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	255113	A. BUILDING _____ B. WING _____	11/30/2023

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RULEVILLE NURSING AND REHABILITATION CENTER LLC	800 STANSEL DR RULEVILLE, MS 38771

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and a complaint investigation (CI) MS #23397 at the facility from 11/28/23 through 11/30/23. 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, F644, F645, F656, F689, F693, F757, F758, F761, and F812. The SA determined the facility was in compliance for CI MS #23397 and no deficiencies were cited related to the complaint. The census at the time of the survey was 110 and the facility was licensed for 111 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	F 550		1/5/24

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

Electronically Signed | 12/19/2023

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F 550	Continued From page 1 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. 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 and interview, the facility failed to maintain a dining experience that promotes dignity as evidenced by staff standing while providing feeding assistance to one (1) of three (3) residents who required feeding assistance in the dining room. Resident #38. Findings Include: An observation of the lunch meal service in the west dining room for Resident #38 on 11/28/23 at 12:48 PM, revealed that the resident was sitting in his wheelchair at the table and Certified Nursing Assistant (CNA) #2 was standing beside the resident feeding him lunch. Upon interview with CNA #2 on 11/28/23 at 12:50	F 550	On 12/01/23, CNA #2 was inserviced by the Director of Nursing (DNS) and Executive Director (ED) on proper feeding while sitting down of residents who required feeding assistance in the dining room. All residents who required feeding assistance in the dining room have the potential to be affected. Beginnning on 12/01/23, the Director of Nursing (DNS) and Executive Director (ED) conducted an inservice for all Certified Nursing Assistants (CNA) on ensuring staff use proper feeding technique of sitting down while providing	

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F 550	Continued From page 2 PM, she stated that she should not be standing while feeding Resident #38. She stated that she should be sitting at eye level while feeding so the resident does not feel intimidated with staff standing over him. CNA #2 stated that she only stands when there are not enough chairs in the dining area to sit in. An observation of the breakfast meal service in the west dining area for Resident # 38 on 11/29/23 at 8:13 AM, revealed that the resident was sitting in his wheelchair at the table with CNA #5 standing beside the resident feeding him breakfast. Upon interview with CNA #5 on 11/29/23 at 8:14 AM, she agreed that she should not be standing to feed the resident. CNA #5 stated that she only stands while feeding residents if they do not have chairs to sit in. During an interview with CNA #4 on 11/29/23 at 8:16 AM, she stated that they frequently do not have chairs in the west dining room sit to in and have to stand to feed residents. During an interview with the Director of Nursing (DON) and Administrator on 11/29/23 at 8:40 AM, they both agreed that staff should not be standing while feeding residents as it does not promote the resident's dignity. An interview with the Administrator on 11/30/23 at 1:00PM, and review of the statement provided on facility letterhead and signed by the Administrator on 11/30/23 revealed, "(Proper Name of Facility) does not have an applicable policy in relation to dining and feeding."	F 550	residents who require feeding assistance in the dining room. Beginning on 12/04/23, the Assistant Director of Nursing (ADNS) will audit/observe the dining room feeding assistants, five (5) days per week times 2 weeks, then two (2) days per week times 10 weeks to ensure Certified Nursing Assistants (CNAs) are using proper feeding techniques of sitting down while providing residents who require feeding assistance in the dining room. Any concerns will be immediately addressed by the Director of Nursing (DNS). All findings will be corrected immediately with results being sent to the Executive Director for review and then to the Quality Assurance committee monthly times three (3) starting with the 01/03/24 Quality Assurance meeting.	

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F 550	Continued From page 3 Record review of the Face Sheet for Resident #38 revealed that he was admitted to the facility on 5/11/2015 with diagnoses that include Dementia and Neurofibromatosis. Record review of Resident #38 's Annual Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 9/1/23, revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact.	F 550		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to submit a change in status referral for a Level II	F 644	Social Services were in-serviced by Executive Director (ED) on 12/01/23 to conduct a change in status referral for a	1/5/24

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F 644	Continued From page 4 Pre-Admission Screen and Resident Review (PASRR) resident review related to a new Mental Disorder (MD) diagnosis for one (1) of six (6) residents reviewed. Resident # 75. Findings include: Review of the facility's policy titled "PASRR (Pre-Admission Screen and Resident Review) Screening for Mental Disorder or Intellectual Disability", dated 9/23, revealed, "Policy: Each resident in the nursing facility is screened for Mental Disorder (MD) as defined or Intellectual Disability (ID) prior to admission and that individuals identified with MD or ID are evaluated by the State mental health authority and receive care with services appropriate to their need. Referring all Level II with new MD, ID, or related conditions, a review upon a significant change in status assessment. RESPONSIBILITY: Social Services Department under the supervision of the Executive Director ..." Record review of Resident #75's Diagnosis/History revealed a new diagnosis after admission to the facility on 8/20/2020 of Schizophrenia, unspecified with an onset date of 3/30/23. Record review of the Psychiatric Evaluation dated 3/23/23 revealed Resident #75 was evaluated by a psychiatric specialist and was diagnosed with Schizoaffective disorder. Upon interview with Social Services (SS) #1, on 11/29/23 at 12:12 PM, she stated that she did not submit a change in status request for a Level II review for Resident #75 upon return from the psychiatric facility. She stated that she thought a	F 644	Level II PASRR on residents with a new MD. On 12/04/23, Resident #75 change in status referral for a Level II Pre-Admission Screen and Resident Review (PASRR) related to a new Mental Disorder (MD) was conducted by Social Services. All residents with a change in status referral for a Level II Pre-Admission Screen and PASRR related to a new MD have the potential to be affected. Starting on 12/01/23, Executive Director (ED) initiated in-servicing of both Social Workers ensuring resident's diagnosis for a change in status referral need for a Level II Pre-Admission Screen and PASRR resident review related to a new MD diagnosis is completed. Starting on 12/04/23, a 100% audit was initiated by Social Services on all residents with a change in status diagnosis referral for a Level II Pre-Admission Screen and PASRR resident review related to a new MD diagnosis. Social Services will monitor new physician orders five (5) times a week for 4 weeks and then two (2) times a week for 8 weeks for a change in status diagnosis, referral for a Level II Pre-Admission Screen, and PASRR resident review related to a new MD diagnosis on the Level II PASRR Review form. Any concerns noted by Social Services are reported to the Director of Nursing (DNS). All findings will be corrected immediately with results being sent to the Executive Director for review	

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F 644	Continued From page 5 change in status request for a Level II review was only completed when a resident had a significant change in status. She stated the purpose for the change in status request for a Level II review was to provide instruction and services for the resident with specific individualized care. SS #1 agreed that she should have submitted a change in status request for a Level II review for Resident #75 and that the resident could be missing needed care due to failure to do so. During an interview with the Administrator on 11/29/23 at 12:29 PM, she confirmed there were no other PASRRs for Resident #75. She stated that it was her expectation that a change in status request for a Level II review would be completed for Resident #75 upon return from a psychiatric stay with a new psychiatric diagnosis. Record review of Face Sheet for Resident #75 revealed he was admitted to the facility on 8/20/20 with diagnoses that include Essential Hypertension and Nontraumatic intercranial hemorrhage. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/31/23 revealed a Brief Interview for Mental Status (BIMS) score of three (3) which indicated Resident #75 had severe cognitive impairment.	F 644	and then to the Quality Assurance committee monthly times three (3) starting with the 01/03/24 meeting.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on	F 645		1/5/24

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F 645	Continued From page 6	F 645		

or after January 1, 1989, any new residents with:
(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-

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F 645	Continued From page 7 (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to complete a Pre-admission Screening and Resident Review (PASRR) for a resident with an identified Mental Disorder for one (1) of five (5) residents reviewed. Resident # 101. Findings include: A review of the facility policy titled, "PASRR (Preadmission Screening and Resident Review) Screening for Mental Disorder or Intellectual Disability" with a history date of 9/23, revealed, " ...Procedure: ...3. A positive Level I screen necessitates an in-depth evaluation of the individual, by the state-designated authority,	F 645	Social Services were in-serviced by the Executive Director to conduct a PASRR for a resident with an identified Mental Disorder. On 12/04/23, Resident #101 Pre-Admission Screen and Resident Review (PASRR) for a resident with an identified Mental Disorder was conducted by Social Services. All residents requiring a Pre-Admission Screen and Resident Review for a resident with an identified Mental Disorder have the potential to be affected. Starting on 12/04/23, the Executive Director initiated in-servicing of Social	

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F 645	Continued From page 8 known as a Level II PASRR which must be conducted prior to admission to the facility ..." A record review of the Level 1 Preadmission Screening (PAS) results for Resident #101, screening date 8/1/23 revealed, Disease Diagnoses: Hallucinations, unspecified ... Referral Questions: Does Resident #101 have any history of mental illness? Yes ... Does Resident #101 take, or have a history of taking psychotropic medications? Yes ... Antipsychotic? Yes. Mood Stabilizers and antidepressants? Yes ...Screening Results: Priority Description: The person is at high risk for institutionalization, has extensive medical and personal care needs and may need daily services and support ...Priority Name: High Risk ...PASRR Activity Required-Yes ..." An interview with the West Wing Social Worker on 11/29/23 at 1:55 PM, she revealed she was unable to find a Level II PASRR referral and confirmed that Resident #101 should have had a Level II PASSR referral based on the results of the Level I Preadmission Screening (PAS) results. The Social Services then revealed the purpose of the Level II referral is to determine if a resident is appropriate for nursing home placement, and to ensure the resident receives the appropriate services and interventions to meet the resident needs. An interview with the Administrator on 11/29/23 at 2:13 PM confirmed Resident #101 should have had a Level II PASRR referral based on the Level I PAS and a potential concern from not doing the Level II PASRR referral is Resident #101 may have missed treatment or care recommended. Record review of the Face Sheet revealed that	F 645	Services ensuring residents with an identified Mental Disorder diagnosis obtain a Pre-Admission Screen and Resident Review. Beginning on 12/04/23, a 100% audit was initiated by Social Services on all residents with a complete Pre-Admission Screening and Resident Review for a resident with an identified Mental Disorder. Social Services will monitor new admitted residents with an identified Mental Disorder for a complete Pre-Admission Screening and Resident Review five (5) times a week for 4 weeks, then two (2) times a week for 8 weeks on the PASSR Review for Mental Disorder form. Any concerns noted by Social Services are reported to the Director of Nursing (DNS). All findings will be corrected immediately with results being sent to the Executive Director for review and then to the Quality Assurance committee monthly times three (3) starting with the 01/03/24 meeting.	

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F 645	Continued From page 9 the facility admitted Resident #101 on 8/01/23 with diagnoses of Generalized Anxiety disorder, Unspecified Mood {affective} disorder, and Unspecified Psychosis not due to a substance or known physiological condition. Record review of the Admission Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 8/10/23, revealed that Resident # 101 had a Brief Interview of Mental Status (BIMS) score of 9 which indicated that he was moderately cognitively Impaired. Section I - Active Diagnoses, revealed anxiety disorder and Psychotic disorder checked as active diagnoses.	F 645		
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	F 656		1/5/24

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F 656	Continued From page 10 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 care plan for changing behavior and side effect monitoring for a resident taking anticoagulants and psychotropic medications (Resident # 56) and failed to fully develop and implement a care plan for a Gastrostomy Tube (Resident #88) for (2) two of 23 residents reviewed for care plans. Findings include: Review of the facility policy titled," Comprehensive Person Centered Care Plans,"	F 656	Beginning on 11/29/23, Resident #56 care plan was revised by MDS for changing behavior and side effect monitoring for a resident taking anticoagulants and psychotropic medications. On 12/04/23, Resident #88 care plan was revised by MDS for a Gastrostomy Tube. Residents #56 and #88 were assessed on 12/01/23 by the Director of Nursing (DNS) with no ill effects noted. All residents requiring a care plan revised for changing behavior and side effect	

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F 656	Continued From page 11 with a history date of 3/18 revealed, "POLICY: Each resident will have person centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care..." Resident #56 Review of the care plan for Resident #56 "Problem Onset: 08/03/2023 I am at risk for complications related to using antidepressant medication for depressive disorder and psychotropic med (medication) for dx (diagnosis) of dementia with unspecified severity ... Approaches: ...Monitor for changes in mood/behavior/cognition, hallucinations, delusions, social isolation, suicidal thoughts, withdrawal, declines in ADLs (activities of daily living) constipation, gait changes, tremors, fatigue, insomnia, loss of appetite, n/v (nausea/vomiting), dry mouth..." Review of the care plan for Resident #56 "Problem Onset: 08/03/2023 I am at risk for bruising r/t (related to) use of Xarelto ...Approaches: ...Monitor for s/sx (signs/symptoms) such as hematuria, tarry stools, bleeding gums, nose bleeds and excessive bruising..." A record review of the November Electronic Medication Administration Record (eMAR) revealed Resident #56 receives Cymbalta 30 mg one capsule daily for depressive features, Zoloft 25 mg tablet daily, and Abilify 5 mg ½ tablet daily. No monitoring for behaviors or side effects were observed for the psychotropic medications. The eMAR also revealed no monitoring for the use of the anticoagulant Xarelto.	F 656	monitoring for a resident taking anticoagulants and psychotropic medications and a Gastrostomy Tube have the potential to be affected. Beginning on 12/01/23, DNS and Executive Director (ED) conducted an in-service with Social Services and MDS regarding care plan implementation for changing behavior and side effect monitoring for residents taking anticoagulants and psychotropic medications. Starting on 12/04/23, Social Services conducted a 100% care plan audit for changing behavior. Starting on 12/04/23, MDS conducted a 100% care plan audit on side effect monitoring for residents taking anticoagulants and psychotropic medications and a Gastrostomy Tube. Beginning on 12/04/23, MDS and/or Social Services will monitor for changing behavior and side effect monitoring for residents taking anticoagulants and psychotropic medications and a Gastrostomy Tube by documenting on flow sheet five (5) times a week for 4 weeks, then two (2) times a week for 8 weeks. Any concerns noted by Social Services and MDS are reported to the Director of Nursing (DNS). All findings will be corrected immediately with results being sent to the Executive Director for review and then to the Quality Assurance committee monthly times three (3) starting with the 01/03/24 Quality Assurance meeting.	

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F 656	Continued From page 12	F 656		

An interview with the Minimum Data Set Nurse on 11/30/23 at 9:14 AM, revealed after the review of the psychotropic care plan and anticoagulant care plan for Resident #56 staff were not following the care plan for monitoring for behaviors and side effects and revealed the purpose of the care plan is to direct staff of the resident specific care needs and by not following the care plan residents' specific needs may not be met.

Record review of the Face Sheet revealed that the facility admitted Resident # 56 to the facility on 1/25/21 with diagnosis of Long-term (current) use of anticoagulants and Unspecified Dementia, unspecified severity, without behavior/psychosis/mood/anxiety.
Resident #88

Review of the care plan for Resident #88 revealed a care plan, last updated 10/28/22, that failed to address checking of placement or checking residual for Resident #88's gastrostomy tube.

Observation on 11/29/23 at 8:40 AM revealed Licensed Practical Nurse (LPN) #1 failed to check placement of the G tube prior to administering medications and flushing the tube.

In an interview on 11/29/23 at 8:55 AM, LPN #1 revealed she was nervous and forgot to check residual prior to administering the medication.

Record review of the November 2023 Physician Orders for Resident #88 revealed an order dated 1/18/23, "CHECK PLACEMENT OF G TUBE VIA RESIDUAL. CHECK HOLD IF RESIDUAL IS > 100 CC ..."

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F 656	Continued From page 13 Interview on 11/30/23 at 10:50 AM, the Director of Nurses (DON) and Registered Nurse (RN) #1 confirmed the care plan failed to address checking the G tube for placement prior to administering medications and water. Record review of the facility Face Sheet revealed the facility admitted Resident #88 on 2/14/22. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/9/23 revealed staff assessment noted as moderate cognitive impairment.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, the facility failed to prevent the potential for an accident by not utilizing appropriate staff when transferring a resident for one (1) of five (5) residents reviewed. Resident #90 Findings include: An observation on 11/28/23 at 10:26 AM revealed Nursing Assistant (NA) #1 had Resident #90 in a	F 689	On 12/01/23 Resident #90 was assessed by Director of Nursing (DNS) for any negative findings related to resident transfer. No negative findings were noted. On 12/04/23, Nursing Assistant (NA) #1 was in-serviced on utilizing appropriate staff when transferring a resident. Residents who require a total body lift for transfer have the potential to be affected.	1/5/24

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F 689	Continued From page 14 total body lift and had stopped the transfer of Resident #90 with the resident lifted approximately one (1) foot above the bed. NA #1 left the resident suspended over the bed and walked to doorway and stepped into the hallway looking down the hallway for other staff to assist her in transfer the resident. An interview, on 11/29/23 at 02:32 PM with the Director of Nurses (DON) revealed that she was very "rattled" over this, mainly because of resident safety. She stated that the facility has trained and done in-service education on this. The DON stated that they had plenty of CNA's working yesterday that could have helped her. At no point should this have happened. The DON stated that they have not had any accident or incident reports involving lifts. An interview on 11/29/23 at 02:43 PM, with the Administrator (ADM) stated she is extremely upset because staff know better. An interview, with Nurse Aide #1 on 11/30/23 at 8:35 AM, she revealed she knew that she was not supposed to lift a resident in the lift without two people and should have never left Resident #90 suspended in the air to look for the other Certified Nurse Assistant (CNA). She revealed the CNA she was assigned to work with had stepped out of the room and confirmed she should have waited until the CNA returned before lifting Resident # 90. The NA then revealed a possible concern from using the lift without assistance and leaving Resident #90 unattended in the lift was that the resident was at an increased risk of falling. An interview with Resident #90 on 11/30/23 at 8:45 AM, she revealed she is not scared of the lift	F 689	Starting on 12/01/23, DNS and Executive Director (ED) initiated in-servicing of all Certified Nursing Assistants (CNAs) and Nurse Trainee Aides ensuring staff use proper lift transfer techniques to ensure safe transfer of all residents. Beginning 12/04/23, the facility DNS will observe three (3) lift transfers five (5) times per week times 4 weeks, then one (1) lift transfer per week times 8 weeks to ensure safe transfers. All findings will be corrected immediately with results being sent to the Executive Director for review and then to the Quality Assurance committee monthly times three (3) starting with the 01/03/24 Quality Assurance meeting.	

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F 689	Continued From page 15 and had no concerns. An interview and record review of Resident #90's Minimum Data Set (MDS) with the DON on 11/30/23 at 12:33 PM, confirmed after review of the MDS dated 11/30/23, it revealed Section G: "Functional Status" for Transfers was coded as Total Dependence of two staff. Record review of the Face Sheet for Resident #90 revealed she was admitted to the facility on 8/17/22 with diagnoses that included Cerebral Palsy, Anxiety, and Depression. Review of Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/12//23 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #90 was cognitively intact.	F 689		
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	F 693		1/5/24

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F 693	Continued From page 16 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: Based on observation, interview and record review, the facility failed to ensure a resident with a gastrostomy tube received care to prevent complications as evidenced by failure to check tube placement prior to medication administration for Resident #88; for one of five care observations. Findings Include: Review of the facility policy titled, "Tube Feeding", with a revision date of July 2018, revealed the policy/procedure failed to address the checking of residual with a gastrostomy tube (G tube) when administering medications. Record review of the November 2023 Physician Orders for Resident #88 revealed an order dated 1/18/23, "CHECK PLACEMENT OF G TUBE VIA RESIDUAL. CHECK HOLD IF RESIDUAL IS > 100 CC ..." Record review of the Electronic Medication Administration Record (eMAR) for Resident #88 revealed "CHECK PLACEMENT OF G Tube VIA RESIDUAL", dated 1/18/23. Observation on 11/29/23 at 8:40 AM, revealed Licensed Practical Nurse (LPN) #1 failed to check placement of the G tube prior to administering medications and flushing the tube.	F 693	On 12/01/23, Resident #88 was assessed by Director of Nursing (DNS) for gastrostomy tube complications for failure to check tube placement prior to administering medication. LPN #1 was educated immediately on 11/29/23 by the DNS for failure to check tube placement prior to medication administration. Any resident on gastrostomy tube could be affected. Starting on 12/01/23, DNS and Executive Director (ED) initiated in-servicing of all Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) ensuring staff check tube placement prior to medication administration. Beginning on 12/04/23, Director of Nursing (DNS) and/or Assistant Director of Nursing (ADNS) will audit/observe gastrostomy feedings and medication administration audits with implementation of checkoffs five (5) times a week for 4 weeks, then two (2) times a week for 8 weeks. Any concerns noted by DNS and/or ADNS will be corrected immediately with results being sent to the Executive Director for review and then to the Quality Assurance committee monthly	

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F 693	Continued From page 17 In an interview on 11/29/23 at 8:55 AM, LPN #1 revealed she was "nervous" and forgot to check residual prior to administering the medication. On 11/30/23 at 10:50 AM, in an interview, both the Director of Nurses (DON) and Registered Nurse (RN) #1 confirmed that a G tube residual should checked prior to medication administration. Interview on 11/30/23 09:02 AM, with Resident #88 revealed the resident was unable to answer questions when asked. Record review of the facility Face Sheet revealed the facility admitted Resident #88 on 2/14/22. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/9/23 revealed staff assessment noted as moderate cognitive impairment.	F 693	times three (3) starting with the 01/03/24 Quality Assurance meeting.	
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- §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	F 757		1/5/24

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F 757	Continued From page 18 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 interview, record review and facility policy review the facility failed to ensure a resident was monitored for medication side effects for the use of an anticoagulant medication for one (1) of three (3) residents reviewed. Resident # 56 Findings include: A review of the facility policy titled, "Medication Monitoring" revealed, " ...General Guidelines: 1. The staff and Physician shall strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication ..." A review of the Physician's Orders List for Resident #56 revealed an order dated 2/9/23 for Xarelto 2.5 mg (milligrams) tablet give one tablet by mouth twice a day with meals. A review of the November 2023 electronic Medication Administration Record (eMAR) for Resident # 56 revealed no monitoring for the use of the anticoagulant Xarelto. An interview with the Director of Nursing (DON)	F 757	On 12/01/23, Resident #56 was assessed by Director of Nursing (DNS) for side effects for the use of an anticoagulant medication. No ill effects were noted. Any residents who receive an anticoagulant could be affected. Starting on 12/04/23, Director of Nursing (DNS) initiated in-servicing of all Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) nursing staff ensuring residents receiving anticoagulant medication are monitored for medication side effects. Starting on 12/04/23, Director of Nursing (DNS) conducted a 100% anticoagulant medication audit for medication side effects monitoring for residents taking anticoagulants. This side effect monitoring will be placed on the Medication Administration Record for proof of documented side effect monitoring. Beginning on 12/04/23, Assistant Director of Nursing (ADNS) will monitor for documentation of medication side effects	

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F 757	Continued From page 19 on 11/29/23 at 4:40 PM revealed she was unable to find any documentation for monitoring for side effects of the use of anticoagulants. She then revealed that when the physician's orders were put in the computer the special requirement for the monitoring was not added so it does not flag on the medication record for the nurses to document. The DON then revealed Resident #56 is at increased risk of bleeding because she is on an anticoagulant and not monitoring for bleeding and bruising staff may miss any acute bleeding. Record review of the Face Sheet revealed that the facility admitted Resident # 56 to the facility on 1/25/21 with a diagnosis including Long-term (current) use of anticoagulants.	F 757	for residents taking anticoagulants five (5) times a week for 4 weeks, then two (2) times a week for 8 weeks. Any concerns noted by nursing staff are reported to the Director of Nursing (DNS). All findings will be corrected immediately with results being sent to the Executive Director for review and then to the Quality Assurance committee monthly times three (3) starting with the 01/03/24 Quality Assurance meeting.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		1/5/24

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F 758	Continued From page 20 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, record and policy review the facility failed to ensure a resident received behavioral interventions or side effect monitoring with the use of psychotropic medications for one (1) of three (3) residents reviewed. Resident # 56 Findings include: A review of the facility policy titled, "Medication	F 758	On 12/01/23, Resident #56 was assessed by Director of Nursing (DNS) for side effects monitoring and behavioral interventions with the use of psychotropic medications. No ill effects were noted. Any resident who receives a psychotropic medication could be affected. Starting on 12/01/23, Director of Nursing	

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F 758	Continued From page 21 Monitoring" revealed, " ...General Guidelines: 1. The staff and Physician shall strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication ..." A review of the November 2023 electronic Medication Administration Record (eMAR) revealed Resident #56 receives Cymbalta 30 mg (milligrams) one capsule daily for depressive features, Zoloft 25 mg tablet daily, and Abilify 5 mg ½ (one half) tablet daily. No monitoring for behaviors or side effects were observed on the eMAR for the psychotropic medications. An interview with the Director of Nursing (DON) on 11/29/23 at 4:40 PM, revealed she was unable to find documentation for monitoring targeted behaviors and side effects of psychotropic medications. She then revealed when the orders were put in the special requirement for the monitoring was not added so it does not flag on the medication record for the nurses to document. The DON then stated potential concerns with not monitoring for targeted behaviors and side effects of psychotropic medications are the resident could have adverse reactions such as increased drowsiness missed or behaviors may be missed. The DON also stated that the facility cannot justify the continued use of the psychotropic medications without proper documentation. Record review of the Face Sheet revealed that the facility admitted Resident # 56 on 1/25/21 with a diagnosis of Unspecified Dementia, unspecified severity, without behavior/psychosis/mood/anxiety.	F 758	(DNS) and Executive Director (ED) initiated in-servicing of all Social Workers, Licensed Practical Nurses (LPNs), and Registered Nurses (RNs) nursing staff to ensure a resident received behavioral interventions or side effect monitoring with the use of psychotropic medication. This side effect monitoring will be placed on the Medication Administration Record for proof of documented side effect monitoring. Starting on 12/04/23, Director of Nursing (DNS) conducted a 100% audit to ensure residents received behavioral interventions or side effect monitoring with the use of psychotropic medication audit. Beginning on 12/04/23, Assistant Director of Nursing (ADNS) will monitor for medication side effects for residents with behavioral interventions or side effect monitoring with the use of psychotropic medication five (5) times a week for 4 weeks, then two (2) times a week for 8 weeks. Any concerns noted by nursing staff are reported to the Director of Nursing (DNS). All findings will be corrected immediately with results being sent to the Executive Director for review and then to the Quality Assurance committee monthly times three (3) starting with the 01/03/24 Quality Assurance meeting.	

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F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, policy review, and record review, the facility failed to ensure controlled medications were stored in a secure locked container for two (2) of six (6) narcotic storage containers. Findings Include: Review of the facility policy, "Medication Storage" revealed, "Medication supply must be accessible	F 761	On 11/30/23, Director of Nursing (DNS) ensured controlled medications were stored in a secure locked container. No resident ill effects were noted. Any resident who receives controlled medications could be affected. Starting on 12/05/23, Maintenance Director secured the locked controlled	1/5/24

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	255113	A. BUILDING _____ B. WING _____	11/30/2023

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F 761	Continued From page 23 only to licensed nursing personnel, or staff members lawfully authorized to administer medications. All drugs, treatments, and biologicals must be stored securely and following the manufacturer's labeled recommendations, or per facility policy." Observation on 11/28/23 11:03 AM, of the West Wing Nurses Station medication room revealed a medication refrigerator with a red lock box for controlled drugs. The medication box was not locked but was secured to the refrigerator shelf. The box contained 12 single dose vials of Lorazapam and one (1) multidose vial of Lorazapam. The observation was confirmed by Licensed Practical Nurse (LPN) #3 and LPN #4. Neither LPN had a key to lock the box. LPN #3 said the box is never locked but confirmed the medications are counted at shift change. Observation on 11/28/23 11:20 AM, of East Wing Nurses Station medication room with LPN #2 revealed a medication refrigerator with a red controlled medication lock box containing 17 Lorazapam single use vials and 2 multidose vials of Lorazapam. This box was locked but was not secured to the refrigerator. LPN #2 stated the refrigerator controlled medication box had never been secured to the refrigerator since he had worked here. Observation on 11/29/23 at 10:27 AM revealed East Wing controlled medication lock box remained unsecured to the refrigerator and West Wing box remained unlocked. On 11/29/23 01:00 PM, a phone interview with the Pharmacy Consultant revealed the narcotic lock box is located behind two locked doors; the med	F 761	medication storage containers to medication room refrigerators. Beginning on 12/05/23, Executive Director (ED) initiated in-servicing of the Maintenance Director, Licensed Practical Nurses (LPNs), and Registered Nurses (RNs) nursing staff to ensure that there is a secure locked container for two (2) controlled medication storage containers in medication room refrigerators. Starting on 12/04/23, Director of Nursing (DNS) conducted a 100% controlled medication storage containers audit. Assistant Director of Nursing (ADNS) will monitor for a secure locked container for controlled medications storage containers two (2) times a week for 4 weeks, then one (1) time a week for 8 weeks. Any concerns noted by ADNS are reported to the Director of Nursing (DNS). All findings will be corrected immediately with results being sent to the Executive Director for review and then to the Quality Assurance committee monthly times three (3) starting with the 01/03/24 Quality Assurance meeting.	

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F 761	Continued From page 24 room door and the refrigerator door. The pharmacy consultant stated the lock box must be attached to the refrigerator. He was not aware of the box not being attached to the refrigerator on the East Wing. Interview on 11/29/23 01:03 PM with the Administrator, revealed she was unaware of the controlled medication boxes in the medication rooms on West Hall being unlocked or that the controlled medication box was not secured on the East Wing. She stated she was going to take care of the boxes being unlocked and unattached immediately.	F 761		
F 812 SS=E	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:	F 812		1/5/24

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F 812	Continued From page 25 Based on observations, staff interviews, record review, and facility policy review, the facility failed to maintain clean ice machines, as evidenced by observations during the annual survey of two (2) of two (2) unclean ice machines, for 96 of 105 residents in the nursing facility who use ice. Findings Include: Review of the facility policy titled, "Ice Handling and Cleaning," for the Guideline and Procedure Manual ... 2020, revealed "Guideline: Ice will be stored and served to residents in a sanitary manner. Procedure: ... 6. Ice machine will be emptied at least quarterly and thoroughly cleaned with an approved sanitizer to remove any settlement or mineral build-up..." An observation on 11/28/23 at 10:35 AM, of the ice machine in the kitchen, revealed a black buildup that was located on the upper right side of the opening of the ice container under the door to the ice storage bin. An observation and interview on 11/28/23 at 10:38 AM, with the Kitchen Aide #2, revealed her use of a wet white paper towel to wipe over the black buildup that was located on the upper right side of the opening of the ice container under the door to the ice storage bin and the black residue was observed to come off on the paper towel. She confirmed the ice machine was not clean. During an observation of the kitchen ice machine and interview with Maintenance #1 on 11/28/23 at 10:42 AM, he confirmed the black buildup that was located on the upper right side of the opening of the ice container under the door to the ice storage bin. The observation also revealed	F 812	On 11/29/23, Maintenance Director cleaned the two (2) ice machines. No resident ill effects were noted. Any resident who receives ice could be affected. Starting on 12/01/23, Executive Director (ED) initiated in-servicing of the Maintenance Director and Certified Dietary Manager to ensure that there are clean ice machines. Starting on 12/04/23, Certified Dietary Manager (CDM) will be conducted a 100% ice machine audit for evidence of unclean ice machines per cleaning schedule five (5) times a week for 6 weeks, then two (2) times a week for 6 weeks. Any concerns noted by CDM are reported to the Director of Nursing (DNS). All findings will be corrected immediately with results being sent to the Executive Director for review and then to the Quality Assurance committee momthly times three (3) starting with the 01/03/24 Quality Assurance meeting.	

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F 812	Continued From page 26	F 812		

there was black mucus consistency buildup inside the top of the ice machine, that was observed on the bottom of the white side cover panel located over the right side of the door of the ice bin. Also, the observation revealed black and yellow buildup on the white panel that covered the element of the ice machine that freezes the ice cubes, black mucus consistency buildup that covered the white panel above the ice freezing element and the water that ran through the ice machine was observed to flow over the black mucus consistency buildup, and flowed down over the ice freezing element. The outer edges of the white plastic case that surrounded the ice freezing element were observed to have a black mucus consistency buildup. He confirmed the ice machine needed to be cleaned, revealed he was aware there was buildup collecting in the ice machine at a faster pace, and had changed his schedule to clean the ice machine every three (3)months. He revealed he was originally cleaning the ice machine every 6 months. Maintenance #1 noted he would complete a task check off in the computer, for each ice machine, and was not able to document cleaning details. State Agency and Maintenance #1 completed a second observation of the ice machine located in the East Wing nurse's station. Maintenance #1 revealed he cleaned the East Wing ice machine three (3) weeks prior to survey, because it was broken. There was black residue observed in the top/inside of the machine located on the top and bottom white plastic case that surrounded the ice making element of the ice machine. The observation revealed that the water flowed over the black residue at the bottom of the white plastic case. Maintenance #1 confirmed there was black residue observed in the top/inside of the machine located on the top and bottom white

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F 812	Continued From page 27	F 812		

plastic case that surrounded the ice making element of the ice machine. The observation revealed that the water flowed over the black residue at the bottom of the white plastic case. He confirmed that he did not completely clean the East Wing ice machine.

An observation and interview on 11/28/23 at 10:51 AM with the Administrator confirmed the black buildup that was located on the upper right side of the opening of the kitchen ice container under the door to the ice storage bin. She also confirmed there was black mucus consistency buildup inside the top of the kitchen ice machine, that was observed on the bottom of the white side cover panel located over the right side of the door of the ice bin. The Administrator further confirmed the observation of the black and yellow buildup on the white panel that covered the element of the kitchen ice machine that freezes the ice cubes, confirmed the observation of the black mucus consistency buildup that covered the white panel above the ice freezing element and the water that ran through the kitchen ice machine was observed to flow over the black mucus consistency buildup, and flowed down over the ice freezing element. The Administrator also confirmed the outer edges of the white plastic case that surrounded the ice freezing element, of the kitchen ice machine, had a black mucus consistency buildup. She further confirmed there was black residue in the top/inside of the East Wing ice machine located on the top and bottom white plastic case that surrounded the ice making element of the East Wing ice machine and confirmed that the water flowed over the black residue at the bottom of the white plastic case. The Administrator confirmed that Maintenance #1 was not adequately cleaning the ice machines

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F 812	Continued From page 28 and there was a possibility of sickness for the residents due to drinking fluids off the ice that was made in the unclean ice machines. Record review of the "Work History Report," revealed " The record review revealed there was one (1) ice machine cleaning task completed in the months of October 2023, August 2023, and July 2023. The record review did not reveal which ice machine was cleaned.	F 812		