with a revision date of	F 565	On 12/6/2023, grievances were opened for Resident #9, Resident #28, Resident #39, Resident #47, and Resident #66. Resident #9-item was in laundry to have her name put in it, it was returned to her on 12/7/2023. Resident #28-two of her shirts were in her closet and two were in the laundry waiting to be laundered. All items were in her closet on 12/8/2023. Resident #39-states on 12/7/2023, "it has been over a year...I haven't said anything to anyone about the shirt, why does this		

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F 565	Continued From page 5 09/06/2022 revealed under, "Complaints and Grievances: ... If a grievance is not resolved, the investigation is not complete, or if the corrective action is still being evaluated within the seven (7) day timeframe, the facility shall send a response to the resident stating that the facility continues to work to resolve the complaint and the facility shall follow-up with another response within 24 hours." ... During the Resident Council meeting on 12/05/23 at 1:10 PM, Resident #54 revealed that items of missing clothing have been a big concern at the previous resident council meetings. She revealed that she frequently gets clothes delivered to her room that are not hers. Residents #9, Resident #28, Resident #39, Resident #47, and Resident #66 agreed that they frequently get other residents' clothing and see other residents wearing their clothes in the hallway. The residents revealed that their clothes are clearly labeled and wonder what could be happening in the laundry for so many items to disappear. Resident #39 revealed that she lost a top that was sentimental to her that her grandson had made. She revealed that the top could never be replaced due to the significance, but the staff did try to find it. Resident #9 revealed she was missing a sweater and two (2) pairs of pants that have not been replaced. She voiced that no one had returned to her to follow up on the issue. Resident #66 revealed she was missing a black pantsuit for about two (2) months. She stated that no one had followed up with her regarding the issue. Resident # 47 revealed she was missing three (3) tops and a couple of pairs of jogging pants. She revealed she was not concerned with the jogging pants because she slept in them, but she would like to find the tops. Resident # 28 revealed she was	F 565	keep being brought up. I told you not to worry about it. She will make me another one when she can." Resident #47-shirts were located in the laundry and returned to resident on 12/7/2023, laundry continues to look for jogging pants. Facility offered to replace items, but resident stated it wasn't necessary. Resident #66-Spoke to Resident Representative on 12/7/2023. He states "my sister is on drugs and does not come to visit or buy her anything, I don't think she brought any clothes up there...my mother isn't missing anything, especially not from my sister who is on drugs. Spoke with resident on 12/12/2023, resident stated "my son said not to worry about it he would buy me some more." Asked resident to allow staff to put her name in any items that were brought in to her as a gift. Resident #54 stated she did not have any issues with laundry, her family does her laundry. All residents were made aware of the outcomes and have stated they are happy with the finding. The facility determined all residents have the potential to be affected. On 12/6/2023 an in-service was conducted by the Administrator with staff on the procedures for opening a grievance, completing and investigation, and following up with the person who filed the grievance to make them aware of the outcome. The Administrator and Director of Nursing will review all grievances submitted by		

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F 565	Continued From page 6 missing four (4) T-shirts. She stated the facility looked but was unable to locate them. Residents #28 and Resident #47 mutually agreed that staff did not follow up with them regarding the missing items. The residents revealed they notified Activity Director #1 and laundry regarding the missing clothing and the facility did attempt to locate the missing items but were unsuccessful. The residents agreed that the missing items/receiving the wrong clothing had been an issue for a while. An interview with Activity Director #1 on 12/06/23 at 8:30 AM, revealed that when a resident complained about missing items in the Resident Council meeting, she made a note and went to look for the item herself, by first looking in the resident's room. She revealed that most of the time she found the clothing, but if she did not, she notified the Housekeeping Supervisor, and they looked through the laundry. She revealed if they were unable to locate the item, she would turn it over to the Social Worker. She revealed that she did get with the Assistant Director of Nursing (ADON) to handle some things. She confirmed that she did not do any documentation on the process; therefore, she had no proof to provide that the residents' concerns, that were voiced in the past Resident Council meetings, were addressed, and resolved. An interview with Housekeeping #1 on 12/06/23 at 8:45 AM, revealed missing clothing items have been a concern for the residents. She stated the Certified Nurse Aides (CNA's) usually came to notify the laundry department or the resident complained about missing clothing when the laundry staff delivered the clothing to the resident's room. She revealed that she was made	F 565	residents beginning 12/7/2023 to ensure all grievances are completed in a timely manner and residents who have filed the grievance are made aware of the outcome. Open grievances will be discussed during the morning stand up meeting daily to ensure a timely resolution occurs. Open grievances has been added to the morning standup form and will become part of the standup discussion ongoing. All grievances will be reviewed by the Quality Assurance Committee monthly beginning January 8, 2024 for three months to ensure substantial compliance has been achieved.		

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F 565	Continued From page 7 aware of some residents having the wrong clothes this past weekend, and she got those corrected. She revealed they have a label machine in the laundry where they label all clothing for the residents. She revealed they have a lot of trouble with newly admitted residents because their clothes do not always get labeled, and they struggle to find who they belong to. An interview with the Assistant Director of Nursing (ADON) on 12/06/23 at 8:58 AM, revealed the facility did not have a written follow-up process regarding the resident concerns that were mentioned in the Resident Council Meeting. She revealed nursing concerns were brought to her and an in-service was conducted. All other things were taken to the Department Supervisor to address the concern. She confirmed that they handled the issues that were discussed in the Resident Council meetings by verbally telling the Department Head, and therefore they have no documentation to prove the issues discussed were acted upon or resolved. An interview on 12/6/23 at 3:58 PM with the Housekeeping Supervisor revealed that she was aware that residents complained about missing clothes or mislabeled clothes, but she was usually able to find them or fix them. She stated that she did not receive a copy of the Resident Council meeting minutes, but that the Activities Director came and talked to her about the complaints that came up during the meeting. She revealed that if she was unable to find a resident's missing clothes, then she would go and tell the Social Worker. She stated that she had never documented anything about what she did to resolve the missing or mislabeled clothing and understands that if the residents complain about	F 565			

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F 565	Continued From page 8 laundry issues during every resident council meeting, then maybe something different should be done to fix it. An interview on 12/6/23 at 5:00PM, with Social Services #1 confirmed that she was aware of the resident complaints about missing clothes. She stated that she had attended Resident Council meetings before but had not heard of a complaint regarding the laundry for a while. She revealed that no one had come and told her that the residents were complaining at almost every resident council meeting regarding laundry issues. She stated that she had never completed a grievance form for a complaint at a resident council meeting. She agrees that an ongoing complaint by residents with no documentation of what was done to resolve the complaint could be considered an unresolved grievance. An interview on 12/06/23 at 5:40 PM, with the Administrator revealed that she received an email copy of the Resident Council meeting and was aware that missing clothing had been a pattern of concern for the residents over the past six (6) months. She confirmed laundry issues were discussed every month. She acknowledged that the facility should have a better system in place to track and follow up on the resident's voiced concerns that were mentioned in Resident Council. She confirmed that without documentation, the facility cannot prove the issues were addressed and resolved. Record review of the Resident Council meeting minutes dated July 19, 2023, revealed Residents #9, Resident #28, Resident #39, and Resident #66 were in attendance. Also revealed under, "Laundry: Residents are still having multiple	F 565			

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F 565	Continued From page 9 clothes hung on hangers, this also results in residents either thinking they have missing clothes, or they have other resident's clothes. I suggested to have some families, if able to remove items or out of season clothing, to insure more room in their closets. Us as staff will do checks when allowed by residents for correct labeling." Record review of the Resident Council meeting minutes dated August 21, 2023, revealed Residents # 9, Resident #28, Resident #47, and Resident #66 were in attendance. Also revealed under, "Laundry: ... We are still finding other people's clothes in the rooms; I have corrected some that were brought to me. Just be on the lookout please. It seems to be the east hall most of the time." Record review of the Resident Council Meeting minutes dated September 26, 2023, revealed Residents #9, Resident #28, Resident #39, Resident #47, and Resident #66 were in attendance. Also revealed under, "Laundry: Please start double checking names on clothes in what room they go to. We have residents that have room changes at times. I have given a small list of items to look for that residents state they are missing." Record review of the Resident Council meeting minutes dated October 24, 2023, revealed Residents #28, Resident #39, and Resident #66 were in attendance. Also revealed under, "Laundry: ... Please double check names to the resident's room when putting up laundry. There still are a lot of missed placements in the wrong rooms."	F 565			

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F 565	Continued From page 10 Record review of the Resident Council meeting minutes dated November 28, 2023, revealed Residents #9, Resident #28, Resident #39, Resident #47, and Resident #66 were in attendance. Also revealed under, "Laundry: Residents #66 and #9 has clothes that were mixed in closets that belonged to other residents. I have started on helping fix this...." Record review of the Resident Council meeting minutes dated 7/19/23, 8/21/23, 9/26/23, 10/24/23 and 11/28/23 revealed no written follow up/or tracking record to prove that the residents' voiced concerns were acted upon or that a follow-up was conducted regarding missing clothing items. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/02/23 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 14, which indicates Resident # 9 is cognitively intact. Record review of the MDS with an ARD of 9/08/23 revealed under section C, a BIMS score of 09, which indicates Resident # 28 is moderately cognitively impaired. Record review of the MDS with an ARD of 11/23/23 revealed under section C, a BIMS score of 14, which indicates Resident # 39 is cognitively intact. Record review of the MDS with an ARD of 10/19/23 revealed under section C, a BIMS score of 12, which indicates Resident # 47 is moderately cognitively impaired. Record review of the MDS with an ARD of	F 565			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/07/2023
NAME OF PROVIDER OR SUPPLIER NEW ALBANY HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 118 SOUTH GLENFIELD ROAD NEW ALBANY, MS 38652		
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F 565	Continued From page 11 10/06/23 revealed under section C, a BIMS score of 15, which indicates Resident # 54 is cognitively intact. Record review of the MDS with an ARD of 10/20/23 revealed under section C, a BIMS score of 15, which indicates Resident # 66 is cognitively intact.	F 565			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and facility policy review, the facility failed to complete a thorough investigation for one (1) of three (3) residents with incidents reviewed. Resident #27 Findings Include:	F 610	On 12/6/2023 Resident #27 was reassessed by the Assistant Director of Nursing to verify the location and extent of the injury. Witnesses were identified and statements were obtained on 12/6/2023. A thorough investigation was completed by the Director of Nursing on 12/7/2023.	1/26/24	

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F 610	Continued From page 12 Record review of the facility policy titled "Incident and Accident Reporting" with a revision date of 9/05/2023 revealed under, "Policy: ... It is important that the incident and accident report and investigation be completed timely and thoroughly to ensure an accurate record of the event..." Record review of the Incident Note dated 11/24/23 at 2:34 PM revealed, "Resident noted sitting in floor with back against w/c (wheelchair) wheels locked on w/c (wheelchair) cushion was under resident able to move upper ext (extremities) without pain. c/o (Complains of) back et hip pain et ambulance services called at this time. No other injuries noted at this time. neuro (neurological) checks initiated et wnl (within normal limits) at this time. transferred from floor to stretcher via 4 (four) ems (emergency medical services). Resident alert et verbal at this time. Leaving facility via ambulance services at this time. md (medical doctor)/don (director of nursing)/rr (resident representative) notified et aware of fall at this time." Record review of the CT (Cat Scan) Spine Lumbar w/o (without) contrast dated 11/24/23 revealed under, "Impression: 1. Acute appearing obliquely oriented fracture involving the anterior superior aspect of the L1 vertebral body extending into an anterior osteophyte" Record review of the Post Fall Evaluation completed by Registered Nurse #1 dated 11/24/23 revealed under, "Fall Details ... 18. Unwitnessed fall with c/o (complaints of) back et hip pain voiced upon movement." Record review of the fall investigation conducted	F 610	The facility has determined that all residents have the potential to be affected. On 12/8/2023, an in-service with nurses and aides was conducted by the Staff Educator on conducting a thorough investigation of incidents and the responsibility of staff members as it relates to the investigation. The Quality Assurance Nurse will conduct an audit on 5 residents' incident reports a week for 4 weeks beginning 12/19/2023, and then 5 residents monthly for 3 months. This plan of correction will be monitored at the monthly Quality Assurance Committee meeting beginning January 8, 2024 until such time consistent substantial compliance is achieved. This plan of correction will be discussed at the monthly Quality Assurance meetings at a minimum for the next 6 months.		

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F 610	Continued From page 13 by the Assistant Director of Nursing (ADON) undated, revealed Resident # 27's fall occurred in the common area by the fish tank around approximately 2:00 PM on 11/24/23. The fall investigation revealed the resident was unsure of what happened. Possible contributing factors was documented as "Repositioning in the chair-cushion slipped" with an intervention of "Dycem under cushion." An interview with Registered Nurse (RN) # 1 on 12/06/23 at 3:10 PM, revealed that she was the unit manager the day that Resident # 27 fell. She revealed that she could not recall who observed the resident on the floor and stated after she was notified of the fall, she went to assess the resident along with a medication nurse. She stated that the resident was found on the floor in the lounge area in front of the fish tank. She stated she did a quick head to toe assessment and the resident was complaining of hip and back pain. The doctor was called, and the resident was transferred to the emergency room. She revealed that Resident # 27's wheelchair cushion slid out of the wheelchair and was located under the resident on the floor. She confirmed that she was unsure if anyone witnessed the fall and confirmed that she did not document a witness in the incident report. An interview with the Director of Nursing (DON) on 12/06/23 at 3:45 PM, confirmed that she did not do a thorough investigation into Resident #27's fall. She stated the only thing that was done pertaining to the fall was an incident report. She revealed that she was told by the nursing staff that the resident slid from the wheelchair, and it was not a high-impact fall. She stated that after the resident was transferred to the hospital, they	F 610			

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F 610	Continued From page 14 determined he had a back fracture, but it did not occur to her to do an investigation. She revealed that she had spoken with the son who confirmed that the resident had a fall at home before his admission to the facility, and he agreed that the fracture most likely occurred at home. She confirmed that despite the residents' fall at home, a thorough investigation should have been conducted at the facility since the fall was unwitnessed and resulted in a major injury. An interview with the Assistant Director of Nursing (ADON) on 12/06/23 at 3:55 PM, confirmed that she did not conduct a thorough investigation into Resident # 27's unwitnessed fall. An interview with the Administrator on 12/06/23 at 4:05 PM, revealed that she was aware of Resident # 27's fall and the back fracture. She revealed that after the resident's fall, an investigation was conducted by the Assistant Director of Nursing (ADON), however no proof of a thorough investigation was provided to the Survey Agency. She acknowledged that the staff could have done a better job on the investigation and the documentation. Record review of the "Admission Record" for Resident # 27 revealed that the resident was admitted to the facility on 11/15/23 with medical diagnoses that included Alzheimer's Disease, Muscle Wasting and Atrophy, Atrial Fibrillation and Acute Kidney Failure. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/04/23 revealed, under section C, a Brief Interview for Mental Status (BIMS) score of 04, which indicates Resident #27 is severely	F 610			

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F 610	Continued From page 15 cognitively impaired.	F 610			
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	F 623		1/26/24	

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F 623	Continued From page 16 (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 623			

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F 623	Continued From page 17 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to send a written notice of transfer or discharge for three (3) of three (3) residents with transfer or discharges reviewed. Resident #2, Resident #30 and Resident #62 Findings Include: Record review of facility policy titled "Transfer and Discharge" dated 10/18/22, revealed, "The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. This notice will include all of the following at the time it is provided: a. The specific reason and basis for transfer or discharge."	F 623	On 12/5/2023, discharge notice letter was created that will be used to notify residents or their representatives of a transfer/discharge. All transfers/discharges from 12/1-12/4/2023 were identified and notices were sent out on 12/5/2023. The facility has determined that all residents that have been transferred or discharged have the potential to be affected. On 12/6/2023, an in-service on Resident Emergency Transfer/Discharge was conducted by the Administrator addressing the circumstances requiring notices for resident and/or their representatives upon transfer/discharge		

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F 623	Continued From page 18 During an interview on 12/5/23 at 1:15 PM, the Administrator confirmed the facility was not sending a written notice of transfer with the reason for the transfer to the resident or to the resident's representative. She stated the facility staff would speak to the family by phone and provide the information on the resident's condition, but they had never sent this with the reason for transfer to the resident or the resident's representative. The Administrator confirmed the facility failed to provide Resident #2's Representative a written notice of transfer with the reason for transfer on 9/2/23. Resident #2 Record review of Resident #2's Physician's Order dated 9/2/23, revealed an order to send the resident to the emergency room (ER) for evaluation due to Respiratory Distress. Record review of Resident #2's "Admission Record" revealed she was admitted to the facility on 6/7/17. Diagnoses included Chronic Obstructive Pulmonary Disease, Shortness of Breath, Stage 4 Chronic Kidney Disease, Dementia, and Type 2 Diabetes Mellitus. Record review of Resident #2's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/14/23, revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident was moderately impaired cognitively.	F 623	from the facility. Beginning on 12/6/2023, during the daily staff stand up meeting a review of any transfers/discharges from the previous day. At this time a notice will be filled out, a copy will be uploaded into the resident's electronic record, and the original will be mailed to the resident representative following the end of the morning stand up meeting. Social services will be responsible for uploading to the electronic record and mailing a notice to the resident representative. The Quality Assurance nurse will conduct an audit of all residents who have been transferred/discharged from the facility beginning December 1, 2023 for 3 months to ensure the record includes a copy of the transfer/discharge notice. A transfer/discharge log will be sent to the state ombudsman via email monthly (this log has been sent timely since it became a requirement). This plan of correction, will be monitored at the monthly Quality Assurance meeting beginning January 8, 2024 until such time consistent substantial compliance has been met. This plan of correction will be discussed at the monthly Quality Assurance meetings at a minimum for the next 6 months.		

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F 623	Continued From page 19 Resident #62 Record review of Notice of Hospital Transfer/Therapeutic Bed Hold Policy for Resident #62 dated 8/27/23 revealed no reason for transfer listed on the form. Record review of Notice of Hospital Transfer/Therapeutic Bed Hold Policy for Resident #62 dated 9/12/23 revealed no reason for transfer listed on the form. Record review of Departmental Notes; Nurses Notes dated 8/27/2023 revealed, "...Reported to Dr (Doctor) with order to send to ER." Record review of the Order Audit Report revealed an order date of 09/12/203, "Send to ER for eval (evaluation) and possible admission one time only for one day." An interview on 12/05/23 at 2:20 PM, the Administrator confirmed Resident #62 had been sick lately and had several hospitalizations. She revealed she was never aware that they had to notify the resident or resident representative in writing each time they went out to the hospital, and that it was supposed to include the reason for the transfer. Record review of the facility "Admission Record" revealed Resident #62 was admitted to the facility on 06/23/2022 with diagnoses that include, Dysphagia following Cerebral Infarction, Hemiplegia and Hemiparesis following Cerebral Infarction, Acute on Chronic Diastolic (congestive) Heart Failure and Malignant	F 623			

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F 623	Continued From page 20 Neoplasm of Prostate. Record review of Resident #62's MDS with an ARD of 9/12/2023 revealed under Section C a BIMS score of 03, which indicated the resident was severely cognitively impaired. Resident #30 Record review of the Progress Note for Resident #30 dated 11/13/23 at 11:25 AM revealed, "Proper name transferred to (Name of Local Hospital) per her request per ambulance service with EMT's (Emergency Medical Technician) in attendance for c/o (complaints of) stomach pain and just felling (feeling) sick all over. Resident stable upon transfer." Record review of the Order Audit Report for Resident # 30 revealed an order dated 11/13/23, "Send resident to ER for eval per resident request." Record review of the Notice of Hospital Transfer/Therapeutic Bed Hold Policy dated 11/12/23 for Resident # 30 revealed there was not a reason listed for the transfer to the hospital and no indication that it was mailed to the Resident Representative (RR). An interview with the Administrator (ADM) on 12/05/23 at 12:45 PM, confirmed that the facility did not send out written notification to the RR for Resident # 30 who was transferred to the emergency room. She revealed the resident returned to the facility the same day; therefore, written notification was not needed. She revealed	F 623			

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F 623	Continued From page 21 that the facility did not mail out written notifications to the RR's for emergency room transfers, and stated she did not know it was a requirement. Record review of the "Admission Record" for Resident #30 revealed Resident #30 was admitted to the facility on 1/23/18 with medical diagnoses that included Heart Failure, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified Dementia and Essential (Primary) Hypertension. Record review of the MDS with an ARD of 12/01/23 revealed under section C, a BIMS score of 13, which indicates Resident # 30 is cognitively intact.	F 623			
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	F 656		1/26/24	

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F 656	Continued From page 22 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 staff interview, record review and facility policy review the facility failed to implement a comprehensive care plan for monitoring of side effects of an anticoagulant (Resident #15) and to provide a privacy bag on a urinary catheter bag (Resident #79) for two (2) of 21 resident care plans reviewed. Resident #15 and Resident #79 Findings Include:	F 656	On 12/5/2023, Resident #79 catheter was covered with a privacy bag. On 12/6/2023, Resident #15's physician was contacted and a new order was implemented to monitor for side effects of anticoagulant medication. The facility determined that all residents have the potential to be affected. A 100% audit of all resident with catheters		

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F 656	Continued From page 23 Record review of facility policy titled, "Comprehensive Care Plan" dated 10/10/22, revealed, "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. ... The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being." Resident #79 Record review of Resident #79's Comprehensive Care Plan, date initiated 9/5/23, revealed, "Focus Potential to injury related to presence of an Indwelling Foley catheter to dependent drainage related to the diagnosis of Neurogenic Bladder ...Intervention/Tasks #16 French catheter ...draining to BSDB (bedside drainage bag) with privacy bag provided ..." An observation on 12/5/23 at 2:50 PM, of Certified Nursing Assistant (CNA) #1 during catheter care for Resident #79 revealed the catheter bag was not covered with a privacy bag. During an interview and observation with the Assistant Director of Nursing (ADON)/Wound Manager on 12/5/23 at 2:55 PM, the ADON observed the catheter bag without a privacy bag, and she revealed it was the facility's policy for a urinary catheter bag to have a privacy bag.	F 656	was conducted by the Quality Assurance nurse on 12/5/2023 to ensure all catheters have privacy bags in care plan and staff are following the plan of care. The staff educator began an in-service on 12/6/2023 with nurses and aides on using privacy bags with all catheters. A 100% audit of all residents on anticoagulant medications was conducted by the Quality Assurance Nurse on 12/6/2023 to ensure monitoring for side effects of anticoagulant medication every shift is implemented and staff are following the plan of care. The staff educator began an in-service with nursing staff on monitoring for side effects of anticoagulant medications every shift on 12/6/2023. The Quality Assurance (QA) Nurse will conduct catheter audits 2 times per week for 4 weeks beginning on 12/5/2023 and then weekly for 3 months to ensure the plan of care is followed. The QA nurse will conduct an anticoagulant audit weekly for 4 weeks beginning on 12/6/2023 and then monthly for 3 months. This plan of correction will be monitored at the monthly Quality Assurance meeting beginning January 8, 2024 until such time consistent substantial compliance is achieved. This plan of correction will be discussed at the monthly Quality Assurance Committee meeting at a minimum for the next 6 months.		

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F 656	Continued From page 24 An interview on 12/6/23 at 3:15 PM, with the Minimum Data Set (MDS) Coordinator revealed she was responsible for entering care plans for the residents. She revealed a care plan was developed for each resident for their specific needs and was used by the staff to provide resident care. She confirmed the care plan for this resident included an intervention to provide a privacy bag for the urinary catheter for privacy and this was not done, therefore, the plan of care was not followed. Record review of Order Summary Report revealed a physician's order dated 11/20/21 for a Foley catheter to bedside drainage bag. Record review of Resident #79's "Admission Record" revealed she was admitted to the facility on 10/18/22 with diagnoses that included Obstructive and Reflux Uropathy. Record review of Resident #79's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/16/23, revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated the resident was cognitively intact. Resident #15 Record review of Resident # 15's Care Plan revealed, "Resident is at risk for bleeding related to use of anticoagulant therapy secondary to diagnosis of HX (history) of DVT (Deep Vein Thrombosis...Intervention/Tasks ... Monitor for signs of bleeding."	F 656			

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F 656	Continued From page 25 Record Review of the December 2023 Medication Administration Record (MAR) revealed no documentation to monitor for the side effects of the anticoagulant medication Eliquis. An interview on 12/06/23 at 3:30 PM, with Registered Nurse (RN) #1 revealed that Resident #15 was receiving an anticoagulant (Eliquis) and did not have a monitoring tool to monitor for signs of bleeding. She confirmed that the residents' care plan was not followed for monitoring the signs of bleeding. An interview with the Director of Nursing (DON) on 12/06/23 at 3:50 PM, confirmed that Resident # 15's care plan was not followed to monitor for signs of bleeding. Record review of the "Admission Record" for Resident # 15 revealed the resident was admitted to the facility on 3/17/23 with medical diagnoses that included Personal History of other Venous Thrombosis and Embolism. Record review of the MDS with an ARD of 9/19/23 revealed, under section C, a BIMS score of 10, which indicates Resident #15 is moderately cognitively impaired.	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:	F 658			1/26/24

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F 658	Continued From page 26 Cross Reference F759 Based on observation, staff interview, record review and facility policy review the facility failed to administer resident medications based on professional standards of practice for 10 of 36 medication administration opportunities. Resident #9 and Resident #59 Findings include. Review of the facility policy titled, "Medication Administration" with a revised date of 06/08/2023 revealed, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. Review of the facility policy titled, "Medication Errors" with a revised date of 09/05/2023 revealed, "The facility shall ensure medications will be administered as follows: According to physician's orders ... In accordance with accepted standards and principles which apply to professionals providing services". Resident #59 On 12/6/23 at 7:50 AM, a medication administration observation with Licensed Practical Nurse (LPN) #1 revealed medication administration to Resident #59. The total number of medications administered to Resident #59 was 11. During medication reconciliation, a record review of the "Order Summary and Medication Administration Record (MAR)" revealed that Resident #59 did not receive six (6) medications	F 658	On 12/6/2023, LPN #1 was immediately removed from the medication cart. The provider was notified, one-time orders were given for each missed medication for residents #59 and #9. The facility has determined that all residents who receive their medications from LPN #1 have the potential to be affected. All licensed nursing staff will be in-serviced by the staff educator and Quality Assurance Nurse on Medication Administration and Professional Standards of Care This in-service began on 12/6/2023. Staff in-service training included observation of each nurse performing medication administration. A medication administration checkoff will be completed for each nurse to determine if each nurse is performing the medication administration correctly beginning on 12/6/2023. Findings will be reviewed with each nurse. Corrective action will be provided as needed. The Staff Educator, Assistant Director of Nursing, and Quality Assurance Nurse will complete medication administration checkoffs of nurses performing medication administration 3 times per week beginning 12/19/2023 for 4 consecutive weeks to ensure compliance. Additional medication administration checkoffs will be conducted 3 times per month. The medication administration checkoff form will be reviewed by the Director of		

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F 658	Continued From page 27 that were prescribed by the Physician to be given during that medication administration time, and one medication that was administered was given in the wrong form. Medications omitted were Allopurinol tablet 100 mg (milligrams), Aspirin 81 mg chew, Pravastatin tablet 40 mg, Thiamine HCL tablet 100 mg, Vitamin D2 capsule 50,000-unit, Vitamin D3 tablet 50 mcg (micrograms), and Ferrous Sulfate Elixir 220/5ml (milliliters) 7.5 ml was not given but a pill form was substituted. On 12/6/23 at 9:45 AM, during an interview with LPN #1, she confirmed that she had missed giving Resident #59 six medications that were due to be given when she gave his morning medications and confirmed she did not give Ferrous Sulfate Elixir but had substituted the medication for Iron 325 mg in pill form. She stated, "Well it equals out to the same dose as the elixir" and confirmed she did not have a physician's order to substitute the medication form. LPN #1 confirmed she did not give Thiamin, Vitamin D2 or Vitamin D3 and stated, "I'll just give it to him when he gets his next medications because it's just a vitamin." She revealed "I guess I missed the medications because I was nervous." LPN #1 revealed she does all her medication passes for all the residents that she is assigned to and then goes to the nurses' station and documents for all of them at one time. Inquired how she could keep it straight and not miss medications, or important things to document for each resident at that specific time and LPN #1 revealed "I usually don't miss any medications." A review of the facility "Admission Record" revealed Resident #59 was admitted to the facility	F 658	Nursing/Quality Assurance Nurse. This plan of correction will be monitored at the monthly Quality Assurance Committee meeting beginning January 8, 2024 until such time consistent substantial compliance is achieved. This plan of correction will be discussed at the monthly Quality Assurance Committee meetings at a minimum of 6 months.		

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F 658	Continued From page 28 on 08/11/2021 with diagnoses that included Localization related symptomatic epilepsy and epileptic syndromes with complex partial seizures, Vitamin D deficiency, Major depressive disorder, Hypertensive heart disease with heart failure. A review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 10/12/2023 revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated Resident #59 had moderate cognitive impairment. Resident # 9 On 12/6/23 at 8:10 AM, a medication administration observation with LPN #1 revealed 11 medications were administered to Resident #9. During medication reconciliation, a record review of the "Order Summary and Medication Administration Record" revealed that Resident #9 did not receive three (3) medications that were prescribed by the Physician to be given during that medication administration time. Medications omitted were Amitiza Oral Capsule 8mcg, Aspirin 81 mg chew, and Azo-standard oral tablet. An interview on 12/6/23 at 9:55 AM, LPN #1 confirmed that she didn't give Resident #9 the Amitiza medication because it wasn't in the cart. An observation was made that the medication was checked off as given yesterday with a date of 12/5/23 and LPN #1 confirmed the initials were hers and it was checked off as given. LPN #1 revealed, "I'm going, to be honest, I'm not sure if it was given. I had a trainee with me, and she was			F 658			

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F 658	Continued From page 29 marking off the medications." LPN #1 confirmed she had missed Resident #9's three medications. LPN #1 confirmed with a review of the narcotic log that the Norco 10 mg was given to the resident she did click yes on the MAR that it was given but it was not logged out in the narcotic logbook. She revealed "I wrote it on my paperwork and then when I document at the end of the med pass, I will write it in the narcotic log." She confirmed that when a narcotic is given, she should have documented it at that time in the narcotic log. A review of the facility "Admission Record" revealed Resident #9 was admitted to the facility on 03/17/2023 with diagnoses that included Sick sinus syndrome, Hyperlipidemia, Vitamin D deficiency, and constipation. A review of the MDS Section C with an ARD of 11/02/2023 revealed a BIMS score of 14 which indicated Resident #9 is cognitively intact. On 12/6/23 at 4:40 PM, in an interview with the Assistant Director of Nurses (ADON) revealed when medications are given, we encourage a triple check, checking the card, dose, and the Medication Administration Record (MAR) checking back and forth. She revealed it is our policy that as a medication is given the nurse documents on the electronic Medication Administration Record (EMAR) whether it was given or not, she revealed nurses are not supposed to wait until all the medications are given for all their residents, and then document. She revealed that leaves a lot of room for errors and is against our policy. She confirmed that with these medications being missed it could have caused a negative outcome if it was continual	F 658			

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F 658	Continued From page 30 practice. The ADON confirmed this is just not acceptable nursing practice and confirmed that when a narcotic is pulled it is our policy that it is written down immediately in the narcotic logbook. On 12/6/23 at 5:05 PM, during an interview with the Director of Nurses (DON) confirmed when a nurse is administering medications, they are supposed to do real-time charting. When they pull the MAR up, they look at the medications to be given and pull those medications. Our policy is for the medication to be documented as given before that nurse moves on to the next resident. She confirmed that with this deficient practice, some important medications could have been missed. She confirmed that the medication that was given to Resident #59 was given in the wrong form and the nurse should have given the medication as the Physician ordered and not substituted it into a pill form. She confirmed that still equates to a medication error. She confirmed the medications were not given according to their policy and that the medication processes are set up like they are for the safety of the residents and to protect the license of the nurse. She revealed documentation is how a nurse protects themselves and how they make sure they don't make an error to cause harm to a resident. She revealed this was unacceptable and the nurse was not following the facility's medication administration policy.	F 658			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		1/26/24	

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F 757	Continued From page 31 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and facility policy review the facility failed to monitor for the side effects of an anticoagulant (blood thinner) for one (1) of five (5) resident medication reviews. Resident #15 Findings Include: Record review of the facility policy titled "High-Risk Medication - Anticoagulants" with a revision date of 12/22/2022 revealed under, "Policy: This facility recognizes that some medications, including anticoagulants, are associated with greater risks of adverse consequences than other medications." ... Also revealed under, "Policy Explanation and Compliance Guidelines: ... 4. The resident's plan of care shall alert staff to monitor for adverse consequences..."	F 757	On 12/6/2023, Resident #15 was assessed by the Quality Assurance Nurse, who noted no side effects from the anticoagulant medication. On 12/6/2023, the physician was contacted and a new order was implemented to monitor for side effects of anticoagulant medications every shift. The facility determined that all residents on anticoagulant medications have the potential to be affected. A 100% audit of all residents on anticoagulant medications was conducted by the Quality Assurance Nurse on 12/6/2023 to ensure monitoring for side effects of anticoagulant medications every shift is implemented. The staff educator began an in-service on 12/8/2023 with		

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F 757	Continued From page 32 Record review of the December 2023 Medication Administration Record (MAR) for Resident # 15 revealed an order with a start date of 9/05/23, "Eliquis tab (tablet) give 1 (one) tablet by mouth every 12 hours related to Personal History of other Venous Thrombosis and Embolism." Record Review of the December 2023 Medication Administration Record (MAR) revealed no documentation to monitor for the side effects of the anticoagulant medication Eliquis. An interview with Registered Nurse (RN) #1 on 12/06/23 at 3:30 PM revealed that Resident #15 was receiving an anticoagulant (Eliquis) and did not have a monitoring tool to monitor for signs of bleeding. She revealed the monitoring tool should be tied to the anticoagulant order for the nurses to chart, but it was not. She confirmed there should be a place on the Medication Administration Record (MAR) to document the observations. She revealed inadequate monitoring of the anticoagulant medication places the resident at risk for bleeding. An interview with the Director of Nursing (DON) on 12/06/23 at 3:50 PM, confirmed that there should be a monitoring tool to document the signs of bleeding for all residents that take an anticoagulant. She revealed that if it's not documented, then it was not done, and this placed Resident #15 at risk of bleeding. Record review of the "Admission Record" for Resident # 15 revealed the resident was admitted to the facility on 3/17/23 with medical diagnoses that included Personal History of other Venous Thrombosis and Embolism.	F 757	licensed nurses on monitoring for side effects of anticoagulant medications every shift. The Quality Assurance Nurse will conduct an anticoagulant audit weekly for 4 weeks beginning 12/6/2023, and then monthly for 3 months. This plan of correction will be monitored at the monthly Quality Assurance Committee meeting beginning on January 8, 2024 at a minimum for 6 months.		

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F 757	Continued From page 33	F 757			
F 759 SS=D	Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/19/23 revealed, under section C, a Brief Interview for Mental Status (BIMS) score of 10, which indicates Resident #15 is moderately cognitively impaired. Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Cross Reference F658 Based on observation, staff interview, record review, and facility policy review the facility failed to maintain a medication error rate of less than 5% by ensuring that residents received all physician-ordered medications for 10 of 36 medication administration opportunities observed during medication pass. The medication error rate was 27.78%. Findings include: Review of the facility policy titled, "Medication Administration" with a revised date of 06/08/2023 revealed, "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice ... 11. Review MAR (Medication Administration Record) to identify the medication to be administered... 19. Sign MAR	F 759	On 12/6/2023, LPN #1 was immediately removed from the medication cart. The provider was notified, one-time orders were given for each missed medication for residents #59 and #9. The facility has determined that all residents who receive their medications from LPN #1 have the potential to be affected. All licensed nursing staff will be in-serviced by the staff educator and Quality Assurance Nurse on Medication Administration and Professional Standards of Care This in-service began on 12/6/2023. Staff in-service training included observation of each nurse performing medication administration. A medication administration checkoff will be completed for each nurse to determine if	1/26/24	

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F 759	Continued From page 34 after administration. 20. If medication is a controlled substance, sign the narcotic book." Review of the facility policy titled, "Medication Errors" with a revised date of 09/05/2023 revealed, " ...POLICY: It is the policy of this facility to provide protection for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of... medication errors. 1. The facility shall ensure medications will be administered as follows: a. According to physician's orders ... c. In accordance with accepted standards and principles which apply to professionals providing services ..." Resident #59 On 12/6/23 at 7:50 AM, a medication administration observation with Licensed Practical Nurse (LPN) #1 revealed, a medication administration to Resident #59. The medications administered were Colchicine Oral Capsule 0.6 mg (milligrams), Depakote Sprinkles oral capsule 125 mg (2 capsules), Iron 325 mg tablet, folic acid tablet 1 mg, Potassium Chloride capsule 1000E (milliequivalent) ER (extended release), Atenolol tablet 100 mg, Baclofen tablet 10 mg, Levetiraceta solution 100mg/ml (milliliter), Sodium bicarbonate tablet 650 mg, Vimpat oral solution 10mg/ml 20ml, and Diltiazem tablet 60 mg. The total number of medications administered to Resident #59 was eleven. During medication reconciliation, a record review of the "Order Summary and Medication Administration Record (MAR)" revealed that Resident #59 did not receive six (6) medications that were prescribed by the Physician to be given	F 759	each nurse is performing the medication administration correctly beginning on 12/6/2023. Findings will be reviewed with each nurse. Corrective action will be provided as needed. The Staff Educator, Assistant Director of Nursing, and Quality Assurance Nurse will complete medication administration checkoffs of nurses performing medication administration 3 times per week beginning 12/19/2023 for 4 consecutive weeks to ensure compliance. Additional medication administration checkoffs will be conducted 3 times per month. The medication administration checkoff form will be reviewed by the Director of Nursing/Quality Assurance Nurse. This plan of correction will be monitored at the monthly Quality Assurance Committee meeting beginning January 8, 2024 until such time consistent substantial compliance is achieved. This plan of correction will be discussed at the monthly Quality Assurance Committee meetings at a minimum of 6 months.		

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F 759	Continued From page 35 during that medication administration time, and one medication that was administered was given in the wrong form. Medications omitted were Allopurinol tablet 100 mg, Aspirin 81mg chew, Pravastatin tablet 40 mg, Thiamine HCL tablet 100 mg, Vitamin D2 capsule 50,000-unit, Vitamin D3 tablet 50 mcg, and Ferrous Sulfate Elixir 220/5ml 7.5 ml was not given but a pill form was substituted. An interview on 12/6/23 at 9:45 AM, LPN #1 confirmed that she had missed giving Resident #59 six medications that were due to be given when she gave his morning meds and confirmed she did not give Ferrous Sulfate Elixir but had substituted the medication for Iron 325 mg in pill form. She stated, "Well it equals out to the same dose as the elixir." LPN #1 She confirmed she did not have a physician's order to substitute the medication form. LPN #1 confirmed she did not give Thiamin, Vitamin D2 or Vitamin D3 and stated, "I'll just give it to him when he gets his next medications because it's just a vitamin." She revealed I guess I missed the medications because I was nervous. LPN #1 revealed she does all her medication passes for all the residents that she is assigned to and then goes to the nurses' station and documents for all of them at one time. Inquired how she could keep it straight and not miss medications, or important things to document for each resident at that specific time. LPN #1 revealed I usually don't miss any medications. A review of the facility Admission Record revealed Resident #59 was admitted to the facility on 08/11/2021 with diagnoses that included Localization related symptomatic epilepsy and epileptic syndromes with complex partial	F 759			

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F 759	Continued From page 36 seizures, Vitamin D deficiency, Major depressive disorder, Hypertensive heart disease with heart failure. A review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 10/12/2023 revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated Resident #59 had moderate cognitive impairment. Resident #9 On 12/6/23 at 8:10 AM, a medication administration observation with LPN #1 revealed medication administration to Resident #9. The medications administered were Ciprofloxacin HCL tablet 500mg, Carvedilol tablet 3.125 mg, Cranberry tablet 450 mg, Docusate sodium capsule 100 mg (2 capsules), Torsemide Oral tablet 20 mg, Symbicort Inhalation Aerosol 2 (two) puffs inhalation, Hydrocodone/APAP tablet 10-325 mg tablet, Vitamin D tablet 2000-unit, Gabapentin tablet 600 mg, Clopidogrel tablet 75 mg, and Gentamicin Sulfate Ophthalmic solution. The total number of medications administered to Resident #9 was eleven. During medication reconciliation, a record review of the Order Summary and Medication Administration Record revealed that Resident #9 did not receive three (3) medications that were prescribed by the Physician to be given during that medication administration time. Medications omitted were Amitiza Oral Capsule 8 mcg, Aspirin 81 mg chew, and Azo-standard oral tablet. An interview on 12/6/23 at 9:55 AM, LPN #1 confirmed that she didn't give Resident #9 the	F 759			

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F 759	Continued From page 37 Amitiza medication because it wasn't in the cart. State Agency observed medication was checked off as given yesterday with a date of 12/5/23, LPN #1 confirmed the initials were hers and it was checked off as given. LPN #1 revealed, "I'm going, to be honest, I'm not sure if it was given. I had a trainee with me, and she was marking off the medications. LPN #1 confirmed she had missed Resident #9's three medications. A review of the facility Admission Record revealed Resident #9 was admitted to the facility on 03/17/2023 with diagnoses that included Sick sinus syndrome, Hyperlipidemia, Vitamin D deficiency, and constipation. A review of the MDS Section C with an ARD of 11/02/2023 revealed a BIMS score of 14 which indicated Resident #9 is cognitively intact. An interview on 12/6/23 at 4:40 PM, the Assistant Director of Nurses (ADON) revealed when medications are given, we encourage a triple check, checking the card, dose, and the MAR checking back and forth. She revealed it is our policy that as a medication is given the nurse documents on the electronic MAR whether it was given or not, she revealed nurses are not supposed to wait until all the medications are given for all their residents, and then document. She revealed that leaves a lot of room for errors and is against our policy. An interview on 12/6/23 at 5:05 PM, the Director of Nurses (DON) revealed when a nurse is administering medications, they are supposed to do real-time charting when they pull the MAR up, they look at the medications to be given and pull those medications, our policy is for the	F 759			

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F 759	Continued From page 38 medication to be documented as given before that nurse moves on to the next resident. She confirmed that with this deficient practice, some important medications could have been missed. She confirmed that the medication that was given to Resident #59 was given in the wrong form and the nurse should have given the medication as the Physician ordered and not substituted it into a pill form. She confirmed that still equates to a medication error. She confirmed the medications were not given according to their policy and that the medication processes are set up like they are for the safety of the residents and to protect the license of the nurse. An interview on 12/6/23 at 5:35 PM, the Administrator (ADM) confirmed that their policy on medication administration was not being followed and it should have been.	F 759			
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review and facility policy review the facility failed to honor a resident's food choice for one (1) of three (3) residents reviewed.	F 806	The Staff Educator conducted and in-service with dietary staff on 12/8/2023 regarding resident preferences and right to choose, and the importance of	1/26/24	

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F 806	Continued From page 39 Resident #17 Findings Include: Review of the facility policy titled, "Resident Rights and Responsibilities" with a revision date of 10/10/22 revealed "...5. Self Determination ...b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident..." An observation and interview on 12/04/23 at 11:39 AM, with Resident #17 stated she does not like rice, and they keep serving her rice. An observation of the resident's lunch tray revealed the resident had rice served on her tray and her meal ticket revealed that rice was a dislike. An interview on 12/5/23 at 10:15 AM, with District Dietary Support revealed that the Certified Nurse Assistants (CNA) goes around to a list of residents and tells those residents what the menu is for the day and what the alternate is. She stated she is not sure who developed that list of residents. She revealed that the dietary staff look at the resident's meal ticket to determine their diet order, likes and dislikes. Record review with her confirmed that rice was served for lunch on 12/4/23 and 12/5/23. An observation and interview on 12/5/23 at 12:15 PM, revealed that Resident #17 received rice on her lunch tray today and the resident stated that she received rice on her tray a lot, but she just doesn't eat it. She stated she has told them about this many times and they have it listed on her meal ticket as a dislike, but they just keep sending it.	F 806	checking resident trays prior to leaving the kitchen to determine diet preferences are adhered to. The facility determined that all residents have the potential to be affected. On 12/8/2023 an in-service was conducted with nurses and aides on resident preferences and right to choose, and the importance of checking resident meal tickets prior to delivering the tray to ensure preferences are adhered to. The dietary manager will monitor 3 meal trays before exiting the kitchen 3 times per week for 3 months beginning 12/20/2023, based on resident likes and dislikes and will honor resident food choices. The Quality Assurance Nurse will conduct an audit of 10 resident trays per week for 3 months beginning 12/20/2023 to validate resident preferences are adhered to. This plan of correction will be monitored at the monthly Quality Assurance Committee meeting beginning January 8, 2024 until such time consistent substantial compliance is achieved. This plan of correction will be discussed at the monthly Quality Assurance Committee meetings for a minimum of 6 months.		

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F 806	Continued From page 40 An interview and record review on 12/5/23 at 2:00 PM, with District Dietary Support confirmed that Resident #17 had a dislike noted on her meal ticket that indicated the resident disliked "rice". She stated that with that dislike noted then the resident should never receive rice because she does not like it. She stated she could get an alternate for that, like mashed potatoes. She admitted that she served the food onto the resident's trays today for lunch and she missed that the resident disliked rice. She confirmed that the CNA did go and ask the residents on the list that she provided a copy of if they wanted the alternate meal. An review of the list of residents requesting an alternate revealed a list of 15 resident names, which did not include Resident #17. She stated she is not sure if the CNA asked all the residents or just the ones on this list. An interview on 12/5/23 at 2:15 PM, with CNA #2 confirmed that she was given a list of residents to ask daily if they want an alternate meal. She stated she was given this list about two months ago from the previous Director of Nurses (DON). A review of the list revealed Resident #17 was not included on the list. She verified if the residents name was not on the list, then she did not go ask them about an alternate meal. An interview on 12/5/23 at 3:45 PM, with the Administrator confirmed that if a resident indicated rice was a dislike and it was noted on their meal ticket then they should not receive rice. Record review of the facility menu for the week of survey revealed that rice was served for lunch on 12/4/23 and 12/5/23. Record review of Resident #17's meal ticket	F 806			

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F 806	Continued From page 41 dated 12/5/23 revealed rice was noted as a dislike. Record review of Resident #17's "Admission Record" revealed the resident was admitted to the facility on 4/11/22 with medical diagnoses that included Ankylosing Spondylitis Lumbar Region. Record review of Resident #17's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/13/23 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident is cognitively intact.	F 806			